STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435073	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda Home of Aberdeen	1224 S High St Aberdeen, SD 57401

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to develop in collaboration with hospice a comprehensive care plan for one of one resident (288) who received oxygen and hospice services. Findings include: 1. Observation and interview on 11/19/24 at 9:42 a.m. with resident 288 in her room revealed: *She was short of breath, spoke softly, and was wearing oxygen nasal cannula tubing (tubing with nasal prongs) on her face. *There was an oxygen concentrator (a device that delivers concentrated oxygen) with a humidifier attached to it. The oxygen flow rate was set at 5 Liters (L) per minute. *A portable oxygen tank was on the back of her wheelchair. 2. Review of resident 288's electronic medical record (EMR) revealed: *Resident 288 had been admitted on [DATE] from home with continued hospice services. *Her diagnoses included malignant neoplasm of unspecified bronchus or lung, chronic obstructive pulmonary disease, chronic kidney disease, and other forms of dyspnea. *There was a physician's order dated 11/7/24 for O2 [oxygen] [with a flow rate of] 1 5L/N/C [liters via nasal cannula] every morning and at bedtime for comfort. 3. Interview on 11/21/24 at 8:40 a.m. with certified nursing assistant I revealed: *She confirmed that resident 288 was receiving hospice services. -She knew how to care for residents receiving hospice services because the nurse reviewed that information with her before each shift. *Her worksheet and the care plan in the provider's EMR also provided information about how much assistance a resident needed for transfers and personal care. *Hospice provided a bath to residents once a week. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*She was unable to locate a hospice care plan for resident 288. 4. Review of resident 288's current care plan revealed: *Focus area: SOB [short of breath] with resting, exertion and laying flat [Resident 288] was admitted on hospice from home. -Intervention: O2 [oxygen] continuously. *Focus area: Resident and family have opted for hospice benefits and comfort care only. -Intervention/Task: Keep family and hospice involved in care planning and decision making as well as updated on any changes in conditions or orders. *The care plan did not include: -The type of oxygen delivery systems used by the resident included continuous oxygen via nasal cannula from an oxygen concentrator with a humidifier, nebulizer treatments, and a portable oxygen concentrator. -The frequency of cleaning and that equipment and changing the oxygen tubing and humidifier. -That resident 288 required assistance administering her nebulizer treatments. -Equipment settings for the prescribed flow rate. -Monitoring of SpO2 (oxygen saturation) levels and/or vital signs, as ordered. -Monitoring for complications associated with the use of oxygen. -Goals integrated from an updated hospice plan of care when the resident moved from her private residence to the facility. -The services and equipment that hospice was providing to the resident. 5. Review of the hospice binder at the north nurse's station regarding resident 288 revealed: *It contained information about which nurse was assigned to resident 288 and instructions for when and how facility staff were to contact hospice. *The hospice plan of care was not located in that binder. *There was no documentation of the resident's oxygen needs or interventions in that binder. 6. Review of resident 288's paper Hospice Plan of Care provided upon request revealed: *It had not been uploaded into resident 288's electronic medical record. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Location Type: Private Residence. *Service Location Home. *Start of care date 09/22/2024. -Resident 288 was admitted to the facility on [DATE]. *Oxygen; 1 ea [each] as directed; Instructions Use 2L/min [liters per minute] via nasal canula [cannula]. *Oxygen; inhalation; gas; 1-5L as needed; Purpose: SOB. *Goal #10: Patient/Caregiver will demonstrate progressive independence in the management of oxygen therapy as evidenced by appropriate adherence to ordered therapy and demonstration of appropriate safety measures by time of discharge. 7. Interview on 11/21/24 at 8:45 a.m. with director of nursing (DON) B revealed: *The services hospice provided to the residents varied from resident to resident based on their hospice diagnosis. -This information would have been found on the resident's care plan. *Minimum Data Set (MDS)/registered nurse (RN) K and infection control RN J were responsible for updating resident facility developed care plans but any nurse can. -The care plan should have been updated when there is any change in the care that a resident received. *Hospice had a separate care plan that was part of the resident's overall care plan. -The hospice care plan was to be uploaded in their EMR system point click care (PCC) when it was completed. -She expected that the hospice care plan would have reflected the care resident 288 was receiving in the facility. -Resident 288's hospice care plan should have been updated when she moved from her private home to the facility. *She confirmed that resident 288's care plan should have included: -Her oxygen needs which included: -The need for assistance completing her nebulizer and the use of the humidifier. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--Resident 288 had been able to self-administer her nebulizer treatments when she came into the facility, but it had been determined that she was no longer able to. -The amount of oxygen she received and the equipment she used. --Hospice provided resident 288 with an oxygen concentrator and she had her own portable oxygen tank. --Hospice provided the oxygen humidifier and nasal cannula tubing for the concentrator and for the portable, however, it was the responsibility of the facility nursing staff to change that oxygen tubing and humidifier. -The frequency of cleaning of the oxygen equipment and changing the oxygen tubing -Resident 288 had been able to self-administer her nebulizer treatments when she came into the facility, but it had been determined that she was no longer able to. Review of the provider's 5/30/23 Oxygen Administration policy revealed: *The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to: -The type of oxygen delivery system. -When to administer, such as continuous or intermittent and/or when to discontinue. -Equipment setting for the prescribed flow rate. -Monitoring of SpO2 (oxygen saturation) levels and/or vital signs, as ordered. -Monitoring for complications associated with the use of oxygen. 8. Review of the provider's April 2019 Comprehensive Care Plan policy revealed: *It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. *The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS [Minimum Data Set] assessment.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review the provider failed to maintain the cleanliness of the oxygen concentrator, tubing, and humidifier and to administer the nebulizer treatment appropriately after determining the resident could not self-administer that treatment for one of one observed sampled resident (288) who received oxygen. Findings include: 1. Observation on 11/19/24 between 8:25 am and 9:02 a.m. with resident 288 in her room revealed: *At 8:25 a.m. registered nurse (RN) F started her nebulizer (neb) machine for the administration of her neb medication treatment and then left the room. -Resident 288 asked the surveyor to return when she completed that nebulizer treatment. *At 8:40 a.m. the nebulizer treatment was running and resident 288 was wearing a neb mask. *At 8:55 a.m. the nebulizer was still running and resident 288 was holding the mask in her hand. *At 9:02 a.m. RN F walked by resident 288's room and into room [ROOM NUMBER]. Resident 288's nebulizer was still running at that time, and her neb mask was on the floor. Observation and interview on 11/19/24 at 9:42 a.m. with resident 288 in her room revealed: *Her breakfast tray was on the table. The individual containers were wrapped in plastic wrap and the fruit cup was unopened. She stated she could not open the fruit cup. I'll just leave it. *She ate in her room by choice. *She was short of breath, spoke softly, and wore oxygen via a nasal cannula. *The oxygen concentrator was stored in the bathroom. -The oxygen concentrator was covered in white dust, and the filter on the back contained visible lint and debris. -The oxygen flow meter was set at five liters. -The oxygen tubing and the humidifier were not labeled or dated. -An oxygen humidifier container with a green top was attached between the concentrator and the tubing. -The humidifier container was dry and contained an unidentified white flaky substance at the bottom. *There was a portable oxygen tank on the back of her wheelchair. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The nasal cannula connected to the portable oxygen was not labeled or dated. 2. Observation and interview with RN F in resident 288's room on 11/19/24 between 9:47 a.m. and 9:56 a.m. revealed: *The concentrator was stored in the bathroom because of the noise it produced and to provide more space in the room. *She stated the oxygen tubing and humidifiers were changed once a week on Wednesday as ordered on the treatment administration record (TAR). *When asked what was in the humidifier, she tapped the humidifier, and stated, A smidge of water. *When asked to confirm that there was no water in the humidifier, she stated there was dry water in the bottom of the container, and stated It's dirty, and that she would go get some sterile water. *She stated that there should have been a sticker on the oxygen tube with the date it had been changed, but it must have fallen off. *At 9:56 a.m. RN F returned to resident 288's room with an oxygen humidifier with a black top that contained water, a nasal cannula, and green oxygen tubing. -She replaced the existing humidifier and tubing and dated it on a piece of tape. *She did not change the oxygen tube on the portable oxygen unit which hung on the back of the wheelchair. *There was no visible jug of distilled water in resident 288's room or bathroom. 3. Interview on 11/19/24 at 10:15 a.m. RN F regarding resident 288's oxygen humidifier revealed: *When asked what had been in the humidifier which she had removed from resident 288's room she stated, Dry water that has been dry for a day. *When asked where the oxygen humidifier brought to resident 288's room had been filled she took the surveyor to the unit kitchenette. *When asked again where the water had come from, she stated The water jug was actually kept in the medication room. *When asked to see the jug, she stated it had been empty and thrown away and the trash had already been taken out. *The water jugs to fill the oxygen humidifiers came from the main kitchen. -She stated there were no more jugs of water on the unit and she would have to get more from the kitchen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*RN F stated she needed to pass medications and ended the interview. 4. Interview on 11/19/24 at 10:21 a.m. with RN C regarding oxygen equipment revealed: *Oxygen humidifiers were to be filled with distilled water. *She showed the surveyor a one-gallon jug stored in the unit's utility room. *Each resident with an oxygen humidifier was expected to have a jug of distilled water in their room. -That jug would be dated on the day it was opened. *Open bottles of distilled water were not stored in the medication room or the kitchenette. *She had not seen resident 288's humidifier and was unaware of where RN F would have filled her humidifier. *Hospice provided resident 288's concentrator, humidifier, and oxygen tubing. *The facility provided the distilled water, and the facility nurse changed the tubing every week on Wednesday, but not the humidifier. -She expected the nurse would have checked the humidifier and refilled it with distilled water as needed. 5. Interview on 11/19/24 at 10:29 a.m. with RN L in resident 288's room revealed: *Hospice had provided resident 288 with the oxygen concentrator. *RN L confirmed that there was no jug of distilled water in resident 288's room. -She stated the distilled water would have been provided by the facility. *At 10:32 a.m. RN F entered the room, placed an unopened jug of distilled water, dated 11/19/24, on resident 288's bedside table, and then left the room. 6. Observation on 11/20/24 at 9:55 a.m. in resident 288's room revealed the nasal cannula attached to the portable oxygen on her wheelchair was resting on the floor. 7. Interview on 11/21/24 at 8:45 a.m. with director of nursing (DON) B revealed: *Hospice provided resident 288 with an oxygen concentrator and she had her own portable oxygen tank. *Hospice provided the oxygen humidifier and nasal cannula tubing for the concentrator and for the portable, however, it was the responsibility of the facility staff to change that oxygen tubing and humidifier. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*There was an order in the resident's treatment administration record (TAR) to change oxygen tubing once a week on Wednesdays. -She expected that oxygen tubing would have been marked with the date they were changed on a small piece of tape. *She expected the oxygen humidifier to have been filled by the nurse with distilled water provided by the facility whenever it was low and needed more water. -Distilled water was kept in a one-gallon jug, with the date it was opened, in each resident's room who required it. *She expected the nurse to clean the oxygen concentrator filter weekly when the tubing and humidifier were changed. -The concentrator was to have been cleaned monthly. *Resident 288 had been able to self-administer her nebulizer treatments when she came into the facility, but it had been determined that she was no longer able to. -She expected that the nurse would have stayed with resident 288 while she completed her nebulizer treatment. 8. Interview on 11/21/24 at 9:35 am with infection control RN J revealed: *There were hooks for oxygen tubing to hang on in each resident's room. -She expected oxygen tubing, when not being used, to have been hung on those hooks. *Oxygen humidifiers were filled with distilled water as needed. -Each resident who required humidified oxygen would have had a dated one-gallon jug kept in their room. 9. Review of resident 288's electronic medical record (EMR) revealed: *Resident 288 had been admitted on [DATE] from home with continued hospice services. *Her diagnoses included malignant neoplasm of unspecified bronchus or lung, chronic obstructive pulmonary disease, chronic kidney disease, and other forms of dyspnea. *Her Brief Interview for Mental Status (BIMS) assessment score was 14, which indicated she was cognitively intact. *An 11/7/24 physician's order for O2 [oxygen] 1-5L/N/C [liters via nasal cannula] every morning and at bedtime for comfort. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*An 11/7/24 physician's order for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG [milligram]/3ML [milliliters]. 1 vial inhale orally four times a day. *An 11/7/24 physician's order for Albuterol Sulfate Inhalation Nebulization Solution (2.5MG/3ML) 0.083%. 1 vial inhale orally via nebulizer every 4 hours as needed for SOB [shortness of breath]. *Her Medication Self-Administration Safety Screen completed on 11/13/24 revealed: -Medications being considered for resident self-administration included: --Albuterol 0.083% q4hour [every four hours]. --Ipratropium-Albuterol Inhalation .05-2.5mg/3ml. -The resident can correctly administer inhalant medications according to proper procedure, was marked Unable. -It is reported that this resident is not capable of taking her neb [nebulizer] treatments unsupervised as before, weakness. Resident reports she falls asleep when she takes it and cant [can't] hold it. will switch to a mask. -IDTC [interdisciplinary team] feels resident is safe to administer listed medications? was marked No. *A physician's order to Clean O2 concentrator with Clorox wipes, clean filters, change tubing. Every day shift every Wed [Wednesday] Clean O2 concentrator with Clorox wipes, clean filters with water and air dry, put new tubing on machine and date with tape. If they have a tank put new tubing on [the] tank. -This was marked as completed on 11/13/24. Review of the provider's 5/30/23 Oxygen Administration policy revealed: *Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. *Cleaning of concentrators and filters will be completed weekly. *Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. *Change humidifier bottle weakly Use only distilled water for humidification. *Cleaning and care of equipment shall be in accordance with facility policies for such equipment. *Staff shall monitor for complications associated with the use of oxygen intake precautions to prevent them Respiratory infections related to contaminated humidification systems.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, record review, and policy review, the provider failed to ensure safe food was at safe temperatures prior to serving residents food by one chef (H) during an observed breakfast meal service. Findings include: 1. Observation and interview on 11/19/24 at 7:45 a.m. with chef M, chef H, and culinary services manager (CSM) D revealed: *Chef M was at the steam table serving breakfast to residents and stated chef H would have done the food temperatures this morning. *Chef H was by the ovens and the food prep area, and stated she forgot to take the food temperatures that morning. -The food temperature logs indicated food temperatures had not been documented that morning and chef H stated she would sometimes take the food temperatures but not log them and sometimes she would just forget to take the food temperatures. -She stated she should check the temperatures of the food coming out of oven and at the steam table. *CSM D told chef H to temp the next batch of food and log those temperatures. Chef H completed that task. 2. Record review and interview on 11/19/24 at 8:00 a.m. regarding food temperatures and documentation with CSM E revealed: *She stated she did not know the food temperatures (temps) had not been done that morning and that temps were not being documented on the logs. -She agreed the temperature logs indicated food temps had not been done as they should have been. -She stated she would check the logs periodically and had not been monitoring them for a while because the temps were being done, and said I see now they aren't logging them again. *When asked how she would know food temperatures were at the appropriate temperature to safely serve food to residents without temping food before serving it to the residents, she stated, I don't. *Food temperature logs were reviewed with CSM E and indicated multiple dates for breakfast, lunch, and supper did not have food temperatures documented. -There was no log sheet started for that week which indicated it should have been started on Sunday 11/17/24. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She expected that food would have been temped three times per day at each meal and documented on the logs. -She stated, We will have to start monitoring the logs again. *She stated she wasn't sure what the policy said and would have to look that up. 3. Observation on 11/19/24 at 11:11 a.m. revealed food temperatures were done for the lunch meal with no concerns and now placing temp log on wall beside steam table with logs from lunch and supper noted on the log. 4. Interview on 11/19/21 at 11:15 a.m. with chef G revealed, Food temps should have been checked with each meal and logged. 5. Interview on 11/20/24 at 9:56 a.m. with chef M revealed he would have temped and logged two meals, twice for each meal, once for food removed from oven then again for food in the steam table during his shift. 6. Interview on 11/20/24 at 12:10 p.m. with administrator A revealed he was not aware that food temperatures were not taken or logged at meal times and expected that the residents' food would be temped with each meal. We have come a long way in kitchen and dining, but temps should have been done. 7. Record review of food temperature logs from 10/19/24 to 11/19/24 revealed the residents' food for thirty 38 of 67 meals had not been temped or logged for breakfast, lunch, and supper. 8. Record review of the Provider's 2021 policy and procedure for food temperatures revealed, the temperatures of all food items will be taken and properly recorded prior to service of each meal.

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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** Based on record review, interview, and review of the Hospice and Nursing Facility Services Agreement, the provider failed to ensure an integrated plan of care had been developed and made accessible between the provider's nursing staff and hospice agency for one of one sampled resident (288) who received hospice services. Findings include: 1. Review of resident 288's facility care plan revealed: *She had been admitted on [DATE]. *Her diagnoses included malignant neoplasm of unspecified bronchus or lung, chronic obstructive pulmonary disease, chronic kidney disease, and other forms of dyspnea. *[Resident 288] was admitted on hospice from home. *A focus area: Resident and family have opted for hospice benefits and comfort care only. *A goal: Will receive additional support from hospice. Have comfort and dignity maintained on [a] daily basis. *Interventions/Tasks: -Keep family and hospice involved in care planning and decision making as well as updated on any changes in conditions or orders. -Keep hospice staff involved with changes and notify them in [the] event of death. -Maintain [an] open line of communication and involvement with hospice staff. -Offer emotional/spiritual support to [the] resident and family. Review of resident 288's paper Hospice Plan of Care provided upon request revealed: *It had not been uploaded into resident 288's electronic medical record. *Location Type: Private Residence. *Service Location: Home. *Principal Program: Home Hospice. *Start of care date 09/22/2024. -Resident 288 was admitted to the facility on [DATE]. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the hospice binder at the north nurse's station regarding resident 288 revealed: *It contained information about which nurse was assigned to resident 288 and instructions for when and how facility staff were to contact hospice. *The hospice plan of care was not located in that binder. *There was no documentation of the resident's oxygen needs or interventions in that binder. 2. Interview on 11/21/24 at 8:40 a.m. with certified nursing assistant I revealed: *She confirmed that resident 288 was receiving hospice services. -She knew how to care for residents receiving hospice services because the nurse reviewed that information with her before each shift. *Her worksheet and the care plan in point click care also provided information about how much assistance a resident needed for transfers and personal care. *Hospice provided a bath to residents once a week. *She was unable to locate a hospice care plan for resident 288. Interview on 11/21/24 at 8:45 a.m. with director of nursing (DON) B revealed: *The services hospice provided to the residents varied from resident to resident based on their hospice diagnosis. -This information would have been found on the resident's care plan. *Minimum Data Set (MDS)/registered nurse (RN) K and infection control RN J were responsible for updating resident facility developed care plans but any nurse can. -The care plan should have been updated when there is any change in the care that a resident received. *Hospice had a separate care plan that was part of the resident's overall care plan. -The hospice care plan was to be uploaded in their EMR system point click care (PCC) when it was completed. -She expected that the hospice care plan would have reflected the care resident 288 was receiving in the facility. -Resident 288's hospice care plan should have been updated when she moved from her private home to the facility. *She confirmed that resident 288's care plan should have included: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435073	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda Home of Aberdeen	1224 S High St Aberdeen, SD 57401

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Her oxygen needs which included: -The need for assistance completing her nebulizer and the use of the humidifier. --Resident 288 had been able to self-administer her nebulizer treatments when she came into the facility, but it had been determined that she was no longer able to. -The amount of oxygen she received and the equipment she used. --Hospice provided resident 288 with an oxygen concentrator and she had her own portable oxygen tank. --Hospice provided the oxygen humidifier and nasal cannula tubing for the concentrator and for the portable, however, it was the responsibility of the facility nursing staff to change that oxygen tubing and humidifier. -The frequency of cleaning of the oxygen equipment and changing the oxygen tubing -Resident 288 had been able to self-administer her nebulizer treatments when she came into the facility, but it had been determined that she was no longer able to. 3. Review of the provider's 1/17/19 Hospice and Nursing Facility Services Agreement revealed: *Facility's representative will perform the following duties: (a) Collaborate with Hospice staff and coordinate Facility staff's participation in the care planning process . *Joint Responsibilities/Mutual and Hospice Promises. Development and Implementation of Plan of Care Hospice and Facility shall jointly develop and agree upon the Patient's plan of care Hospice and Facility each shall maintain a copy of each Patient's plan of care in the respective clinical records maintained by each Party. *Hospice Plan of Care. All services provided to Hospice Patients under the Agreement must be in accordance with the plan of care. -The plan of care shall identify the care and services needed and specifically identify whether Hospice or Facility is responsible for performing the respective functions that have been agreed upon and included in the plan of care. -The plan of care shall reflect the participation of Hospice, Facility and the Hospice Patient and such Patient's family, to the extent possible including a description of the Hospice Services, Inpatient Services and Room and Board Services furnished by Facility.