STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175406	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant View Home	108 N Walnut Inman, KS 67546

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 26768 The facility had a census of 78 residents. The sample included 18 residents with three reviewed for Center for Medicare and Medicaid Services (CMS) Beneficiary Liability notices. Based on record review and interview, the facility failed to provide Resident (R) 25 and R277 complete information on the Notice of Medicare Non-Coverage (NOMNC) Form-10123 which informed the beneficiary of the right to an expedited review by a Quality Improvement Organization (QIO). This placed the residents at risk of uninformed decisions about their skilled services and the inability to appeal. Findings included: - A review of the CMS Form 10123 informed the beneficiary that Medicare may not pay for future skilled therapy services. The form included directions for the beneficiary (resident or resident representative) to contact the QIO for questions regarding appeals. R277's NOMNC revealed Medicare Part A skilled services ended on 05/23/24. The facility provided CMS Form-10123 lacked the QIO name and contact information for R277. R25's NOMNC revealed Medicare Part A skilled services ended on 05/09/24. The facility provided CMS Form-10123 lacked the QIO name and contact information for R25. During an interview on 10/08/24 at 11:45 AM, Administrative Staff A verified staff were to insert the QIO name and phone number on each CMS Form-10123 when the resident was discharged from Medicare Part A services. The facility's Medicare Denial Notices policy, dated 09/2022, stated the facility would provide each resident with written notification with the necessary information to decide whether or not to appeal a decision to terminate Medicare care and services at least three days prior to the planned change in payor status or discharge. The Notice of Medicare Non-Coverage (NOMNC-form 10123) would include the instructions for filing an appeal along with the address and phone number of the appointed QIO. The facility failed to provide complete information on the NOMNC which informed the beneficiary of the right to an expedited review by the QIO. This placed the residents at risk of uninformed decisions about their skilled services and the inability to appeal.

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

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 78 residents. The sample included 18 residents, with two reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interview, the facility failed to prevent a facility-acquired deep tissue injury (DTI- purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) for Resident (R) 15, who sustained a DTI to her left buttock (either of the two round fleshy parts that form the lower rear area of a human trunk) when staff placed a bed pan under R15 backward and left it under her for too long. The facility staff further failed to remove a mechanical lift sling (a material device used in conjunction with a hoist, to assist in safely transferring a person) from under R15 and she sustained a reddened area on her right buttocks. This placed the resident at risk for further skin injury and breakdown. Findings included: - The Electronic Medical Record (EMR) for R15 documented diagnoses of dementia with psychotic disorder (a progressive mental disorder characterized by failing memory and confusion), reduced mobility, edema (swelling resulting from an excessive accumulation of fluid in the body tissues), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and cerebrovascular disease (conditions that affect blood flow to your brain). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R15 had moderately impaired cognition. R15 was dependent upon staff for toileting, transfers, and lower body dressing; she required partial assistance for mobility and did not ambulate. The assessment documented R15 was frequently incontinent of bowel, always continent of bladder, and did not have any skin issues. R15's Pressure Ulcer Care Area Assessment (CAA), dated 03/06/24 documented R15 had the potential for skin breakdown due to activities of daily living impairment and directed staff to assess her skin weekly, encourage her to change positions frequently and implement interventions as needed to prevent skin breakdown. The Braden Scale Assessment, (a formal assessment for predicting pressure ulcer risk) dated 08/24/24 documented R15 was at risk for skin breakdown. R15's Care Plan, initiated on 08/06/23, directed staff to encourage R15 not to scratch at areas and ask for lotion for dry areas. The update, dated 06/05/24, directed staff to use the call light to ask for assistance, keep skin clean and dry, report any changes in skin integrity, and reposition every two hours within 30 minutes of the two hours. The update, dated 10/04/24, directed staff to use a cushioned bed pan and to remove the old bed pan. The plan directed staff to turn R15 every two hours from the left to the right while in her bed. The plan directed staff to use the bedpan for 10 minutes at a time, then take it out. The update, dated 10/08/24, documented R15 had a raised, blanchable (skin that can be made to turn pale or white by applying pressure) area to her right buttock and directed therapy to do staff education on sling removal. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Nurse's Notes, dated 10/04/24 at 02:52 PM, documented R15 had an area to her left buttocks that measured 8.1 centimeters (cm) by 7.5 cm and had two purple discolorations that were slowly blanchable which measured 2.4 cm by 0.3 cm and measured 4 cm by 0.4 cm. The note further documented the area was consistent with a bedpan. The note documented that staff would remove the old bedpan, use a round bedpan, and ensure R15 was turned and repositioned from left to right every two hours while in bed until the area healed. The Physician Order, dated 10/04/24, directed staff to monitor the red, blanchable area to the left buttock every shift until healed. The Nurse's Note, dated 10/07/24, documented as a late entry on 10/08/24, included R15 had a red/purple area, that was unopened at that time. The area was blanchable, but the darker lines were slower to blanch, and staff repositioned R15 from left to right to ensure she stayed off that area as much as possible. The Nurse's Note, dated 10/08/24 at 12:45 PM documented Certified Nurse Aides (CNAs) assisted R15 back to bed after lunch and discovered a new area to R15's right buttock. The area measured 8.2 cm by 1.6 cm and 3.3 cm by 0.4 cm, The areas were red, blanchable, and tender to the touch. The areas were consistent with a full light sling that R15 sat on while in her wheelchair. The nursing staff requested therapy to perform staff education that week to assist with lift sling removal while in her wheelchair to help with skin integrity. The Physician Order, dated 10/08/24, directed staff to monitor the red, blanchable area to the right buttock for signs and symptoms of infection every shift until healed. The Nurse's Note, dated 10/09/24 at 07:36 AM, documented that the skin injury to the left buttock was improved and measured 6 cm by 6 cm, and was pink in color with light purple fading in the linear-shaped area. The area continued to be blanchable and more characteristic of normal tissue. The Wound Management Record, dated 10/09/24, documented R15 had an area on her left buttock that was identified on 10/04/24 and as of 10/09/24 the area measured 6 cm by 6 cm. The Physician Order, dated 10/09/24, directed staff to apply Skin-prep (liquid skin protectant) to R15's bottom as needed. On 10/08/24 at 10:54 AM, observation revealed CNA P applied barrier cream (a topical product designed to create a protective barrier on the skin's surface) to R15's left buttock which had a round, reddened area with a dark purple line through it. Further observation revealed after R15 was transferred to her wheelchair by the mechanical lift, she stated she did not feel right and was not comfortable. Staff attempted to reposition her by pulling on the sling that was left under her after she had been transferred. R15 continued to state she was not comfortable, and staff left the sling under her despite a question from the survey team about whether the sling might be bunched up under the resident. (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/09/24 at 08:30 AM, observation revealed R15 sat at the dining table in her wheelchair with the mechanical lift sling still underneath her. Continued observation at 09:00 AM revealed CNA P and CNA N attached the sling to the mechanical lift and transferred R15 into bed. Observation revealed two reddened marks on R15's right buttock which were not opened. CNA N stated she was unaware she was supposed to remove the sling from under R15 after staff transferred R15 into her wheelchair. R15 stated she needed to use the bathroom and CNA N placed a large bedpan underneath the resident. R15 stated the area on her left buttock was sore. The bedpan was under R15 for less than 10 minutes and as CNA N removed the bedpan, there was an indention from the bedpan that ran directly in the center of the DTI on R15's left buttock. During an interview on 10/08/24 at 11:00 AM, CNA P stated R15 was left on the bedpan too long by agency staff so staff had replaced the old bedpan with one that fit her better. CNA P stated they could only leave the resident on the bedpan for 10 minutes. On 10/08/24 at 02:32 PM, Administrative Nurse D stated she was told that R15 was only on the bedpan for about 15 minutes. She considered the area a skin injury, but not a pressure injury from the plastic bedpan. Administrative Nurse D said she did not realize the area on R15's buttocks from the bedpan had not resolved. Administrative Nurse D stated she would assess the area and agreed, that since it was still reddened, it was most likely a DTI. Administrative Nurse D further stated the physician would be notified to see what treatment would be best for the area. On 10/09/24 at 09:20 AM, Licensed Nurse (LN) J stated she was notified of R15's DTI from the bedpan on Friday and said she felt that the agency staff had placed it under R15 backward and the reddened area was from the handle of the bedpan. LN J stated she did not know how long R15 was left on the bedpan and confirmed she had not contacted the agency staff to inform them that R15 had received a skin injury from the bedpan. LN J stated she arranged for staff to receive training regarding bedpan placement and how to remove the sling from under the resident on 10/24/24. LN J said she was waiting for an order for Skin-prep to be used on R15's bottom. On 10/09/24 at 11:57 AM, Administrative Nurse D stated she was notified that R15 had an area on her right buttock from the lift sling that was left under the resident and stated she directed LN J to request that the restorative nurse train her so that she could train the staff on sling removal and bedpan use. The facility's Pressure Ulcer Management policy, dated 03/24, documented all residents were considered to have some risk for the development of pressure ulcers. A licensed nurse would perform a full body skin assessment on the day of admission and after conducting an inspection of the resident's skin, the nurse would review the resident assessment protocol for pressure ulcers to identify risk factors for the development of pressure ulcers. An immediate plan to reduce a resident's risk of pressure ulcers or to treat an existing pressure ulcer would be developed and implemented. The facility's Bed Pan policy, undated, documented the facility ensured the dignity, safety, and comfort of residents who required the use of a bed pan while maintaining resident safety with high hygiene standards. The policy directed staff to stay with or near the resident if needed, ensure the resident call light was within reach for signaling when they were done, and no residents should remain on any bedpan for greater than 10 minutes to avoid skin impairment unless a tissue tolerance test indicated longer use was safe to avoid skin breakdown through pressure. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility failed to prevent a facility-acquired pressure injury for R15, who obtained a DTI to her left buttock when staff placed an incorrectly sized bed pan backward under R15 and left it under her for too long. The facility staff further failed to remove the mechanical lift sling from under R15 resulting in a reddened area on her right buttocks. This also placed the resident at risk for further skin injury and breakdown.

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F 0689 Level of Harm - Minimal harm or potential for 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** 32360 The facility had a census of 78 residents. The sample included 18 residents with seven reviewed for accidents. Based on observation, interview, and record review the facility failed to prevent accidents for Resident (R) 5 when staff transported her in a wheelchair without footrests and R5 fell forward onto the floor and hit her head. This placed R5 at risk for injuries and increased pain. The facility also failed to ensure an environment free from accident hazards when staff failed to secure hazardous chemicals placing all confused, independently mobile residents at risk for accidental ingestion. Findings included: - The Electronic Medical Record (EMR) for R5 documented diagnoses of dementia without behavioral disturbance (a progressive mental disorder characterized by failing memory and confusion), macular degeneration (progressive deterioration of the retina), and pain. The Quarterly Minimum Data Set (MDS), dated [DATE], documented R5 had severely impaired cognition. R5 was dependent on staff for toileting and required substantial assistance with dressing, personal hygiene, mobility, and transfers. R5 had no functional impairment, no falls, and was dependent on staff while in the wheelchair. The Annual MDS, dated [DATE], documented R5 had severely impaired decision-making skills and was dependent upon staff for toileting, dressing, personal hygiene, and required substantial assistance with mobility, and transfers. R5 had no functional impairment, had one fall with injury, and was dependent upon staff while in the wheelchair. The Fall Risk Assessment, dated 04/23/24, documented R5 was at risk for falls. R5's Care Plan, dated 08/20/24 and initiated on 11/16/23, directed staff to place a floor mat beside the resident's bed, rearrange the room so one side of the bed was against the wall, and use a winged mattress. An update, dated 08/11/24, directed staff to use wheelchair foot pedals on the resident's wheelchair for all mobility and to consider relocation of the scale to the unit. The Fall Investigation, dated 08/11/24 at 10:30 AM, documented that staff transported R5 in her wheelchair from her household to another household to obtain her weight without foot pedals. As staff started to push her up the incline, R5 planted her feet on the ground, fell forward out of the wheelchair, and hit her head on the floor. R5 sustained a large hematoma (collection of blood trapped in the tissues of the skin or an organ, resulting from trauma) to the left side of her forehead and was sent to the emergency room (ER) by ambulance. The Nurse's Notes, dated 08/11/24 at 04:23 PM, documented R5 returned to the facility and all scans were negative for any fractures. The staff was directed to initiate neurological checks (a physical examination to identify signs of disorders affecting the brain, spinal cord, and nerves) per facility protocol. R5 denied pain or discomfort. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nurse's Note, dated 08/11/24 at 08:26 PM, documented that R5 had a hematoma to the left side of her forehead that measured six centimeters (cm) by 10 cm in size, red with a scant amount of serosanguineous (semi-thick blood-tinged drainage) drainage. R5's forehead also had a red abrasion which measured four cm by four cm in size and staff attempted to apply a cold pack which R5 did not tolerate. R5 did not complain of pain or discomfort. The Nurse's Note, dated 08/13/24 at 01:51 PM, documented R5 had new bruising to the right eye that measured 2.5 cm by 0.5 cm, bruising to the left hand which measured 1.5 cm by 1.5 cm, and bruising to her right knee which measured six cm by 4.5 cm. The note documented that R5 moaned when getting out of bed with transfers. On 10/08/24 at 12:45 PM, observation revealed R5 in her wheelchair with her feet on her wheelchair pedals as Certified Nurse Aide (CNA) Q pushed R5 to a recliner in the living room area. Further observation revealed CNA Q placed the sit-to-stand lift sling (a material device used in conjunction with a hoist, to assist in safely transferring a person) around R5's waist, cued her to hold onto the handles of the lift as CNA O used the lift controller to raise R5 to a standing position and then transferred her into a recliner. On 10/08/24 at 01:00 PM, CNA O stated she was not working at the time of R5's fall, but had since been instructed to make sure the wheelchair pedals were on when R5 was taken anywhere in her wheelchair. On 10/09/24 at 09:30 AM, Licensed Nurse (LN) I stated that staff assisted R5 to another area of the facility to get her weight and they did not put wheelchair pedals on R5's wheelchair. LN I explained that R5 put her feet down as staff were pushing the wheelchair and the resident fell from the chair. LN I said R5 did have a hematoma but did not have any broken bones. LN I stated that although it was not care planned, wheelchair pedals were to be used for every resident in a wheelchair when being transported anywhere. On 19/09/24 at 11:54 AM, Administrative Nurse D stated staff should have put the pedals on R5's wheelchair. Adminstrative Nurse D stated that after R5's fall, the nurse put black bags on the backs of all the wheelchairs in the facility to ensure the pedals stayed with the wheelchair and staff had them placed on the wheelchairs. The facility's Fall Prevention undated policy documented that each elder at the facility would be provided services and care that ensured the environment remained as free from accident hazards as possible and each elder received adequate supervision and assistive devices to prevent accidents. The policy documented every elder would be assessed for the causal risk factors for falls at the time of admission, upon return from a health care facility, and after every fall in the facility. The interdisciplinary team would develop a plan for services to improve or maintain the elders' standing and sitting balance and other interventions to reduce the elder's risk for falls. The facility failed to ensure R5's environment remained free from accident hazards when they failed to put wheelchair pedals on R5's wheelchair. This placed the resident at risk for increased pain and further falls with injury. 26768 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 10/08/24 at 03:35 PM, observation revealed the elevator on the main floor had a green button to push that deactivated the door alarm. Two staircases on the main floor (one on the left side of the hall across from the medication cart, and one to the right of the elevator) also had a green button to deactivate the door alarms. The staircases and elevator led to the lower floor of the facility where a maintenance shop was accessible through an unlocked double door. Observation revealed four spray bottles and four one-gallon jugs of hazardous chemicals accessible in the maintenance room. The facility identified two residents who were cognitively impaired, independently mobile, and resided on the main floor of the facility. On 10/08/24 at 03:35 PM, Social Services X verified the maintenance door was unlocked with no staff in that area and hazardous chemicals were accessible in the room. On 10/08/24 at 03:40 PM, Administrative Nurse D agreed the elevator and the exits to the stairways being accessible was a potential accident hazard. She stated the facility did not have any residents attempting to use the elevator or stairs without staff. On 10/09/24 at 08:00 AM, Administrative Staff A stated the stairs were fire exits. The facility's Fall Prevention Protocol policy, undated, stated each elder residing at this facility would be provided services and care to ensure the elder's environment remained as free from accident hazards as possible. The facility failed to ensure hazardous chemicals were not accessible to confused, independently mobile residents.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 26768 The facility had a census of 78 residents. The sample included 18 residents. Based on observation, interview, and record review the facility failed to identify and dispose of expired medications appropriately. This deficient practice placed residents at risk for ineffective medications. Findings included: - On 10/07/24 at 02:59 PM, observation revealed the Harvest Household medication cart contained the following expired medications: A bottle of calcium supplements with an expiration date of 11/2023. A bottle of senior multivitamins (MVI) with an expiration date of 10/2023. A bottle of MVI with an expiration date of 06/2024. A bottle of magnesium oxide (supplement) with an expiration date of 08/2024. A bottle of D3 (vitamin) with an expiration date of 08/2024. A Metamucil (fiber laxative) canister with an expiration date of 08/2024. A bottle of bisacodyl (laxative) pills with an expiration date of 09/2024. A bottle of Preservision (vision supplement) with an expiration date of 09/2024. On 10/07/24 at 02:59 PM, Certified Medication Aide (CMA) R verified the dates on the expired medications. On 10/08/24 at 03:10 PM, Administrative Nurse D stated staff periodically inspected the medication carts to check the expiration date for medications. Administrative Nurse D stated staff should have removed the expired medications. She stated the nurse coordinators were also responsible for checking for expired medications and the pharmacist consultant checked medication carts monthly. The facility's Disposition of Unusable and Outdated Drugs policy, dated 03/2024, stated all discontinued, outdated, contaminated drugs would be returned to the provider pharmacy for proper disposal or destroyed onsite. Those drugs would be stored in an isolated area designated for the storage of unusable drugs until the drugs could be destroyed or returned. All drug storage areas of the facility would be inspected, including the emergency kit, for outdated drugs on a weekly basis by facility nursing staff and on a monthly basis by the contracted consulting pharmacist. The responsible staff member conducting the inspection would remove all outdated drugs from the area and record the type and amount of drugs removed. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to identify and dispose of expired medications appropriately, placing residents at risk of receiving ineffective medication.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 32358 The facility had a census of 78 residents and one kitchen. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to store, prepare, distribute, and serve food by professional standards for food service safety. This placed the residents who received their meals from the facility's kitchen at risk for foodborne illness. Findings included: - On 10/08/24 a 10:15 AM, observation in the kitchen revealed the following concerns: 1. Four upper and six lower wooden cupboards located by the three sinks had numerous different-sized scrapes on the outer surface. 2. Three wooden bottom cupboards and nine cupboard drawers located by the ice machine had numerous different-sized scrapes on the outer surface. 3. Two white fans on the wall had grayish debris on the blades. 4. The right door frame, located by the entrance to three sink areas, approximately four feet high, was missing a piece of trim. 5. A black trash can located to the left of the entrance door to the three sink areas had numerous different-sized streaks of brownish substance around the sides of it and on the lid. 6. Four bottom wooden and five upper cupboards located by the counter silver microwave, next to the bread rack, had numerous different size scrapes in the outer wood. 7. The mop board around the perimeter of the kitchen had numerous different-sized areas with a grayish-black substance on them. The facility's Kitchen Cleaning Sheet, had tasks listed for dietary staff to complete daily, weekly, and as used. On 10/08/24 at 12:30 PM, Certified Dietary Manager BB verified the above findings and stated the dietary aides had a cleaning schedule to follow. She said she was aware of the issues with the kitchen cupboards. The facility's Kitchen Cleaning and Sanitation of Dining and Food Service Areas Policy, revised 05/01/2013, documented that food service staff would maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule. The facility failed to store, prepare, distribute, and serve food by professional standards for food service safety for the 78 residents who received their meals from the facility's kitchen. This placed the 78 residents at risk for foodborne illness.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175406	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant View Home	108 N Walnut Inman, KS 67546

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	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** 32358 The facility had a census of 78 residents. The sample included 18 residents. Based on observation, record review, and interview the facility failed to ensure a communication process between the hospice provider and the facility for one of two residents reviewed for hospice services, Resident (R) 29. This placed the resident at risk of not receiving adequate end-of-life care. Findings included: - R29's Electronic Medical Record (EMR) documented the resident had diagnoses of chronic obstructive pulmonary disease (a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), heart failure, and cerebrovascular disease (conditions that affect blood flow to your brain). R29's Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status score of 12, which indicated moderate cognitive impairment. The MDS documented R29 required partial to moderate staff assistance with toileting hygiene, showering, upper and lower body dressing, putting on and taking off footwear, sitting to lying and lying to sit, sitting to stand and transfers, and supervision with ambulation and eating. The MDS noted that R29 received hospice services. R29's Care Plan, revised 09/04/24, documented the resident required supervision and limited staff assistance with activities of daily living (ADL). The care plan lacked mention of R29's hospice admission and guidance for staff regarding hospice services. The 07/02/23 Physician Order instructed staff to admit R29 to hospice service. On 10/08/24 at 08:15 AM, observation revealed R29 sat in a recliner in his room. He had his eyeglasses on, shoes on, and no signs or symptoms of pain. During an interview on 10/09/24 at 10:05 AM, Administrative Nurse D verified the facility care plan lacked a section regarding hospice services and stated it should have one. The Nursing Facility Hospice Services Agreement, dated October 2024, revealed hospice would provide a comprehensive set of services identified and coordinated by an interdisciplinary team to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and family members, as delineated in a specific plan of care in collaboration with the facility. The facility failed to ensure a communication process between the hospice provider and the facility for R29, to include a plan of care from the hospice and a description of the services provided, noting visit frequency, medications, and medical equipment. This placed the resident at risk of not receiving adequate end-of-life care.