STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175553	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Moundridge Manor	710 N Christian Avenue Moundridge, KS 67107

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 71 residents. The sample included 18 residents, with 12 reviewed for accidents. Based on observation, record review, and interview, the facility failed to provide adequate supervision to ensure a safe environment for Resident (R) 10, after a fall while outside alone. As a result, R10 had a second fall while outside alone resulting in abrasions and a laceration (cut) to his right palm (the underside of the hand), that required sutures (stitches) as well as right rib fractures. The facility also failed to evaluate R17 for his ability to safely handle hot liquids to identify risk and implement interventions and education to prevent accidents. Subsequently, R17 spilled his coffee and sustained multiple burns including a second-degree burn (potentially painful burn that affects the first and second layer of the skin). These failures also placed the residents at risk for increased pain. Findings included: - The Electronic Medical Record (EMR) for R10 documented diagnoses of dementia with behavioral disturbance (a progressive mental disorder characterized by failing memory and confusion), hemiplegia/hemiparesis (weakness and paralysis on one side of the body) affecting the right dominant side, Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). The Annual Minimum Data Set (MDS), dated [DATE], documented R10 had intact cognition. R10 was independent with all activities of daily living (ADLs) and had no functional impairment. The MDS recorded R10 had one fall with injury since his prior assessment. The Quarterly MDS dated 07/17/24, documented R10 had intact cognition. R10 required substantial assistance with personal hygiene, supervision with dressing, and partial assistance with ambulation. R10 was independent with toileting and mobility and had no functional impairment. The MDS recorded R10 had one fall since his prior assessment. R10's Fall Assessment, dated 04/17/24 and 07/17/24 documented R10 was at high risk for falls. R10's Care Plan updated 04/18/24, documented R10 maintained functional range of motion through his ADLs including going outside per wheelchair to care for his garden when in season. The plan directed R10 transferred himself, and independently ambulated short distances in his room. The update dated 07/11/24 directed staff to do visual checks on R10 every 30 minutes if he was outside during the day and especially at night. The plan documented the resident had a call light pendent to use when (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175553	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER Moundridge Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 710 N Christian Avenue Moundridge, KS 67107	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	going outdoors on the patio.

The Fall Investigation, dated 04/15/24 at 08:56 AM, documented R10 self-propelled himself outside in his wheelchair heading to the facility's chicken [NAME] and was going too fast which caused him to fall forward onto his knees. The investigation further documented R10 sustained abrasions (scrapes) to his left knee which measured 1.5 centimeters (cm) by 1.5 cm, and to his right knee which measured 3 cm by 6 cm. Nursing staff assisted R10 to his wheelchair and took him to his room. The investigation documented R10 was alert with cognitive loss and had poor safety awareness and R10 voiced understanding of the need to go slower down the pathway to the chickens and was able to go up and down the sidewalk in his wheelchair safely. Staff were directed to gently guide R10 when he was observed being unsafe as he would often become angry when he felt staff told him what to do. Staff notified R10's physician and family of the fall.

The Nurse's Note, dated 04/18/24 at 11:59 AM, documented R10 had right and left knee abrasions. The abrasions were covered with Telfa (a nonstick bandage) and secured with tape. The areas had a small amount of serosanguineous (semi-thick blood-tinged drainage) drainage but had no odor or redness around the wounds.

The Nurse's Note, dated 04/18/24 at 11:59 AM, documented R10 had right and left knee abrasions. The abrasions were covered with Telfa (a nonstick bandage) and secured with tape. The areas had a small amount of serosanguineous (semi-thick blood-tinged drainage) drainage but had no odor or redness around the wounds.

The Nurse's Note, dated 06/28/24 at 09:11 AM documented the nurse was notified by maintenance staff that R10 was lying on the ground. The nurse observed R10 lying still on his back near the chickens next to his wheelchair. The nurse along with multiple other staff ran to assist the resident. Staff called R10's name and he raised his head and stated yes? There was a large amount of blood noted on the sidewalk, and the resident's hands and clothing. R10's phone was on the ground next to him. Upon assessment the nurse noted a deep laceration across the palm of R10's right hand. The staff assisted R10 into his wheelchair. The resident denied hitting his head, but neurological evaluations were initiated anyway due to the resident was confused at times.

The Fall Investigation, dated 06/28/24 at 07:59 AM, documented R10 reported he self-propelled outside to see the chickens when one of his wheels went off the sidewalk which caused him to fall out of his wheelchair. R10 sustained a deep, seven-inch laceration (cut) to his right palm, and pressure was applied. R10 stated he was going too fast when he went down the slight incline of the sidewalk by the chicken [NAME] and he veered off the sidewalk. Staff assisted R10 into his wheelchair and sent him to the hospital for an X-ray (a type of electromagnetic radiation that can pass through most objects to create images of its internal structure) and sutures for his hand. The investigation documented that maintenance would paint caution signs on the sidewalk at the slight incline to serve as a warning for R10 to take precautions when the wheelchair went down the incline or when someone walked on the sidewalk.

The X-ray Report, dated 06/28/24, documented there was no fracture of the right hand but documented R10 had multiple chronic right rib fractures.

The Physician's Order, dated 06/28/24, directed staff to administer hydrocodone (for moderately severe pain), 5-325 milligrams (mg), one tablet, every four hours for pain.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Moundridge Manor	710 N Christian Avenue Moundridge, KS 67107

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Nurse's Note, dated 06/29/24, documented R10's right hand was redressed with gauze, Telfa, and a non-stick bandage. The note recorded all 12 sutures were intact, and a moderate amount of bright red blood had seeped through. R10 had hydrocodone twice during the shift for rib and hand pain. The Nurse's Note, dated 06/30/24, documented R10's sutures were intact, and the edges were approximated (to place or bring closer) though his hand was swollen and oozing serosanguinous fluid. On 09/24/24 at 01:05 PM, observation revealed R10 in his wheelchair outside by the chicken [NAME]. The sidewalk by the chicken [NAME] had two yellow painted lines, one at the beginning of the slight incline and one after the incline. R10 propelled himself backward on the sidewalk around the corner to get to the patio. R10 continued to propel himself backward until he got right in front of the entrance door to his household. R10 continued to sit there and watch the chickens. Observation revealed there was no call light pendant visible on R10. On 09/24/24 at 01:00 PM, Certified Nurse Aide (CNA) N stated R10 often went outside to check on the chickens and said the resident was supposed to have a call light pendant with him when he went outside. CNA N then went outside to check R10 and came back and confirmed R10 did not have the pendant all light with him. On 09/24/24 at 01:10 PM, Licensed Nurse (LN) H stated there was always a pendent call light hanging at the entrance of the door to the household for any resident to use to come back inside. When asked how residents call for assistance when they are outside, away from the entrance, and fall if they do not have a call pendant with them, LN H responded That's a good question. On 09/25/24 at 09:00 AM, Administrative Nurse E said staff were to visualize R10 every 30 minutes when the resident was outside. Administrative Nurse E further stated R10 did know the code to get outside, and a pendant call light hung by the door outside so R10 could call for staff to help him back inside once he was outside. On 09/25/24 at 09:49 AM, Administrative Nurse E stated the facility had provided R10 a pendant call light to wear when he was outside and R10 was not happy about it, but agreed to wear it when he was outside. On 09/25/24 at 11:46 AM, Administrative Nurse D stated when R10 fell while he outside alone the first time, staff educated him to slow down when he propelled his wheelchair. Administrative Nurse D verified this was the only intervention implemented after the first non-injury fall outside. Administrative Nurse D said when R10 fell outside again, the staff painted yellow stripes on the sidewalk so he would know when the incline began and ended. Administrative Nurse D stated there was a pendant call light at the door for R10 to use to call staff to let him back into the building. Administrative Nurse D further stated R10 did not always tell staff when he went outside but when the door was opened it alerted to the staffs' radios. Administrative Nurse D said the 30-minute checks were not initially one of the fall interventions until they discussed it and decided to implement it. Administrative Nurse D verified R10 had not been educated on the risks should he decide to not use the pendant call light when he was outside, but stated he would discuss the risks with him and document the conversation in the medical record. The facility's Resident Falls/Accidents policy dated, 07/15, documented that a fall risk assessment would be completed within 7 days of admission and would be reviewed at least every 90 days. A licensed Charge Nurse would investigate each fall, and a review or update in the plan of care would be (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Moundridge Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 710 N Christian Avenue Moundridge, KS 67107	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	implemented, all falls would be reviewed weekly by involved staff, and would review interventions, modify interventions, and evaluate the outcomes. The facility failed to provide adequate safety interventions and supervision for R10 in order to promote a safe environment free from accident hazards after R10 had a fall while outside. As a result, R10 had a second fall while outside which resulted in a palm laceration that required sutures as well as identification of multiple right rib fractures. This also placed the resident at risk for increased pain and decreased mobility. - The Electronic Medical Record (EMR) for R17 documented diagnoses of hemiplegia/hemiparesis (weakness and paralysis on one side of the body) affecting the right dominant side, and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) with nephropathy. The Quarterly Minimum Data Set (MDS), dated [DATE], documented R17 had intact cognition and was dependent upon staff for dressing, personal hygiene, mobility, transfers, and required set-up assistance for eating. R17 had upper and lower functional impairment on one side. The MDS recorded R17 had no skin issues. R17's Care Plan, dated 07/10/24 and initiated on 04/03/24, documented R17 was on a low concentrated sweet, mechanical-soft diet with cut-up meat. Staff were directed to offer R17 his favorite beverage and provide a plate guard at meals. The care plan lacked interventions related to R17's preference to not use a lid or related to R17's ability to manage hot liquids. R17's clinical record lacked evidence the facility assessed R17's ability to safely handle hot liquids. The Physician's Orders, dated 09/03/24, directed staff to administer hydromorphone (used for moderate to severe pain), 4 milligrams (mg), one tablet, by mouth, every 2 hours as needed for pain. The facility Investigation, dated 09/08/24 at 12:29 PM, documented the Certified Nurse Aide (CNA) gave R17 his coffee and walked out of the room. The CNA heard a noise, went back into the room, and noted R17 had spilled his coffee. Staff removed the covers and applied cold compresses to R17's left upper inner thigh and left groin area as both areas were red. R17's left upper thigh had five blisters; one was open, and the area was 17 centimeters (cm) long. Staff called the doctor who ordered a moisture barrier. R17 also had a 19.5 cm red area to his left palm and forearm with a width of 3 cm in the palm that tapered to 0.5 cm on the forearm. R17 had discoloration to his left thumb area of 1.5 cm by 1 cm. The investigation noted that R17 stated he had done it himself. A Physician's Orders, dated 09/08/24, directed staff to apply Z-Guard (topical barrier medication to treat burns), apply to the red and blistered areas on R17's upper leg, every day, for seven days until healed. This was discontinued on 09/09/24. The Investigation Follow Up, dated 09/09/24, documented R17 stated he had taken his coffee in his right hand and was going to put it to his lips when his elbow caught in the halo rail on his bed, and he spilled his coffee. R17 stated he tried to move the blanket away but was unable to get it moved fast enough. The investigation noted that R17 stated he drinks his coffee without a lid and wanted to have his coffee very hot despite the offer to provide cooler coffee. The investigation noted the facility implemented an intervention to place a Chux (an absorbent pad that protects furniture and (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Moundridge Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 710 N Christian Avenue Moundridge, KS 67107	

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F 0689 Level of Harm - Actual harm Residents Affected - Few	bedding from leaks) on R17 to cover his body when he was drinking hot liquid in his room. The resident also agreed to use a lid on his coffee, however, he tended to dribble all over and wondered if there was a sippy cup or something to trial. The investigation documented that the dietary department evaluated the coffee coming out of the pot and it had a temperature of 145-149 degrees Fahrenheit which was not adjusted due to the resident's request for his coffee to remain at that temperature. The staff were directed to use a two-handled cup with a lid that had four tiny holes in it for hot liquids for R17. The Nurse's Notes, dated 09/09/24 at 10:17 AM, documented the facility called for an appointment with the physician for a follow-up on R17's burn. The Nurse's Note, dated 09/09/24 at 10:58 AM, documented that in the past R17 wished to drink his coffee from a cup without a lid but was willing to try a lid on it. The note documented R17 would use a Chux barrier when drinking hot liquids. The Nurse's Note, dated 09/09/24 at 11:00 AM, documented R17's upper left leg was assessed after his bath and had a raw, open area to his inner thigh near the scrotum that measured 3 cm by 3.5 cm, with a small amount of serosanguineous (semi-thick blood-tinged drainage) drainage. The area above it had a T-shaped intact blister which measured 5 cm by 3.5cm, and the surrounding area was difficult to assess as there was Z-Guard ointment on it. The Physician's Order, dated 09/10/24, directed staff to apply Z-Guard to the red and blistered areas on R17's upper leg, daily for seven days, and chart measurements of the wound on Mondays and Thursdays after his bath. This was discontinued on 09/15/24. The Physician's Order, dated 09/11/24, directed staff to apply Silvadene External Cream (topical antimicrobial cream used for the prevention and treatment of second and third-degree burns), apply topically, every 12 hours, as needed for red areas with blisters. The Nurse's Note, dated 09/17/24 at 01:39 PM, documented R17's burn to the inside of his left palm measured 2 cm by 1 cm, and the top of his thumb had a 1 cm scabbed area. The left leg area continued to measure the same and had no drainage, and staff would continue to monitor. On 09/24/24 at 08:15 AM, observation revealed a two-handled cup with a lid on R17's bedside table to the right of him. Continued observation at 08:27 AM, revealed R17 sat in a Broda chair (a special chair with the ability to tilt and recline), his left arm rested on a pillow. Licensed Nurse (LN) G, with a gloved hand, pulled down R17's pants, which revealed a healing, darkened area approximately six inches long and two to three inches wide at the widest part on his left upper thigh. R17 also had a scabbed area on his thumb that covered the entire area on the outer portion of his thigh. R17 stated he had been in his bed and went to reach for his coffee from the bedside table and his elbow hit the halo rail which caused his coffee to spill. R17 stated it was his fault, not the facility's and he had removed the lid. R17 stated he liked his coffee very hot and did not like to have a lid on his cup. On 09/24/24 at 08:30 AM, LN G stated R17 liked to remove the lid from his coffee cup but stated he would not remove the lids anymore since he was burned and has started to use cups with lids. On 09/24/24 at 01:10 PM, CNA M stated R17 always removed the lid from his cups but since he was burned, he used a cup with a lid and a barrier on his lap. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 09/24/24 at 03:15 PM, Administrative Nurse F stated R17's Care Plan had not been updated yet, but staff were provided communication cards that informed them to use cups with lids and to use the Chux for R17. Administrative Nurse F said the facility's policy was that the communication cards were part of the resident's medical record and at that time did not know when the care plan would be updated with interventions to prevent further injury or burns. Administrative Nurse F verified the facility did not assess any residents for safe abilities to handle hot liquids. On 09/24/24 at 03:20 PM, Administrative Nurse D stated that the facility had not documented the risks of R17 drinking hot coffee without the lid because R17 was capable of drinking without spilling. Administrative Nurse D said the event was an accident and the coffee would have spilled even if a lid was on the cup. Administrative Nurse D further stated Dietary BB stated when R17's coffee was brought to him, there was a lid on it strictly for transport from the kitchen to the room but R17 would remove the lid because he liked to drink without a lid getting in the way. Administrative Nurse D stated R17 liked his coffee very hot and the coffee from the pot was temped at 145-149 degrees Fahrenheit after the incident. Administrative Nurse D stated R17 wanted to continue to receive very hot coffee but the facility had not discussed and documented any risks or hazards of injury should he remove the lid from the coffee cup and spill it on himself. Administrative Nurse D stated R17 was cognitively intact and was capable of knowing that he could spill the coffee therefore staff did not feel it was necessary to discuss identify risks and implement anything or educate R17; the resident would know it was a possibility if he removed the lid. The facility's Resident Falls/Accidents policy, dated 07/15, documented the facility provides a safe environment and monitors, evaluates, and modifies interventions. A licensed Charge Nurse would investigate each fall or accident, and a review or update in the plan of care would be implemented, all falls, and accidents would be reviewed weekly by involved staff, and would review interventions, modify interventions, and evaluate the outcomes. The facility failed to assess R17's ability to handle hot liquids to identity risks and implement safety intervention including education for the resident regarding potential hazards. As a result, R17 spilled his coffee and sustained second degree burns. This also placed R17 at risk for increased pain.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. The facility had a census of 71 residents. The sample included 18 residents. Seven residents received ground meat. Based on observation, record review, and interview, the facility failed to serve palatable food during the noon meal for two of the residents in the facility who received ground meat from the facility kitchen. This placed the residents at risk for foodborne illness and decreased quality of life. Findings included: - The 09/24/24 lunch menu recorded hamburgers, baked beans, potato chips, and ice cream. On 09/24/24 at 11:50 AM, observation during the noon meal revealed seven portions of ground hamburger placed on the steam table to be served. Further observation revealed Dietary CC scooped out a portion of the ground hamburger, placed it on the bun, and scooped out a portion of baked beans on the same plate. Further observation revealed another dietary aide placed lettuce, tomato, and onion on the plate and sat it at the kitchen window to be served. Observation revealed Dietary CC did this again for another resident. Observation revealed Dietary CC had not checked the ground meat temperature after she had taken it out of the oven. When asked, Dietary CC stated she would assess the temperature if the surveyor wanted her to. Continued observation revealed Dietary CC took a thermometer, placed it into the ground meat, and then started to scoop out another portion of the ground hamburger. Upon further question regarding the temperature Dietary CC stated the temperature of the ground hamburgers was 132 degrees Fahrenheit. When asked what the correct holding/serving temperature for the meat is, Dietary CC stated, I don't know, should I heat it in the microwave? Dietary CC then requested assistance from the Certified Dietary Manager (CDM), Dietary BB. Dietary CC returned and stated she should place the ground hamburger in the microwave, as it needed to be heated to 165 degrees Fahrenheit. Dietary CC placed the meat in the microwave, and it took two attempts at reheating to get the meat up to a servable temperature. On 09/24/24 at 12:15 PM, Dietary BB stated the ground hamburger meat should not have been served if it was not at the appropriate temperature. The facility's Food Temperatures policy, dated 11/2017, documented that all hot food items must be cooked to appropriate internal temperatures and held until serving at a temperature of 140 degrees or above. A thermometer must be used to check the internal temperature of foods. Temperatures are taken at the beginning and in the middle of serving to ensure hot foods stay above 140 degrees and cold foods stay below 41 degrees during the holding and plating process. The facility failed to ensure the holding temperature of ground meat was at or above 140 degrees, to ensure appropriate palatability as well as inhibit the growth of bacteria. This placed the residents at risk for foodborne illness and decreased quality of life.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 71 residents. The sample included 18 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 facility with the care and services provided by hospice, was developed and available for Resident (R)42. This placed the resident at risk for inappropriate end-of-life care. Findings included: - R42's Electronic Health Record (EHR) revealed diagnoses of malignant neoplasm prostate (cancer, tumor in the gland of the male reproductive system), left ventricular failure (heart failure), and morbid obesity (weight more than 100 pounds over the ideal body weight). R42's Quarterly Change Minimum Data Set (MDS), dated [DATE], recorded R42 had a Brief Interview for Mental Status score of 15 and was cognitively intact. The MDS recorded he required extensive assistance of two staff with bed mobility and transfers and maximal assistance with Activities of Daily Living (ADLs). The MDS documented the resident received hospice services. R42's Care Plan, dated 07/24/24, recorded that R42 required extensive assistance with most activities of daily living (ADL) care. R42's Care Plan documented the resident was admitted to hospice on 01/15/24. The care plan documented GSH but did not document what the abbreviation stood for. The care plan directed the staff to administer the medications ordered and notify the physician if there is breakthrough pain. The care plan lacked instruction on the services provided by hospice visits, supplies and medical equipment provided by hospice, medications covered by hospice, and the hospice provider including their address and phone number. A review of R42's clinical record revealed the resident was admitted to hospice care on 01/15/24. The facility had a plan of care provided by the hospice in a communication book. On 09/24/24 at 02:30 PM, R42 sat in an electric scooter propelling himself throughout the A hall and down the common halls. The resident stopped and visited with staff and other residents. On 09/24/24 at 02:30 PM, Administrative Nurse D verified the facility lacked specific information on the facility care plan that coordinated with the hospice care plan. The Hospice Services policy, dated October 2017, documented the facility would arrange the provision of hospice services through an agreement with one or more Medicare-certified hospices. The facility would ensure that the hospice services would meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of services. The facility would have a timely agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the facility before hospice care is furnished to any resident. The written agreement would set out the services the hospice would provide and determine the hospice's responsibility to determine the appropriate hospice plan of care. The services the facility would continue to provide are based on each resident's plan of care. A communication process, including how the communication would be documented between the facility and the hospice provider, to (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ensure the needs of the resident are addressed and met 24 hours a day. The unit manager would be responsible for working with hospice representatives to coordinate care to the residents provided by facility staff and hospice staff. The unit manager would collaborate with hospice representatives and coordinate facility staff participation in the hospice care planning process. Communicate with hospice representatives and health care providers and ensure quality care for the resident and family. Hospice would provide the most recent plan of care specific to each resident and a provision that hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. The unit manager would be responsible for working with hospice representatives to coordinate care to the residents provided by the facility staff and hospice staff. The unit manager would ensure that each resident's written care plan includes both the most recent hospice care plan and a description of services furnished by the facility to attain the resident's highest practicable physical, mental, and psychosocial well-being. The facility failed to coordinate care between the facility and the hospice provider for R42, who received hospice services. This deficient practice placed him at risk for inappropriate end-of-life care.