STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155744	A. BUILDING 00 B. WING	02/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LUTHERAN LIFE VILLAGES	351 N ALLEN CHAPEL RD KENDALLVILLE, IN 46755

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00401421. Complaint IN00401421 - Unsubstantiated due to lack of evidence. No deficiencies related to the allegations are cited. Survey dates: February 14, 15, 16, 17, and 20, 2023 Facility number: 000570 Provider number: 155744 AIM number: 100275010 Census Bed Type: SNF/NF: 69 SNF: 7 Total: 76 Census Payor Type: Medicare: 5 Medicaid: 39 Other: 32 Total: 76 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 21, 2023	F 0000	Please accept this as our credible allegation of compliance to our recent ISDH Annual Recertification and State Licensure Survey that was completed on February 20, 2023. Submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. Please also consider this Plan of Correction for paper compliance. Supportive Documents Uploaded: Audit Forms In-Service Training Agenda	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sadie Fenstermaker	Administrator	03/03/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility failed to ensure orders, treatments, and assessments for a skin tear were completed for 1 of 3 residents reviewed. (Resident 57) Findings include: During an observation and interview 02/16/23 at 10:42 AM, Resident 57 had a clear dressing on the left forearm. the dressin had slightly rolled edges with greying under the edges. The dressing had no date to indicate when it was placed. Under the dressing appeared to be a thick brownish red straight mark, approximately 2 inches long. Resident 57 indicated he had a skin tear from his arm falling off of his wheelchair and hitting something. Resident 57 denied pain to the area, and indicated he was "unable to feel much of anything on that side of his body". Resident 57 indicated the incident happened about a week or 2 ago. Resident 57 had no other disruptions of his skin observable at that time. Resident 57's record was reviewed on 2/16/23 at 12:17PM. Diagnoses included stroke, flaccid left nondominant side, anxiety, and heart disease. A review of physician orders indicated to assist resident in using Velcro strap on wheelchair for left upper extremity, monitor left upper extremity for skin integrity and circulation, and weekly skin assessment. A review of the TAR (Treatment Administration	F 0684	1. Resident 57 – DON reviewed resident orders and treatments and an order for a skin tear dressing was added on 2/16/2023. Progress note documenting assessment of skin integrity was completed on 2/16/2023. 2. Other Residents: DON reviewed all residents with skin tears throughout the building on 2/21/2023. No concerns were identified. 3. Education: Skin Management policy reviewed on 2/21/2023 and no changes necessary. DON provided in-service education to nursing staff on 2/27/2023 regarding correct assessment, orders, and treatment for skin tears. (See attached In-Service Agenda) 4. Quality: Audit tool was developed by DON to monitor residents with skin tears. Audit will be completed by the DON/designee weekly for 4 weeks and then monthly for a total of 6 months. Audit results will be reported monthly during the QAA meeting by the DON/designee. (See attached audit tool)	03/03/2023

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	Record) date January and February 2023 indicated the following: There was no documentation of daily skin integrity documented on 1/23/23, 1/24/23, 1/26/23, 2/6/23, and 2/12/23. There was no documentation regarding assisting Resident 57 to use Velcro strap after 2/15/23. Weekly skin assessments were documented as completed as ordered. Resident 57's weekly skin assessments completed by nursing on 1/8/23, 1/13/23, 1/20/23, 1/27/23, 2/3/23, and 2/10/23 indicated no skin impairment was noted. There was no documentation regarding the condition of the skin tear to the left forearm. Resident 57's progress notes indicated the following: On 1/22/23, his daughter alerted nursing to the skin tear on his left forearm. The documentation indicated they cleansed it with normal saline, applied a tefla dressing then notified the doctor and wound care nurse. The progress note did not indicate an order was received for treatment. On 2/3/23, a note indicated the skin tear to the left forearm was resolved. On 2/16/23 at 7:48 am indicated Resident 57 had picked a scab from a skin tear on his left forearm and now it was bleeding. Resident 57's physician orders dated 1/23/23 included to change dressing to left forearm skin tear daily. The order was updated on 1/29/23 to include cleanse skin tears to left forearm with soap and water then apply tegaderm dressing change dressing every 5 days. A review of the TAR dated February of 2023 indicated the dressing had not been changed for			

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	the month February. In an interview on 02/16/23 at 02:30 PM, the DON (Director of Nursing) indicated the tegaderm was placed by LPN 3 (Licensed Practical Nurse). The DON indicated the dressing was not dated nor initialed due to not wanting to draw Resident 57's attention to the dressing. The DON stated, "he is a picker" and indicated Resident 57 had the behavior of picking at scabs. The DON indicated Resident 57 frequently had scabs on the left forearm. The DON indicated there was no order, assessment, or progress note completed becasue LPN 3 did not have time to do so. Resident 57's behavior monitoring for the last 30 days indicated no behaviors were noted. Resident 57 had no specific behavior tracking for picking. Resident 57's current care plan indicated a new intervention under skin integrity initiated on 2/16/23 of "I have a tendency to pick skin/scabs. Staff to cover as needed". Another intervention included keep skin clean and dry. Use lotion on dry skin, initiated 8/7/20. The care plan addressed diagnosis of anxiety and indicated the anxiety shows as restlessness and seeking out staff attention. The behavior of picking at skin had not been addressed. On 2/18//23 at 2:30 PM, a current policy and procedure titled "Skin Management", revised May 2019, was provided by ED (Executive Director) indicated; "Residents who are at risk or with wounds are/or pressure injuries and those at risk for skin compromise are identified, assessed, and provided appropriate treatment to encourage healing and/or integrity. Ongoing monitoring and evaluation are provided to ensure optimal resident outcomes .... Skin tear... can be partial or full			

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	thickness, usually due to friction an/or shear forces...15. Skin tears will be reported to the licensed nurse upon occurrence. An incident report will be completed in the electronic medical record if from unknown origin. The nurse will notify the physician and the resident representative of the kin tear. The Licensed nurse will initiate skin care with attending physician/s order until healed ... 3.1-37(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure oxygen tubing changes were performed according to standards in 2 of 2 residents reviewed (Resident 15 and Resident 67). 1.During an observation at 11:31 AM on 2/14/23, Resident 15 was observed in bed with a nasal cannula in place delivering 3 liters of oxygen. A piece of tape attached to the oxygen tubing was dated 1/30/23. At 9:23 AM on 2/15/23, Resident 15 was observed in her chair using oxygen at 3 liters by nasal cannula. The tubing was dated 1/30/23.	F 0695	1. Resident 15 – On 2/15/2023 the oxygen tubing was replaced and dated for 2/15/2023. Resident 67 - On 2/15/2023 the oxygen tubing was replaced and dated for 2/15/2023. 2. Other Residents: DON audited other residents on oxygen on 2/15/2023. No concerns were identified. 3. Education: Oxygen policy reviewed on 2/21/2023 and no changes necessary. DON facilitated in-service training on 2/27/2023 with nursing staff to	03/03/2023

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	During a record review at 9:36 AM on 2/15/23, Resident 15 had diagnoses including chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, and Alzheimer's disease with late onset. A Minimum Data Set (MDS) dated 12/28/22 was reviewed. The MDS indicated Resident 15 was cognitively impaired and unable to be interviewed. A physician's order dated 12/17/22 indicated oxygen should be administered at 3 liter per minute by nasal cannula continuously. Another physician's order dated 11/28/22 indicated oxygen tubing should be changed weekly on Sunday nights. 2. During an observation at 9:44 AM on 2/14/23, Resident 67 was observed sitting in a chair in her room with a nasal cannula in place delivering oxygen at 5 liters. No date was observed on the oxygen tubing. During an observation at 9:35 AM on 2/15/23, Resident 67 was observed sitting in her chair using oxygen at 5 liters by nasal cannula. No date was observed on the oxygen tubing. During a record review at 9:48 AM on 2/15/23, Resident 67 had diagnoses including chronic obstructive pulmonary disease (COPD), essential hypertension, and unspecified dementia. An MDS dated 12/22/22 indicated Resident 67 was cognitively impaired and unable to be interviewed. A physician's order dated 12/15/22 indicated oxygens should be administered at 5 liters by nasal cannula every shift for shortness of breath related to COPD. A physician's order dated 12/24/33 indicated oxygen tubing should be		remind them to change/date oxygen tubing weekly as ordered. (See Nursing In-Service Agenda) 4. Quality: Audit tool was developed by DON to monitor resident's weekly oxygen tubing change. Audit will be completed by the DON/designee weekly for 4 weeks and then monthly for a total of 6 months. Audit results will be reported monthly during the QAA meeting by the DON/designee. (See attached audit tool)	

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	changed weekly every Sunday night. During an interview at 9:22 AM on 2/15/23, Licensed Practical Nurse 5 indicated oxygen tubing should be changed weekly on Sunday nights and dated. A current policy titled Policy and Procedure: Oxygen, last revised 2/16/18, indicated oxygen tubing should be changed every Sunday night on night shift. 3.1-47(a)(6)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview, and record review the facility failed to ensure non-pharmacologic interventions were implemented for 2 of 5 residents reviewed. (Resident 8 and Resident 75) 1) During an observation and interview on 2/16/23 at 10:57 AM Resident 8 was observed grimacing, moving very slowly and cautiously. Resident 8 indicated she had been in a great deal of pain from kidney stones. Resident 8 indicated staff were aware of her continued pain and would administer pain medication. Resident 8 denied having any other interventions offered for pain. Resident 8's recorded review began on 2/16/22 at 1:18PM. The record indicated diagnosis included	F 0697	1. Resident 8 – On 3/3/2023 staff began correctly documenting pain assessment and two non-pharmacological interventions attempted prior to PRN pain medication administration. Resident 75 – On 3/3/2023 staff began correctly documenting pain assessment and two non-pharmacological interventions attempted prior to PRN pain medication administration. 2. Other residents: DON audited other residents with PRN pain medication orders on 3/3/2023. No concerns were identified. 3. Education: It is noted that	03/03/2023

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	osteoarthritis of knee, deficit following a stroke, and muscle weakness generalized. Resident 8's physician orders included; Norco tablet 5-325mg give one every six hours for pain, observe for side effects related to opioid medication, offer at least 2 non-pharmalogical interventions prior to giving PRN pain medication, and access pain level every shift. A review of the Medication Administration Record (MAR) dated February 2023 indicated day shift there were 2 times the pain level was not documented. On 2/7/23 pain was documented a 2 on night shift. On 2/8/23 night shift documented pain level was 1. The MAR dated February 2023 indicated Resident 8 was administered Norco 5-325mg tablet at the following times: On 2/1/23 at 2045, 2 non pharmalogical interventions were offered. The documentation indicated the non pharmalogical interventions were ineffective. There was no documentation indicating what the interventions were. On 2/2/23 at 1734, 2 non pharmalogical interventions were offered. The documentation indicated the non pharmalogical interventions were effective, yet the PRN pain medication was given. There was no documentation of what the non pharmalogical interventions were or why the medication was still given. On 2/3/23 at 1812, 2 non pharmalogical interventions were offered. The documentation indicated the interventions were effective, yet the PRN pain medications was given. There was no documentation of what the intervetions were or		facility updated the pain assessment in the EMR on 3/1/23 to give nursing staff the option to show details as to what two non-pharmacological interventions were attempted. Pain Management policy was reviewed on 2/21/2023 with no identified changes. On 2/27/2023 DON in-serviced nursing staff on the pain management policy, reviewed two non-pharmacological interventions, and proper pain assessment documentation. (See attached In-Service Agenda) 4. Quality: Audit tool was developed by DON to monitor residents with a PRN pain medication order. Audit will be completed by the DON/designee weekly for 4 weeks and then monthly for a total of 6 months. Audit results will be reported monthly during the QAA meeting by the DON/designee. (See attached audit tool)	

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	why the pain medication was given. On 2/6/23 at 1852, 2 non pharmalogical interventions were offered. The documentation indicated the non pharmalogical interventions were effective, yet the PRN pain medication was given. There was no documentation of what the non pharmalogical interventions were or why the medication was still given. On 2/7/23 at 0153, there was no documentation of 2 non pharmalogical interventions offered. On 2/7/23 at 1719, 2 non pharmalogical interventions were offered. The documentation indicated the non pharmalogical interventions were effective, yet the PRN pain medication was given. There was no documentation of what the non pharmalogical interventions were or why the medication was still given. On 2/8/23 at 1908, there was no documentation of 2 non pharmalogical interventions offered. On 2/9/23 at 1747, 2 non pharmalogical interventions were offered. The documentation indicated the non pharmalogical interventions were effective, yet the PRN pain medication was given. There was no documentation of what the non pharmalogical interventions were or why the medication was still given. On 2/10/23 at 1640, 2 non pharmalogical interventions were offered. The documentation indicated the non pharmalogical interventions were effective, yet the PRN pain medication was given. There was no documentation of what the non pharmalogical interventions were or why the medication was still given.			

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	On 2/15/23 at 1110, 2 non pharmalogical interventions were offered. The documentation indicated the non pharmalogical interventions were effective, yet the PRN pain medication was given. There was no documentation of what the non pharmalogical interventions were or why the medication was still given. 2) Resident 75's record was reviewed on 2/16/23 at 11:43. Diagnosis included displaced fracture of right femur, type 2 diabetes, and history of stroke. Resident 75's physician orders included offer at least 2 non-pharmological interventions prior to PRN pain medication, observe for side effects related to opioid use, pain level every shift, and Norco 5-325mg give one tabled every 8hrs as needed for severe pain. Resident 75's pain level was documented three times a day from 2/1/23 to 2/15/23 as zero (no pain). She was given Tylenol on 2/4/23 at 1935 with pain documented as zero and twice on 2/12/23 with pain documented each time at a level of 1. Resident 75 was documented as receiving Norco 5-325mg as follows: On 2/1/23 at 2001 there was no documentation of 2 non pharmalogical interventions offered. On 2/2/23 at 2105 there was no documentation of 2 non pharmalogical interventions offered. On 2/3/23 at 0410, 2 non pharmalogical interventions were offered. The documentation indicated the non pharmalogical interventions were ineffective. There was no documentation of what the non pharmalogical interventions were.			

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	On 2/3/23 at 2008, 2 non pharmalogical interventions were offered. The documentation indicated the non pharmalogical interventions were ineffective. There was no documentation of what the non pharmalogical interventions were. On 2/4/23 at 0551 there was no documentation of 2 non pharmalogical interventions offered. On 2/5/23 at 0845, 2 non pharmalogical interventions were offered. The documentation indicated the non pharmalogical interventions were ineffective. There was no documentation of what the non pharmalogical interventions were. On 2/8/23 at 2000, 2 non pharmalogical interventions were offered. The documentation indicated the non pharmalogical interventions were ineffective. There was no documentation of what the non pharmalogical interventions were. On 2/10/23 at 2007 there was no documentation of 2 non pharmalogical interventions offered. On 2/12/23 at 1956 there was no documentation of 2 non pharmalogical interventions offered. On 2/14/23 at 1953 there was no documentation of 2 non pharmalogical interventions offered. On 2/15/23 at 2013, 2 non pharmalogical interventions were offered. The documentation indicated the non pharmalogical interventions were ineffective. There was no documentation of what the non pharmalogical interventions were. In an interview on 02/16/23 at 2:34 PM, LPN 5 (Licensed Practical Nurse) indicated there should had been non-pharmacologic interventions			

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	implemented and documented or marked refused on the MAR prior to the administration of pain medication. LPN 5 indicated if the non pharmalogical interventions were effective no pain medication should be dispensed. On 2/18//23 at 2:00 PM, a current procedure titled "Pain Management", revised October 2020, indicated; "approach for recognition, assessment, treatment, and monitoring of pain ...Recognition: 1...a. recognizes when the resident is experiencing pain. 2. d. facial expressions .... Pain assessment 2. b. asking the patient to rate the intensity of his/her pain using a numerical scale ...Pain management and treatment. 5. Non pharmalogical interventions will include but are not limited to: a. environmental comfort ...b. loosening any restrictive clothing.c. applying splinting ... d. physical modalities. ...e... exercise to address stiffness .... f. cognitive/behavioral interventions ... 3.1-37(a)			
F 0849 SS=D Bldg. 00	483.70(o)(1)-(4) Hospice Services §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in			

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	an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice			

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	155744	A. BUILDING 00 B. WING	02/20/2023

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	assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the			

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	LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.			

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	(iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. Based on observation, interview, and record review, the facility failed to ensure instructions for contacting the correct hospice company were clearly communicated to staff for 1 of 3 residents reviewed (Resident 67).	F 0849	1. Resident 67 – On 2/16/23 the physician order, nurse assignment sheet, hospice binder, and care plan were updated to reflect the correct hospice company. 2. Other residents: DON audited	03/03/2023

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	During a family interview at 1:28 PM on 2/14/23, a family member of Resident 67 indicated they had previously used hospice services from Heart-to-Heart hospice but had recently changed to Parkview Noble Hospice services. The family had initiated and approved this change. During a record review at 9:48 AM on 2/15/23, Resident 67 had diagnoses including chronic obstructive pulmonary disease (COPD), essential hypertension, and unspecified dementia. An MDS dated 12/22/22 indicated Resident 67 was cognitively impaired and unable to be interviewed. A physician order dated 1/10/23 indicated Resident 67 was admitted to Heart-to-Heart Hospice for a diagnosis of end stage COPD. A phone number was listed in the physician's order with instructions to call Heart-to-Heart hospice for hospice care. A physician's order dated 2/6/23 indicated Resident 67 may have Parkview Noble Hospice care evaluate and admit. A care plan dated 12/15/22 indicated Resident 67 received hospice care from Heart-to-Heart hospice. During an observation with Licensed Practical Nurse (LPN) 6 at 10:25 on 2/16/23, red binder labeled Heart-to-Heart hospice was observed with Resident 67's name on it. The binder included records including physician's orders, care plans, and staff visit records and notes. Positioned next to that binder was a green binder labeled Parkview Noble Hospice with Resident 67's name on it containing physician's orders, care plans, and staff visit records and notes.		other residents on hospice services on 2/16/2023. No concerns were identified. 3. Education: Hospice services policy reviewed on 2/21/2023 and no changes necessary. DON provided in-service education to nursing staff on 2/27/2023 regarding hospice orders, care plans, binders, and assignment sheets reflecting the correct hospice company. (See attached In-Service Agenda) 4. Quality: Audit tool was developed by DON to monitor residents on hospice services. Audit will be completed by the DON/designee weekly for 4 weeks and then monthly for a total of 6 months. Audit results will be reported monthly during the QAA meeting by the DON/designee. (See attached audit tool)	

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	During an interview during an observation at 10:25 on 2/16/23, LPN 6 indicated staff should refer to the current physician orders to determine which hospice service a resident is using. He indicated when there is a discrepancy in the orders, staff should refer to a daily assignment sheet. A current daily assignment sheet provided by LPN 6 indicated Resident 67 used Heart-to-Heart hospice service. LPN 6 indicated the physician's orders for Heart-to-Heart hospice should have been discontinued and the records should have been updated to reflect the change to Parkview Noble Hospice. A policy regarding clarification of hospice choice was not available for review.			