STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175437	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McPherson Operator, LLC	1601 N Main Street McPherson, KS 67460

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 27168 The facility identified a census of 42 residents. Based on interviews and record review, the facility failed to conduct a criminal background check as required for one facility employee. The employee was allowed access to residents without knowing if they had been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law. This deficient practice placed the affected residents at risk for abuse, neglect, misappropriation, or mistreatment. Findings included: - On 04/22/25 at 03:40 PM review of staffing for background checks was completed for facility Staff. Upon request and review, the facility was unable to provide evidence a criminal background check was completed for Certified Medication Aide (CMA) R, who had worked at the facility since his hire date of 08/29/24. On 04/22/25 at 04:30 PM, Administrative Staff A stated the business manager would obtain criminal background/record checks on all employees prior to the employee working at the facility. Administrative Staff A verified facility staff could not find a criminal record check for CMA R, and the business office manager who was at the facility started in August 2024. Administrative Staff A verified CMA R would be placed on suspension and not work in the building until they obtained a criminal background check. The facility's Abuse Prevention Program, Screening of Employees dated October 2024 documented the community will not employ or otherwise engage individuals who have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law, entered into the State nurse aide registry or against the professional license they hold with the state licensure body. The facility administration and employees were committed to protect residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, and staff from the agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any there individual. Background checks were completed per state guidelines on each employee. The community would not knowingly employ an individual who: Has been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; Have a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of their property, or; Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse. Neglect, exploitation, mistreatment of residents, or misappropriation of resident property. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Pre-employment screening would consist, at a minimum: Employment history, Information from former employers as available, and Documentation of status and any disciplinary actions from license or registration boards or registries. The facility would report to the state nurse aide registry or licensing authorities any knowledge of actions by a court of law if found during a background check or ongoing employment. Regardless of the source of the check, the facility would maintain the document that the screening occurred.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 42 residents. The sample included 12 residents, with three reviewed for abuse. Based on observation, record review, and interview, the facility staff failed to immediately report to the nurse in charge an incident between Resident (R) 12 and R17. This placed R17 at risk for ongoing abuse and/or mistreatment and a lack of adequate supervision. Findings included: - R17's Electronic Health Record (EHR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), and muscle weakness. R17's Quarterly Minimum Data Set (MDS), dated [DATE], recorded R17 had moderately impaired cognitive function. The MDS recorded R17 required extensive assistance with transfers, activities of daily living (ADL), and propelled in a wheelchair. The MDS documented the resident received Hospice services. The MDS documented the resident had no behaviors and received antidepressants (a class of medications used to treat mood disorders), antipsychotics (a class of medications used to treat major mental conditions that cause a break from reality), and opioids (a class of controlled drugs used to treat pain). R17's Activities of Daily Living (ADL) Care Plan, dated 03/24/25, recorded R17 required extensive staff assistance with most ADL care. R17's Care Plan documented the resident had bilateral lower extremity contractures, and staff would monitor for skin breakdown and increased immobility. R17's Smoking Care Plan, dated 03/24/25, recorded R17 had the potential for injuries related to smoking. R17's plan of care documented the resident had been placed in Group 2 for supervised smoking breaks, and staff assisted the resident with smoking, including lighting and extinguishing the cigarettes, and the resident would wear a smoking apron. R17's Behaviors Care Plan, dated 03/24/25, recorded R17 had behaviors related to dementia, anxiety, and the disease progression. R17's plan of care recorded the resident had behaviors related to smoking and had attempted to get cigarettes out of the smoking box, had been more anxious and fixated on supervised smoke breaks, and would yell out for a cigarette as soon as the residents went outside for the smoke break. R17's plan of care directed staff to intervene as necessary, protect the rights and safety of others, and be removed from the situation and taken to an alternate location as needed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nurses Notes dated 03/14/25 at 11:00 PM (late entry) documented Certified Medication Aide (CMA) R reported to the charge nurse that R12 had made contact with her open hand to R17's left shoulder just prior to a smoke break. CMA R reported R12 was wheeling onto Presidential hallway with her wheelchair, and she tried to maneuver around R17 when R12 made contact with an open hand to R17's left shoulder in an attempt to get R17 to move out of the way. R17 recounted the event to nursing staff, stating R12 was behind her in the wheelchair, and R12 tried to get around her, and R17 stated, I guess I did not move fast enough. CMA R immediately separated the residents. The charge nurse performed a skin assessment, and no redness or signs of injury were noted at the time of the incident. R17's Facility Report Investigation dated 03/20/25, documented on 03/14/25 at 08:00 PM, CMA R witnessed the incident between R12 and R17 and did not report the incident to the charge nurse until approximately 09:45 PM on 03/14/25. The charge nurse made contact with the administrative staff and the Director of Nursing. The charge nurse completed a skin assessment following the incident and noted no redness, discoloration, or pain, or any other signs of injury in the area where the contact was made. The nurse asked R17 what happened, and the resident stated, I guess I did not move quickly enough. R12 was put on 1:1, the primary care physician saw R12 the following day, and psychiatric staff saw R12 the following Monday. The intervention was to put the two residents on different smoke breaks to eliminate the potential for further encounters. CMA R completed a witness statement regarding the encounter. On 04/22/25 at 09:30 AM, R17 sat in a wheelchair, dressed in street clothes, on the patio outside the Presidential hallway exit door. The resident was smoking a cigarette with 4 other residents and a staff member present. On 04/22/25 at 08:45 AM, Administrative Nurse D stated that on 03/14/25 at 08:00 PM, R17 was hit on the shoulder by R12, and CMA R stated the residents were friends, so he thought it was no big deal and failed to report it until 09:45 PM. Administrative Nurse D verified it was the facility policy to have staff report and incident of this nature immediately, and the facility would investigate and determine what further action was needed to be done. On 04/22/25 at 08:50 AM, Administrative Staff A stated CMA R failed to report the incident to the nurse in charge immediately, and he should have. Administrative Staff A verified that they investigated, gathered CMA R's witness statement, and reported to the State agency. Administrative Staff A verified that R12 was put on 1:1 after the incident was reported at 09:45 PM, and R12 was seen the following day by the primary care physician and psychiatric the following Monday. The facility's Abuse, Neglect, and Exploitation policy, dated August 2024, recorded it was the responsibility of the employees, facility consultants, Attending Physicians, family member, visitors etc. to promptly report any incident or suspected incident of neglect, exploitation, or resident abuse, including injuries of unknow source, and theft or misappropriation of resident's property to facility management as outlined below. Failure to report such an incident may result in legal/criminal action being filed against the individual(s) withholding such information. The policy documented when an incident of resident abuse is suspected or confirmed, the incident must be immediately reported to facility management, regardless of the time lapse since the incident occurred. Reporting procedures should be followed as outlined in this policy: 1. A licensed nurse or physician shall immediately examine the resident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Findings of the examination must be recorded in the resident's medical record. c. 3. The person performing the examination must document the examination findings in the resident's record and obtain a written, signed, and dated statement from the person reporting the incident. 4. A completed copy of documentation forms and written statements from witnesses, if any, must be provided to the Administrator. Reporting to the state is per state guidelines. 5. Upon receiving information concerning a report of abuse, staff shall be assigned to monitor the resident's reactions to statements regarding the incident and his/her involvement in the investigation 6. All phases of the investigation would be kept confidential in accordance with the facility's policies governing the confidentiality of medical records. 7.Administrative policies governing the notification of the resident's representative (sponsor) and Attending Physician are located in our facility's resident rights policies and procedures. Inquiries concerning abuse reporting and investigations should be referred to the Administrator or Abuse Coordinator.

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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** 27168 The facility had a census of 42 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to ensure an environment free from accident hazards when staff left an unlocked shower door open on Country Hall and Resident (R) 12 entered, fell , and sustained a fractured wrist. This placed the residents at risk for preventable accidents or injuries. Findings included: - R12's Electronic Medical Record (EMR) recorded diagnoses of chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and muscle weakness. R12's Quarterly Minimum Data Set (MDS), dated [DATE], recorded a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R12 required partial to moderate staff assistance with most Activities of Daily Living (ADL) and with tub to shower transfer. The Fall Care Area Assessment (CAA), dated 0716/24, was triggered but lacked a reason for the triggered area. R12's ADL Care Plan, dated 01/08/25, directed staff to provide one staff to assist with bathing and required supervision to one staff assistance with personal hygiene tasks, including brushing hair, oral care, and perineal cleansing. The care plan documented R12 frequently did not wait for assistance and would self-transfer and would frequently refuse staff assistance with ADLs. The care plan documented R12 would remove her oxygen at times and/or ambulate out of the room with her oxygen on, and staff would have to assist her to reapply her oxygen to avoid respiratory complications. R12's Fall Care Plan, dated 02/08/25, documented that the resident was at risk for falls, staff would place non-slip strips on the floor in front of the recliner, wear skid socks or shoes when ambulating, and staff to check on the resident frequently. The Fall Care Plan directed staff to place a non-slip pad on the wheelchair or chair and to use the call light when she needed assistance. The Fall Risk Evaluation, dated 12/09/24, documented a score of 14.0 (a score of 10.0 or greater indicated a high risk for falls). On 04/21/25 at 08:15 AM, observation revealed the shower room door on Country Hall was locked. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Nurses Note, dated 02/08/25 at 10:34 PM, recorded R12 was at the nurse's station around 07:45 PM and asked when her shower days were. The nurse aide stated on Tuesdays and Thursdays with hospice. The resident stated hospice was not here, and she wanted a shower. The nurse told the resident the staff were busy at the time, but they would get someone to assist her when things were less busy. R 12 went back to her room. The nurse was passing medications to other residents at the nurses' station. At approximately 10:00 PM, the nurse walked down the hall to take medications to another resident when someone was calling out from the shower room. The nurse entered the shower room and observed R12 sitting on her buttocks, naked on the floor, with her legs crossed. Observation revealed the resident's wheelchair was sitting in the doorway with her oxygen tank on her walker in her room across the hall from the shower house. The resident had a pull-up and her pajamas sitting on the counter, and her dirty clothes were folded on the counter in the shower room. The nurse reached for the resident's arm to obtain her blood pressure, and the resident requested her right arm be used. She held up her left arm and stated, This wrist is broken. Observation revealed the left wrist was swollen and deformed on the radial side (side closest to the wrist). The resident denied hitting her head, no other injuries were noted at that time, and her vital signs were obtained. The nurse asked the resident how she got into the shower room, and R12 stated, I just opened the door. The resident apologized and stated it was a bad idea. The Director of Nursing was notified of the fall at 10:06 PM, and the resident was sent to the hospital by Emergency Medical Services at 10:35 PM. The resident was transported to the hospital out of town due to the fractured wrist. R12's Facility Report Investigation undated, documented on 02/08/25 at 10:00 PM, License Nurse (LN) H was passing medications down Country Hall and heard someone yelling from the shower house. LN H opened the door and observed R12 naked on the floor in the shower, sitting on her buttocks, with her legs crossed. LN H stated the water was on, the shower chair positioned behind the resident LN H observed the wheelchair just inside the shower room door, and the resident's walker with the oxygen tank was still in the resident's room. The investigation documented the resident was alert and oriented, and R12 reported the shower room door was not closed, and she went into the shower house independently and slipped, falling on her left wrist. The resident reported to the nurse that her wrist was broken. The resident reported pain of a 10 out of 10 to the left wrist but denied any other pain or injury and denied hitting her head. Emergency Medical Services were contacted at 10:06 PM for transport to the emergency room . The resident returned to the facility on [DATE] and was diagnosed with a left radial and ulnar fracture. The facility had a staff in-service to educate on keeping all doors closed with keypads or locks shut, including the shower house, public restrooms. Laundry room, kitchen, ect. to prevent injury. The facility installed self-closures on all shower house doors. The investigation revealed the resident was interviewed for preference for showers days/times, and the information was updated on the care plan, nurse aide tasks, and the shower schedule. On 04/21/25 at 04:00 PM, observation revealed R12 sat in the recliner in her room, with oxygen on per nasal cannula, and watching TV. On 04/22/25 at 09:15 AM, Administrative Nurse D verified R12 entered the open shower house unattended and had the fall that resulted in a fractured left wrist. Administrative Nurse D stated the keypad on the door was locked; however, the door was not pulled shut, so the resident was able to enter the shower house. Administrative Nurse D verified the facility had an in-service and educated staff to keep all doors with keypads or locks shut, and the maintenance staff had installed self-closures on all the shower house doors. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 04/23/25 at 01:30 PM, Administrative Staff A verified R12 fell in the shower house that resulted in a fractured wrist. Administrative Staff A verified that they did an investigation and determined the door was not completely closed, and the resident was able to enter on her own. Administrative Staff A verified that they did an investigation but did not report to the state due to the resident was able to state what happened. The facility's Accidents policy, dated October 2024, documented the facility strives to make the environment as free from accident hazards as possible. Resident safety, supervision, and assistance to prevent accidents are facility-wide priorities. The facility-oriented and resident-oriented approaches to safety are used together to implement a system approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusted interventions accordingly. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. The type and frequency of resident supervision may vary among residents and over time for the same resident. The facility completed the following corrective actions prior to the surveyors entering the facility. The facility submitted education regarding shower room doors: assuring the shower room doors were closed and locked at all times for resident safety, the facility added a self-locking number pad lock to the shower doors, added self-closure to shower door, added self-closure springs to door hinges as added security and back up, and the facility purchased and attached self-closures to utilize in place of the hinge springs for added protection and back up and was completed by 03/20/25. This deficient practice was deemed to be Past Non-Compliance (PNC) as all corrections were completed prior to the surveyors entering the building. The scope and severity of the deficient practice remained at a G.

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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. 32360 The facility had a census of 42 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to measure and record food temperatures for food items at mealtime and the daily refrigerator and freezer temperatures for the evening shift. The facility further failed to record the chemical Parts Per Million (PPM) of the sanitizing solution (Chemical PPM- 50-400) on the Sanitizer Bucket Log three times a day. This placed the residents at risk for food borne illnesses. Findings included: - On 04/21/25 at 07:45 AM, during the initial kitchen tour, the daily temperature logs for the refrigerator and freezer for April 2025, lacked documentation of the temperatures were taken during the following days on the evening shift: 04/10/25, 04/11/25, 04/12/25, 04/13/25, 04/15/25, 04/16/25, 04/17/25, 04/18/25, 04/19/25, and 04/20/25 On 04/21/25 at 07:50 AM, Dietary Staff BB verified the lack of documentation and stated the temperatures of the refrigerator and freezer were supposed to be taken daily in the morning and in the evening. On 04/22/25 at 11:30 AM, during the full kitchen tour, the daily temperature logs for the refrigerator and freezer that previously lacked daily temperatures on the initial tour were filled in with identical temperatures for each day. Dietary Staff CC verified that a dietary staff member had filled in the log and was unsure if the numbers on the log were the accurate temperatures for the refrigerator and freezer. On 04/22/25 at 12:10 PM, Dietary Staff BB obtained the temperatures of the noon meal (taco meat and refried beans) and documented the temperatures in the weekly Temperature Log. Upon record review, the logs for April 2025, the log lacked documentation of daily food temperatures for the following days and mealtimes: 04/01/25- dinner 04/02/25-dinner 04/03/25-dinner 04/04/25-breakfast, lunch, and dinner 04/05/25-dinner 04/06/25-dinner 04/07/25-dinner (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	04/10/25-dinner 04/11/25-dinner 04/12/25-dinner 04/13/25-dinner 04/14/25-dinner 04/15/25-dinner 04/16/25-dinner 04/17/25-dinner 04/18/25-breakfast and lunch 04/20/25-dinner On 04/22/25 at 12:15 PM, Dietary Staff CC verified the lack of documentation and stated the meal temperatures were to be taken for every meal served. On 04/22/25 at 12:25 PM, Dietary Staff BB plated the noon meal. On two separate occasions, Dietary Staff BB found plates with dried food particles on them and set them both on the meal preparation table. On 04/22/25 at 12:30 PM, Dietary Staff CC stated they were aware of resident complaints of dirty dishes and stated they adjusted the spot treatment solution and were using a type of brillo pad (a scouring pad used for cleaning dishes, made from steel wool) to clean the cups. Dietary Staff CC stated staff were to record the PPM three times a day to make sure they have the right solution when cleaning the kitchen areas. Upon review of the facility's daily Sanitizer Bucket Log for April 2025 the log lacked documentation of the chemical PPM for the sanitizing solution for the following: Morning: 15 times out of 22 opportunities Afternoon:15 out of 21 opportunities Evening: 20 out of 21 opportunities The facility's Food Preparation and Service policy, dated 10/24, documented, residents are provided with meals that were prepared by methods that conserve value, flavor, and appearance. Residents were provided with food and drink that was palatable, attractive, and at a safe and appetizing temperature. Food service employees shall prepare and serve food in a manner that complies with safe food handling practices. Thermometers would be placed in hot and cold storage areas and checked for accuracy by accepted public health standards. The temperature of foods held in steam tables would be monitored by food service staff. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Sanitation policy, dated 10/24, documented that equipment, food contact surfaces, and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions. Between uses, cloths and towels used to wipe kitchen surfaces would be soaked in containers filled with approved sanitizing solution. Sanitizing solution would be changed at least once per shift or if the solution becomes cloudy or visibly dirty.

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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** 27168 The facility had a census of 42 residents. The sample included 12 residents, with one reviewed for hospice (a type of health care that focused 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 coordinated care and services provided by the facility with the care and services provided by hospice for Resident (R) 17. This placed the residents at risk for inadequate end-of-life care. Findings included: - R17's Electronic Health Record (EHR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), and muscle weakness. R17's Quarterly Minimum Data Set (MDS), dated [DATE], recorded R17 had moderately impaired cognition. The MDS recorded she required extensive staff assistance with transfers and activities of daily living (ADL). The MDS documented R17 received hospice services. R17's Activities of Daily living (ADL) Care Plan, dated 03/24/25, recorded R17 required extensive staff assistance with most ADL care. R17's plan of care documented the resident had bilateral lower extremity contractures and staff would monitor for skin breakdown and increased. immobility. R17's Hospice Care Plan, dated 03/24/25, documented the resident received hospice services due to the end-of-life process. R17's care plan documented staff would administer medication for comfort and keep the resident as comfortable as possible. The care plan lacked instructions on the services provided by hospice, including the frequency and type of support visits, supplies and medical equipment provided by hospice, medications covered by hospice, and the hospice contact information. Review of R17's clinical record revealed the resident was admitted to hospice care on 01/14/24 with a diagnosis of sarcopenia (a condition characterized by the gradual loss of muscle mass and function, primarily occurring with age). The facility had a plan of care provided by hospice in the electronic health record. On 04/22/25 at 11:15 AM, R17 was dressed in street clothes in a recliner in her room. R17 was eating some candy and visiting with her husband. On 04/22/25 at 04:30 PM, Administrative Nurse D verified that the facility lacked specific information on the facility care plan that coordinated with the hospice care plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175437	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McPherson Operator, LLC	1601 N Main Street McPherson, KS 67460

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Hospice Program policy, dated October 2024, documented the community may contract for hospice services for residents who wish to participate in such programs, including services that would be provided and the coordination of services. The facility would obtain a physician's order for Hospice services to include diagnosis, including physician orders for the prognosis and the basis for prognosis that matched the hospice information on the certification of terminal illness. The policy documented the facility would clarify the residents' advance directives and preferences for end-of-life planning. Identify in writing the services that Hospice would be providing and address in the resident's person-centered care plan. The policy documented hospice would along with the Hospice provider, discuss, plan and obtain orders for preferences in pain management, symptom control, treatment of acute illnesses, and choices regarding hospitalization . Although the Hospice provider retains the primary responsibility for the provision of the hospice care and services, including but not limited to, the community must coordinate the care and ensure the resident receives all necessary care and services.