

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/30/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175229	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PARKWAY OPERATOR LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 749 BLAKE STREET EDWARDSVILLE, KS 66111		
(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 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation # 175644.	F 000			
F 550 SS=D	The 2567 was sent electronically on 11/30/22. 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. §483.10(b)(1) The facility must ensure that the	F 550			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

11/30/2022

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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F 550	Continued From page 1 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 40 residents. The sample included 12 residents with one reviewed for dignity. Based on observation, interviews, and record review, the facility failed to treat Resident (R) 31 with respect and dignity and care for him in a manner that promoted quality of life. This placed the resident at risk for impaired dignity. Findings included: - R31's Electronic Medical Record (EMR) revealed a diagnosis of chronic kidney disease (inability to filter waste from the body), and urinary retention (difficulty urinating and completely emptying the bladder). R31's quarterly "Minimum Data Set" (MDS), dated 09/28/22, recorded the resident had intact cognition. The MDS recorded the resident required an indwelling urinary catheter (a tube inserted into the bladder to drain urine). The "Urinary Catheter" care plan dated 09/28/22, directed the staff to position the urinary catheter bag and tubing below the level of the bladder and away from the door entrance.	F 550			

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F 550	Continued From page 2 On 11/17/22 at 09:20AM, observation revealed R31 laid in bed on his back. Further observation revealed a urinary catheter bag hanging on the side of the bed uncovered with urine visible from hall/doorway. On 11/21/22 at 09:45AM, observation revealed R31 laid in bed on his back. Further observation revealed an uncovered urinary catheter bag with urine in it hanging on the side of the bed visible from the doorway. On 11/21/22 at 10:15AM, Administrative Nurse D verified the uncovered urinary catheter bag. Administrative Nurse D stated the urinary catheter bag should be stored in a covered bag. The facility's "Resident Rights" policy, dated May 2022, stated the facility staff are to provide care for each resident to promote and maintain resident dignity and respect. The facility failed to provide dignity for R31, placing the resident at risk for impaired dignity.	F 550			
F 637 SS=D	Comprehensive Assessment After Significant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and	F 637			

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F 637	Continued From page 3 requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: The facility had a census of 40 residents. The sample included 12 residents with two reviewed for pressure ulcers (localized injury to skin and/or underlying tissue as a result of pressure, or pressure in combination with shear and/or friction). Based on record review and interview, the facility failed to complete a significant change assessment after the development of an unstageable pressure ulcer for one of two sampled residents, Resident (R) 40. This placed the resident at risk to have an inaccurate assessment of his health status. Findings included: - The "Physician Order Sheet," dated 11/02/22, recorded R40 had diagnoses of cerebrovascular accident (CVA) (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain), diabetes mellitus (when the body cannot use glucose, not enough insulin made, or body cannot respond to insulin) and hemiplegia (paralysis of one side of the body) The "Quarterly Minimum Data Set" (MDS), dated 11/08/22, recorded R40 had a Brief Interview for Mental Status (BIMS) score of zero (severely impaired cognition) with physical behaviors and rejection of cares. The MDS recorded R40 required total staff assistance with bed mobility, transfers, had an unstageable pressure ulcer (wound bed obscured slough [dead tissue usually cream or yellow in color] or eschar (dead tissue) and Moisture Associated Skin Damage (MASD).	F 637			

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F 637	Continued From page 4 The "Pressure Ulcer Care Plan," dated 11/08/22, recorded R40 at risk for skin issues due to limited mobility, diabetic disease process, non-compliance with cares and a history of skin breakdown. The "Pressure Ulcer Care Plan" directed staff to provide R40 treatments and preventive interventions for wounds as ordered by the physician and to monitor for wound changes weekly. The "Physician Progress Note," dated 10/26/22, recorded R40 had an unstageable pressure ulcer on the right buttocks. The "Physician Progress Note," recorded the wound clinic continued to provide cares and treatment. The "Wound Care Center Progress Note," dated 10/31/22, recorded R40 had right buttock unstageable pressure ulcer with odorous serosanguinous drainage (semi-thick reddish drainage). On 11/22/22 at 10:17 AM, Administrative Nurse D stated staff should have completed a significant change assessment for R40, who developed an unstageable pressure ulcer. The "Comprehensive Assessment Policy," dated August 2022, recorded a significant change was defined as a condition that will not resolve itself without physician and staff intervention, and requires interdisciplinary review and care plan revisions. The "Comprehensive Assessment Policy" directed staff to complete a significant change MDS assessment within 14 days of a significant change in the resident's condition. The facility failed to complete a significant change assessment after R40 developed of an	F 637			

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F 637	Continued From page 5 unstageable pressure ulcer, placing the resident at risk to have an inaccurate assessment of his health status	F 637			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: The facility had a census of 40 residents. The sample included 12 residents with two reviewed for diabetic ulcers (open wound caused by neuropathy (weakness, numbness, and pain from nerve damage) and/or poor blood circulation). Based on record review and interview, the facility failed to provide heel protectors (medical device used to offload pressure from the heel and foot to wounds and pressure ulcers) as ordered by the wound clinic for one of two sampled residents, Resident (R) 40. This placed the resident at risk to worsen his current diabetic ulcer or develop more skin issues. Findings included: - The "Physician Order Sheet," dated 11/02/22, recorded R40 had diagnoses of cerebrovascular accident (CVA - (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain), diabetes mellitus (when the body	F 684			

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F 684	Continued From page 6 cannot use glucose, not enough insulin made, or body cannot respond to insulin) and hemiplegia (paralysis of one side of the body) The "Quarterly Minimum Data Set" (MDS), dated 11/08/22, recorded R40 had a Brief Interview for Mental Status (BIMS) score of zero (severely impaired cognition) with physical behaviors and rejection of cares. The MDS recorded R40 required total staff assistance with bed mobility, transfers, had an unstageable pressure ulcer (wound bed obscured slough (dead tissue usually cream or yellow in color) or eschar (dead tissue) and Moisture Associated Skin Damage (MASD). The "Pressure Ulcer Care Plan," dated 11/08/22, recorded R40 at risk for skin issues due to limited mobility, diabetic disease process, non-compliance with cares and a history of skin breakdown. The "Pressure Ulcer Care Plan" directed staff to provide R40 treatments and preventive interventions for wounds as ordered by the physician. The "Pressure Ulcer Care Plan" lacked documentation staff provided R40 heel protectors at all times as recommended by the wound clinic. The "Physician Order," dated 10/31/22, directed staff to apply Betadine (topical medication that provide infection protection) and a foam dressing to R40's left heel every Monday, Wednesday, and Friday. The "Wound Care Center Progress Note," dated 11/14/22, recorded R40's left posterior heel diabetic ulcer was debrided and directed staff to ensure R40 had heel protectors on all times. The "Physician Progress Note," dated 11/16/22,	F 684			

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F 684	Continued From page 7 directed staff to send R40 to the hospital for a coccyx wound infection related to possible osteomyelitis (local or generalized infection of the bone or bone marrow). Review of R40's medical record lacked documentation of R40's wound clinic ordered heel protectors on 11/22/22 (8 days after the wound clinic order). On 11/22/22 at 10:17 AM, Administrative Nurse D stated staff should have documented and followed the wound clinic recommendation for R40 to wear heel protectors at all times. The "Skin/Wound Care" policy, dated 07/14/22, directed staff to implement preventative measures to help protect and heal existing wounds, and this included heel protectors/pressure relief boots. The facility failed to provide heel protectors as ordered by the wound clinic for R40, placing the resident at risk to worsen his current diabetic ulcer or develop more skin issues.	F 684			
F 689 SS=D	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:	F 689			

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F 689	Continued From page 8 The facility had a census of 40 residents. The sample included 12 residents with three reviewed for accident hazards. Based on observation, record review and interview, the facility used side rails without a safety assessment or accident hazard care plan for one of three sampled residents, Residents (R) 36. This placed the resident at risk for entrapment and falls. Findings included: - The "Physician Order Sheet, " dated 11/02/22, recorded R36 had diagnoses of dementia (persistent mental disorder marked by memory loss and impair reasoning), multiple sclerosis (progressive disease of the nerve fibers of the brain and spinal cord), paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), muscle weakness and lack of coordination. The "Annual Minimum Data Set" (MDS), dated 09/21/22, recorded R36 had a Brief Interview for Mental Status (BIMS) score of three (severely impaired cognition). The MDS recorded R36 required total staff assistance with bed mobility and transfers, impaired balance that required staff assistance to stabilize, and limited range of motion in the extremities on one side of the body. The MDS further recorded R36 was a fall risk and had a recent minor injury fall. The "Accident Hazard and Fall Care Plan," dated 10/20/22, recorded R36 was assessed a high risk for falls due to confusion, poor safety awareness, impaired balance, limited mobility, and a history of falls. The "Accident Hazard and Fall Care Plan" recorded R36 required extensive staff assistance to reposition in bed and transfer and directed staff	F 689			

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F 689	Continued From page 9 not to leave the resident unattended in the wheelchair due to her involuntary movements. R36's "Accident Hazard and Fall Care Plan" lacked documentation for the use of side rails. The "Side Rail Evaluation," dated 06/04/22, recorded R36 was a high risk for falls, and lacked assessment documentation for R36's safe use of side rails. The "Fall Assessment," dated 09/23/22, recorded R36 was a high risk for falls due to cognitive impairment, limited mobility, confined to bed or wheelchair and a recent fall from her wheelchair on 09/19/22. On 11/17/22 at 01:21 PM, observation revealed the resident resting quietly in bed with side rails raised on both sides of the bed. Continued observation revealed R36 had scooted toward the foot of the bed, her left arm dangled over the side of the bed and a blanket was wrapped around one of the resident's legs. Continued observation revealed the side rails had gaps R36 could easily pass her extremities through. On 11/21/22 at 11:06 AM, Licensed Nurse (LN) G stated R36 was a fall risk due to cognitive impairment and multiple sclerosis, and the resident should not have the side rails raised on her bed. LN G stated R36 spent most of her time in bed and the resident was able to scoot and move in the bed without purpose. On 11/22/22 at 10:07 AM, Administrative Nurse D stated staff should not raise the side rails on R36's bed due to her history of falls and the side rails had gaps that could entrap the resident.	F 689			

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F 689	Continued From page 10 The facility's "Side Rail" policy, dated 08/01/21, directed staff to complete routine side rail assessments to ensure the resident's need, appropriateness, and safety for the use of side rails. The facility used side rails without a safety assessment or accident hazard care plan for R36, placing the resident at risk for entrapment and falls.	F 689			
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: The facility had a census of 40 residents. The	F 700			

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F 700	Continued From page 11 sample included 12 residents with three reviewed for accident hazards. Based on observation, record review and interview, the facility failed to complete an assessment for the safe use of side rails the three sampled residents, Residents (R) 16, 25, 36. This placed the residents at risk for entrapment and injuries. Findings included: - The "Physician Order Sheet, " dated 05/03/22, recorded R16 had diagnoses of dementia (persistent mental disorder marked by memory loss and impair reasoning), diabetes mellitus (the body cannot use glucose, not enough insulin made, or body cannot respond to the insulin), and chronic kidney disease (kidneys unable to filter waste from the blood), and muscle weakness. The "Quarterly Minimum Data Set" (MDS), dated 10/18/22, recorded R16 had a Brief Interview for Mental Status (BIMS) score of nine (moderately impaired cognition). The MDS recorded R16 required total staff assistance with bed mobility and transfers, had impaired balance that required staff assistance to stabilize, and limited range of motion in all his extremities. The "Activities of Daily Living (ADLs) Care Plan," dated 11/08/22, recorded R16 spent most of his time in bed and required extensive to total staff assistance with bed mobility and transfers. The "ADL Care Plan" lacked documentation for the use of side rails on the resident's bed. The "Fall Assessment," dated 01/08/22, recorded R16 had no history of falls but was a high fall risk due to cognitive impairment, limited mobility, and confined to bed and chair.	F 700			

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F 700	Continued From page 12 The "Side Rail Evaluation," dated 03/23/22, recorded R16 used partial side rails on both sides of the bed but lacked assessment documentation for R16's functionality and safe use of side rails. On 11/21/22 at 09:43 AM, observation revealed R16 rested in bed with the head of the bed elevated and side rails raised on both sides of the bed. Continued observation revealed the side rails had gaps R16 could easily pass his extremities through. On 11/21/22 at 11:06 AM, Licensed Nurse (LN) G stated R16 spent most his time in bed and had side rails raised to prevent falls. LN G stated R16 required extensive staff assistance for bed mobility and transfers, and was a fall risk due to muscle weakness and limited mobility. On 11/22/22 at 10:07 AM, Administrative Nurse D stated staff should complete the side rail assessment to ensure R16's function and safety were appropriate for the use of side rails. The facility's "Side Rail" policy, dated 08/01/21, directed staff to complete routine side rail assessments to ensure the resident's need, appropriateness, and safety for the use of side rails. The facility failed to complete an assessment for the safe use of side rails for R16, placing the resident at risk for entrapment and injuries. - The "Physician Order Sheet, " dated 05/03/22, recorded R25 had diagnoses of Cerebrovascular Accident (CVA) (sudden death of brain cells due to a lack of oxygen caused by impaired blood flow	F 700			

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F 700	Continued From page 13 to the brain) and persistent vegetative state (state of wakefulness accompanied by a complete lack of cognitive function). The "Quarterly Minimum Data Set" (MDS), dated 22, recorded R25 was in a persistent vegetative state with no discernible consciousness and required total staff assistance with bed mobility and transfers. The "Activities of Daily Living (ADLs) Care Plan," dated 09/11/22, recorded R25 used side rails and was at risk for entrapment and injury. The "ADLs Care Plan" directed staff to provide total assistance for R25's bed mobility, turn and reposition the resident frequently and provide frequent checks when R25 is in bed. The "Side Rail Evaluation," dated 10/06/22, recorded R25 used partial side rails on both sides of the bed but lacked assessment documentation for R25's functionality and safe use of side rails. The "Side Rail Evaluation," dated 11/01/22, recorded R25 used partial side rails on both side of the bed but lacked documentation of any resident assessment. On 11/21/22 at 02:40 PM, observation revealed R25 rested in bed positioned with pillows for support and comfort, and side rails raised on both sides of the bed. Continued observation revealed the side rails had gaps R25 could pass his extremities through. On 11/21/22 at 11:06 AM, Licensed Nurse (LN) G stated R25 spent most his time in bed and had side rails raised to prevent falls. LN G stated R25 was in a total vegetative state, required total staff	F 700			

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F 700	Continued From page 14 assistance for bed mobility and transfers and was a fall risk. On 11/22/22 at 10:07 AM, Administrative Nurse D stated staff should complete the side rail assessment to ensure R25's function and safety were appropriate for the use of side rails. The facility's "Side Rail" policy, dated 08/01/21, directed staff to complete routine side rail assessments to ensure the resident's need, appropriateness, and safety for the use of side rails. The facility failed to complete an assessment for the safe use of side rails for R25, placing the resident at risk for entrapment and injuries. - The "Physician Order Sheet, " dated 11/02/22, recorded R36 had diagnoses of dementia (persistent mental disorder marked by memory loss and impair reasoning), multiple sclerosis (progressive disease of the nerve fibers of the brain and spinal cord), paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), muscle weakness and lack of coordination. The "Annual Minimum Data Set" (MDS), dated 09/21/22, recorded R36 had a Brief Interview for Mental Status (BIMS) score of three (severely impaired cognition). The MDS recorded R36 required total staff assistance with bed mobility and transfers, impaired balance that required staff assistance to stabilize, and limited range of motion in the extremities on one side of the body. The MDS further recorded R36 was a fall risk and had a recent minor injury fall.	F 700			

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F 700	Continued From page 15 The "Accident Hazard and Fall Care Plan," dated 10/20/22, recorded R36 was assessed a high risk for falls due to confusion, poor safety awareness, impaired balance, limited mobility, and a history of falls. The "Accident Hazard and Fall Care Plan" recorded R36 required extensive staff assistance to reposition in bed and transfer and directed staff not to leave the resident unattended in the wheelchair due to her involuntary movements. R36's "Accident Hazard and Fall Care Plan" lacked documentation for the use of side rails. The "Side Rail Evaluation," dated 06/04/22, recorded R36 was a high risk for falls, and lacked assessment documentation for R36's safe use of side rails. The "Fall Assessment," dated 09/23/22, recorded R36 was a high risk for falls due to cognitive impairment, limited mobility, confined to bed or wheelchair and a recent fall from her wheelchair on 09/19/22. On 11/17/22 at 01:21 PM, observation revealed the resident resting quietly in bed with side rails raised on both sides of the bed. Continued observation revealed R36 had scooted toward the foot of the bed, her left arm dangled over the side of the bed and a blanket was wrapped around one of the resident's legs. Continued observation revealed the side rails had gaps R36 could easily pass her extremities through. On 11/21/22 at 11:06 AM, Licensed Nurse (LN) G stated R36 was a fall risk due to cognitive impairment and multiple sclerosis, and the resident should not have the side rails raised on her bed. LN G stated R36 spent most of her time in bed and the resident was able to scoot and	F 700			

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F 700	Continued From page 16 move in the bed without purpose. On 11/22/22 at 10:07 AM, Administrative Nurse D stated staff should complete the side rail assessment to ensure R36's function and safety were appropriate for the use of side rails. The facility's "Side Rail" policy, dated 08/01/21, directed staff to complete routine side rail assessments to ensure the resident's need, appropriateness, and safety for the use of side rails. The facility failed to complete an assessment for the safe use of side rails for R36, placing the resident at risk for entrapment and injuries.	F 700			
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 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	F 849			

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F 849	Continued From page 17 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	F 849			

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F 849	Continued From page 18 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(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	F 849			

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F 849	Continued From page 19 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 849			

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F 849	Continued From page 20 (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 40 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to develop a comprehensive plan of care which included collaboration with the hospice provider for Resident (R) 39 who received hospice services. This placed the resident at risk for inappropriate end of life care. Findings included: - R39's electronic medical record (EMR) documented diagnosis of emphysema (a condition in which the air sacs of the lungs are damaged and enlarged, causing trouble breathing). The "Significant Change Minimum Data Set" (MDS), dated 10/18/22, recorded the resident had	F 849			

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F 849	Continued From page 21 moderately impaired cognition. The MDS further indicated the resident required extensive one staff assistance with bed mobility, and transfers. The MDS documented R39 received hospice services. The "Physician's Order, dated 11/08/22. directed the staff to provide hospice services for the resident. Review of R39's medical record revealed the comprehensive care plan lacked direction for staff regarding hospice services provided. R39's clinical record lacked evidence of coordination of care which identified the resident's diagnosis, a common problem list, palliative interventions, palliative goals/objectives, responsible disciplines, responsible providers and/or the resident's end of life choices regarding care and goals. On 11/21/22 at 08:30AM, observation revealed R39 in bed, on his left side. On 11/22/22 at 10:00AM, Administrative Nurse D verified the facility lacked a comprehensive hospice care plan. The facility's "Hospice Program", policy dated 06/2021, documented a written comprehensive care plan would be established and maintained, to identify hospice needs, and services provided by the hospice. Hospice will be responsible for the professional management and the coordination of the care plan with input from the facility. The facility failed to develop a comprehensive hospice plan of care which included collaboration with the hospice provider for R39, who received	F 849			

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F 849	Continued From page 22 hospice services, placing him at risk for inappropriate end of life care.	F 849			