STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155157	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Richmond Care Center	1042 Oak Dr Richmond, IN 47374

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 50436 Based on observation, interview, and record review, the facility failed to have the interdisciplinary team (IDT) determine and document self-administration of medications were clinically appropriate for 1 of 6 residents reviewed for medication administration. (Resident T) Findings include: The clinical record for Resident T was reviewed on 11/8/24 at 10:20 a.m. The diagnoses included, but were not limited to, chronic respiratory failure with hypoxia, dry eye syndrome, and chronic viral hepatitis. An Annual Minimum Data Set (MDS) assessment, completed 9/18/24, indicated she was cognitively intact for daily decision making. On 11/6/24 at 10:55 a.m., Resident T had one blue oblong pill sitting in a medicine cup at the bedside. Resident T indicated she did not want the pill, but did not tell the nurse she didn't, so it was left at the bedside. During an observation of Resident T on 11/7/24 at 11:47 a.m., one bottle of Visine eye drops was sitting on the bedside table. Resident T indicated, a nurse just left it here one time, so she just left it. During an interview on 11/7/24 at 11:53 a.m., Licensed Practical Nurse (LPN) 3 indicated Resident T should not have any medications at the bedside and was not sure who left it there. LPN 3 indicated Resident T cannot have any medications left at the bedside nor self-administer medications. During an interview on 11/8/24 at 1:58 p.m., the Director of Nursing Services (DNS) indicated Resident T had not had a self-administration of medication order or care plan in place for self-administration of medications. On 11/12/24 at 12:05 p.m. a Resident Self-Administration of Medications Policy was provided by Unit Manager. The policy indicated, .A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely This citation relates to Complaint IN00446364. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-11(a)

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50436 Based on interview and record review, the facility failed to ensure a proper code status order and care plans were in place for 2 of 4 residents reviewed for code status and care plans. (Resident EE & Resident GG) Findings include: 1. The clinical record for Resident EE was reviewed on 11/8/24 at 1:55 p.m. The diagnoses included, but were not limited to, essential tremor, peripheral vascular disease, and chronic respiratory failure. Resident EE had a Physician Orders for Scope and Treatment (POST) form dated 4/29/24. The form indicated Resident EE was a Do Not Resuscitate (DNR). Resident EE had a physician order for DNR status placed on 7/30/24. An Advance Directive care plan, initiated 12/7/23, indicated Resident EE was a full code. During an interview with the Director of Nursing Services (DNS) on 11/8/24 at 1:50 p.m., she indicated Resident EE had a full code care plan because it had not been updated properly. 2. The clinical record for Resident GG was reviewed on 11/8/24 at 12:30 p.m. The diagnoses included, but were not limited to, diabetes mellitus, depression, and chronic ischemic heart disease. The clinical record indicated Resident GG was admitted to the facility on [DATE]. No POST form, code status order, or code status care plan were present in the clinical record. During an interview with the DNS on 11/12/24 at 12:25 p.m., she indicated Resident GG had not made her mind up yet about her code status. So, we treat them as a full code, and nothing is documented in the Electronic Health Record (EHR) until we get everything signed and completed. A Communication of Code Status Policy provided by the Unit Manager, on 11/12/24 at 12:04 p.m., indicated the following, .It is policy of this facility to adhere to residents' rights to formulate advance directives. In accordance to these rights, this facility will implement procedures to communicate a resident's code status to those individuals who need to know this information .2. When an order is written pertaining to a resident's presence or absence of an Advanced Directive, the directions will be clearly documented in designated sections of the medical record. Examples of directions to be documented include, but are not limited to . a. Full Code, b. Do Not Resuscitate .4. The designated sections of the medical record are: Orders Section This citation relates to Complaint IN00446364. 3.1-4(f)(5)

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 25054 Based on interview and record review the facility failed to provide privacy for residents' medical condition by taking pictures and videos on personal cell phones for 2 of 4 residents reviewed for privacy (Resident KK and Resident W). Findings include: During an interview with Licensed Practical Nurse (LPN) 5 on 11/8/24 at 10:40 a.m., she indicated she had called the on-call Nurse Practitioner (NP) about Resident KK's wound on her leg, and they responded with continuation to monitor the area. LPN 5 indicated she was a new nurse and did not feel comfortable with that. LPN 5 took a picture of the wound on her cell phone and sent it to the Director of Nursing Services (DNS) to get her opinion. LPN 5 indicated she did not send the picture to anyone else and deleted the picture off her phone. During an interview with LPN 4 on 11/8/24 at 2:41 p.m., she indicated she did take a video of Resident W and sent it to the DNS. LPN 4 indicated she was working third shift, and Resident W had a total change in condition. The resident was making a snoring sound, breathing weird, hitting himself, banging on his chest, banging on the walls and tore up his bedroom. This was out of character for the resident. LPN 4 indicated she had tried to call the DNS and when she did not answer she video tapped Resident W and sent it to the DNS. LPN 4 indicated she wanted the DNS to understand how serious the situation was. LPN 4 indicated she did not send the video to anyone else, and she deleted it from her cell phone. During an interview with the DNS on 11/12/24 at 12:13 p.m., she indicated the facility previously had the capability to send pictures of wounds via the electronic health record system and they no longer had that option. LPN 5 and LPN 4 did send the DNS a picture and video of residents because the nurses did not feel like the provider was responding appropriately about these situations and wanted my help. The DNS indicated Resident W was delusional and having hallucinations on the video. Resident W was yelling and hitting himself. LPN 4 had called the on-call Nurse Practitioner (NP), and she gave an order for Ativan (antianxiety medication), and it did not help Resident W. That was why LPN 4 called her and sent the video to her. The resident photograph policy provided by the Executive Director, on 11/6/24 at 10:20 a.m., indicated taking photographs and/or videos of residents was a violation of the residents rights' to privacy and confidentiality. This citation relates to Complaint IN00446364. 3.1-3(o)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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. 25054 Based on observation, interview, and record review the facility failed to utilize smoking aprons during smoking for safety of the residents as assessed for 3 of 3 residents reviewed for smoking safety (Resident J, Resident Z and Resident BB). Findings include: 1. During an observation on 11/7/24 at 11:43 a.m., Resident J was outside smoking with other residents and a staff member. Resident J did not have on a smoking apron. During an interview with Resident J on 11/7/24 at 12:00 p.m., he indicated he did not wear a smoking apron when smoking. Resident J indicated the smoking apron was only for residents who drop things and were not safe during smoking. Review of the record of Resident J, on 11/8/24 at 2:18 p.m., indicated the diagnoses included, but were not limited to, chronic respiratory failure, difficulty walking, chronic obstructive pulmonary disease, diabetes, heart failure and dependence on nicotine. The plan of care for Resident J, dated 7/9/24, indicated the resident was at risk for smoking related injury. The interventions included, but were not limited to, provide a smoking apron while smoking. The Quarterly Minimum Data Set (MDS) assessment for Resident J, dated 8/29/24, indicated the resident was cognitively intact for daily decision making. The smoking and safety assessment for Resident J, dated 10/29/24, indicated the resident was lethargic/falls asleep easily during task or activities. The intervention included, but were not limited to, utilize a smoking apron. 50436 2a. During an observation of the designated smoking area, on 11/6/24 at 11:41 a.m., Resident Z and Resident BB were smoking without a smoking apron in place. The clinical record for Resident Z was reviewed on 11/8/24 at 10:46 a.m. The diagnoses for Resident Z included, but were not limited to, flaccid hemiplegia (neurological condition with a loss of voluntary movement in a limb) affecting left non-dominant side, dependence on supplemental oxygen, and vascular disease. An Annual Minimum Data Set (MDS) assessment, dated 9/17/24, indicated Resident Z was cognitively intact and had limited range of motion of upper extremity on one side and utilized a wheelchair for ambulation. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Smoking and Safety assessment provided by the Director of Nursing Services (DNS), on 11/8/24 at 9:30 a.m., indicated Resident Z had limited or no Range of Motion (ROM) in arms or hands and was to utilize a smoking apron. During an interview on 11/7/24 at 1:50 p.m., Resident Z indicated she occasionally wore a smoking apron and was aware that she was supposed to at all times. Resident Z indicated she had never had any burns while smoking. 2b. The clinical record for Resident BB was reviewed on 11/8/24 at 10:47 a.m. The diagnoses included, but were not limited to, essential hypertension, hypothyroidism, and chronic obstructive pulmonary disease (COPD). A Quarterly MDS assessment, dated 10/2/24, indicated Resident BB had moderate cognitive impairment and was wheelchair dependent for mobility. A Smoking and Safety assessment provided by the DNS, on 11/8/24 at 9:30 a.m., indicated Resident BB was to utilize a smoking apron. During an interview on 11/7/24 at 1:46 p.m., Resident BB indicated he would wear a smoking apron every now and then, when you guys were here. Resident BB indicated he was aware that he was supposed to utilize a smoking apron at all times while smoking. He indicated he had never been burned while smoking but he had gotten ashes on his clothing that caused burn holes in his clothing. During an interview on 11/6/24 at 11:41 a.m., the DNS indicated the facility does a smoking assessment on all residents who smoke. That assessment assesses their abilities to safely smoke. If a resident triggers for not being able to smoke without a risk, they will trigger for a smoking apron to be worn. If they do not trigger, then they are not required to wear one. A Resident Smoking Policy was provided by the Executive Director (ED) on 11/6/24 at 10:20 a.m. The policy indicated the following, .it is the policy of the facility to provide a self and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents .6. Residents who smoke will be further assessed, using the Resident Safe Smoking Assessment, to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all .10. All safe smoking measures will be documented on each resident's care plan This citation relates to Complaint IN00446364. 3.1-45(a)(2)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 45291 Based on interview and record review, the facility failed to obtain physician orders to crush medications for 3 of 5 residents reviewed for medication administration. Findings include: 1. The clinical record for Resident L was reviewed on 11/7/2024 at 1:30 p.m. The medical diagnoses included diabetes. During an interview with Resident L, on 11/6/2024 at 1:15 p.m., they indicated they take their medication crushed since they were admitted to the facility. The physician orders did not reflect an active order to crush medications as needed. 2. The clinical record for Resident O was reviewed on 11/7/2024 at 1:40 p.m. The medical diagnoses included diabetes. The physician orders did not reflect an active order to crush medications as needed. 3. The clinical record for Resident P was reviewed on 11/7/2024 at 1:45 p.m. The medical diagnoses included chronic obstructive pulmonary disease. The physician orders did not reflect an active order to crush medications as needed. During a confidential staff interview completed during the survey, the staff member indicated they crush medications based on nursing judgement. Resident L, Resident O, and Resident P take their medications crushed and have since the staff member has worked with them. The staff member verified Resident L, Resident O, and Resident P do not have orders to crush medications. An interview with Registered Nurse (RN) 1, on 11/6/2024 at 1:41 p.m., indicated they had issues with medication not being able to be crushed, but the pharmacy was unaware of the resident taking medications crushed because of not having physician orders when they review medications. RN 1 stated they provided the Director of Nursing Services (DNS) and the Executive Director (ED) with a list of residents that take crushed medications, but no orders have been obtained for those residents. A blank nursing report sheet was provided by the DNS on 11/7/2024 at 2:30 p.m. The document indicated Resident L, Resident O, and Resident P received crushed medications. A policy, entitled Medication Administration, was provided by the ED on 11/6/2024 at 10:20 a.m. The policy indicated, .Crush medications as ordered . This citation relates to Complaint IN00446364. 3.1-25(b)

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 25054 Based on interview and record review the facility failed to follow-up with monitoring and have an indication for use on a one-time order for Ativan (antianxiety medication) for a resident who was experiencing an acute change in condition for 1 of 3 residents reviewed for change in condition (Resident W). Findings include: During an interview with Licensed Practical Nurse (LPN) 4 on 11/8/24 at 2:41 p.m., she indicated she did take a video of Resident W and sent it to the Director of Nursing Services (DNS). LPN 4 indicated she was working third shift, and Resident W had a total change in condition. The resident was making a snoring sound, breathing weird, hitting himself, banging on his chest, banging on the walls and tore up his bedroom, which was out of character for the resident. LPN 4 indicated she had tried to call the DNS and when she did not answer she video tapped Resident W and sent it to the DNS, on 10/18/24 around 2:30 a.m. LPN 4 indicated she wanted the DNS to understand what a serious situation that was. LPN 4 indicated she did not send the video to anyone else, and she deleted it from her cell phone. During an interview with the DNS on 11/12/24 at 12:13 p.m., she indicated LPN 4 did send the DNS a video of Resident W because the nurse did not feel like the provider was responding appropriately about the situation and wanted my help. The DNS indicated Resident W was delusional and having hallucinations on the video. Resident W was yelling and hitting himself. LPN 4 had called the on-call Nurse Practitioner (NP), and she gave an order for Ativan (antianxiety medication), and it did not help Resident W. That was why LPN 4 called her and sent the video to her. Review of the record of Resident W, on 11/12/24 at 10:36 a.m., indicated the diagnoses included, but were not limited to, opioid dependence, hypertension, muscle weakness, and fatigue. The Admission Minimum Data Set (MDS) assessment, dated 9/30/24, indicated the resident was cognitively intact for daily decision making. The resident was consistent and reasonable. The resident did not have hallucinations, delusions, or behaviors. A progress note for Resident W, dated 10/18/24 at 3:32 a.m., indicated the resident had been in his room since early A.M., around 1:30 a.m., with altered mental status. The resident was standing with eyes rolling in the back of his head, laying on the couch halfway, screaming out, stating that someone was going to push him off his bed if he got on it. The resident was beating on his chest and face with his fists, while seemingly being asleep. The resident was not getting any better, only worse. This nurse sat resident down numerous times to keep him safe and prevent him from falling. There was nothing that was helping the situation. The on-call provider was notified, and the DNS was notified. A progress note for Resident W, dated 10/18/24 at 3:37 a.m., indicated the Nurse Practitioner (NP) response was to administer Ativan two milligrams (mg); one dose. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record did not indicate what the Ativan two milligrams was utilized for or indication of follow up if the Ativan was effective or not effective for Resident W. A progress note for Resident W, dated 10/18/24 at 6:52 a.m., indicated the resident was thrashing on the couch uncontrollably, vital signs were normal, and was unable to answer questions appropriately. The writer suspects resident had taken unprescribed medication. The NP was called, and an order was received to send the resident to the emergency room . A progress note for Resident W, dated 10/18/24, indicated since around midnight the resident had been thrashing, yelling, hitting himself, eyes rolling back in head and general disoriented to person, time, and place. The resident had refused care of his cellulitis this past week and could be septic although his vital signs were normal. The resident became very disoriented, combative with staff, and hitting himself. Ativan two mg was given, around 2:00 a.m., with little effect on his demeanor. The resident was experiencing hallucinations and agitation. The resident was disoriented with mental status changes, usually this resident was very kind and respectful and was currently yelling and hitting himself. The resident was unable to answer if he had taken any substance that he was not supposed to or why his condition suddenly spiraled out of control. The resident was being transported to the emergency room . The progress note was electronically signed by NP 2. A progress note for Resident W, dated 10/18/24 at 7:10 a.m., indicated the fired department was at the facility to transport the resident, NP 2 was in the resident's room as well. The hospital records for Resident W, dated 10/18/24, indicated the resident was admitted to the local hospital with toxic encephalopathy (sudden, severe change in mental function) secondary to cocaine and amphetamine use. The resident had left the long-term care facility yesterday and when he returned, he was altered and confused. The resident remained in the emergency room for several hours, with attempts at metabolizing, but despite this he remained quite sleepy and had to be placed on oxygen. Given the prolonged period of observation in the emergency department, still without return to baseline I do feel that patient will warrant further inpatient management. The provision of physician ordered services policy provided by the Executive Director, on 11/12/24 at 3:00 p. m., indicated the purpose of this policy was to provide reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality. This citation relates to Complaint IN00446364. 3.1-48(a)(3) 3.1-48(a)(4)

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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. 50436 Based on observation and interview, the facility failed to ensure open medication bottles were dated in 2 of 2 medication carts observed for medication storage and four open, un-identified medications laying in medication drawers in 2 of 2 medication carts observed. Findings include: During an observation of Extended Care Unit (ECU) Medication Cart 1 with Registered Nurse (RN) 1, on 11/6/24 at 9:45 a.m., several medication bottles were noted not to have open dates marked on the bottles. Bottles included: one 236 milliliter (ml) Guaifenesin, one 433 ml Enulose, three Polyethylene Glycol 3350 8.3 ounce (oz) bottles, one 473 ml Milk of Magnesia, three 355 ml oral simethicone, one 473 ml Guaifenesin, two Almacone bottles, one 236 ml Dermal Wound Cleanser, and one 10 ml Refresh Optive Advanced. One Fluticasone Propionate inhalation powder was noted to not have a resident label or dates labeled on it. One half of a loose orange oblong pill was laying in the medication drawer. During an interview on 11/6/24 at 9:45 a.m., RN 1 indicated she was unsure where the open pill came from, and it should have been discarded if not used. RN 1 indicated when a new medication bottle is opened, they were to put an open date and expiration date on them. During an observation of the ECU Medication Cart 2 with Licensed Practical Nurse (LPN) 2 on 11/6/24 at 10:00 a.m., one loose blue pill was noted in medication drawer. LPN 2 indicated she was unsure who's medication it was or where it came from, and open medications should not be stored in the medication cart. One Albuterol 90 microgram (mcg) inhaler with spacer was noted laying in the bottom drawer with no resident label on it. LPN 2 indicated, she was unsure who the medication belonged to, and it should be labeled. LPN 2 discarded all loose and unidentified medications. During an observation of the ECU Medication Cart 2 with LPN 2 on 11/6/24 at 10:00 a.m., several medication bottles were noted not to have open dates labeled on them. Bottles included: one 473 ml Enulose, four Guaifenesin 473 ml bottles, one Max Tussin 300 ml bottle, one Milk of Magnesia 473 ml bottle, one 8.3 oz. Polyethylene Glycol, and one Potassium Chloride 10% 473 ml bottle. LPN 2 indicated when a bottle was opened, the open date should be recorded on them. During an interview with the Director of Nursing Services (DNS) on 11/8/24 at 1:20 p.m., they indicated nursing puts the open date and the dispose date anytime a new medication bottle is opened. The DNS indicated they keep a binder at the nurses' stations that has what the discard time lengths should be for different medications. A Medication Storage Policy provided by the Executive Director, on 11/6/24 at 11:22 a.m., indicated the following, .It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations .8. The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, or deteriorated medications with worn, illegible, or missing labels (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This citation relates to Complaint IN00446364. 3.1-25(j) 3.1-25(o)

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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. 50436 Based on interview and record review, the facility failed to ensure an order and care plan were in place for a resident receiving hospice services for 1 of 3 residents reviewed for hospice. (Resident DD) Findings include: The clinical record for Resident DD was reviewed on 11/6/24 at 1:26 p.m. The diagnoses included, but were not limited to, anxiety disorder, diabetes mellitus, and chronic pain syndrome. Resident DD's hospice binder indicated he was placed on hospice on 9/15/24. The clinical record indicated there was not an order for hospice nor a hospice care plan in the Electronic Health Record (EHR). During an interview with the Director of Nursing Services (DNS) on 11/7/24 at 10:29 a.m., they indicated Resident DD's physician put a one-time order in for a hospice services consult for one day only, then the order fell off the EHR after that day, and an order was not put in after that. An interview with the DNS on 11/8/24 at 10:00 a.m., they indicated the facility recently switched over their care plan library for auditing purposes, on 10/28/24, and all of the old care plans were disappearing. A hospice care plan, dated 11/7/24, indicated interventions to coordinate plan of care with hospice services and to obtain physician order and appropriate referral. A Coordination of Hospice Services Policy was provided by the Executive Director (ED) on 11/6/24 at 2:40 p. m. The policy indicated the following, .the facility and hospice provider will coordinate a plan of care and will implement interventions .5. The facility will monitor and evaluate the resident's response to the hospice care plans This citation relates to Complaint IN00446364. 3.1-37(a)