Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 27, 2024

Norfolk COUNTY

Ontario Health

OVERVIEW

Norview Lodge is a 179-bed long-term care home owned and operated by the Corporation of Norfolk County.
Norview Lodge is situated in an area surrounded by trees and wildlife with three landscaped courtyards featuring covered gazebos, and a pavilion. Norview Lodge has recently had some urban development begin around the home and there has been a commitment from the new developer to landscape with a peaceful and as close to rural atmosphere as possible.

The home is a two-storey building featuring eight home areas, one of which is a secure dementia area. Each home area provides both basic and private accommodation for either 22 or 23 Residents, a dining room and shared servery, spa, activity room, family room with fireplace, communication centre and medication room. The central area of the home includes a gift shop, public washrooms, meeting rooms, chapel, hair care salon, therapy room, and a gathering place.
Norview Lodge promotes quality improvement in its day-to-day operations. Our quality improvement plan involves a multidisciplinary approach which encourages and includes ongoing input from staff, through the CQI program process, and from Residents, family members and service providers through surveys, audits, and meetings.

Quality Improvement is on the standing agenda for departmental meetings. The Leadership Team reviews all recommendations and suggestions to determine if the implementation of these will be successful and effective.

As per the Ministry of Long-Term Care regulations, a written

response to all concerns from Resident and Family Council meetings are responded within 10 days.

Community partners such as the Alzheimer's Society, Senior Support Services etc. are integral in providing support and helping Norview to provide the best quality care to suit the individual needs of our Residents.

Norview Lodge's quality indicators show progress in achieving goals as well as reducing risks to Residents through enhanced monitoring of potential areas of concern.

ACCESS AND FLOW

Norview lodge has been working diligently to use all the additional funds provided to promote staff enhancement. From the 4 hours of direct care including the funds received for Allied Health professionals, Norview Lodge has hired a Health Care Practitioner to perform the Nurse practitioner duties within the home. In addition, Norview Lodge has added a Supervisor, Education, Training and Infection Prevention and Control (IPAC) Back-Up. This position is to enhance our ability to educate staff, Residents, and families on all aspects of living and care within the Long-Term Care Home (LTCH). This position enhances our IPAC protocols which helps increase the health and safety of all Residents, staff, and family members.

Furthermore, Norview Lodge has added a permanent part-time Recreation Therapist to the Recreation department to provide additional programming coverage. These enhancements allow Norview Lodge to better serve the mental and therapeutic needs of its Residents. The stimulation that the recreation department provides supports the Residents in many ways.

Norview lodge has a permanent full-time Restorative Care Aide to assist with required restorative care needs for Residents. Behavioral Supports Ontario (BSO) are now an embedded model here at Norview Lodge. Two BSO members are on site for approximately 3-4 days per week assisting Residents. BSO staff provide support related to episodic referrals and transition support through admission. Also, BSO do enter the home for transitional leads and this provided support assists Residents from the community into the LTC home for up to 6 weeks.

EQUITY AND INDIGENOUS HEALTH

Norview Lodge is an equal opportunity LTC home as well as Norfolk County is an equal opportunity employer. Staff are provided with the ability to disclose additional languages that they can speak. This assists with Resident suffering from limitations of health condition that bring them back to the primary cultural speaking ability.

Some examples of the training provided to staff are the Respectful Workplace and Violence Prevention Policy located on our electronic training platform called Surge Learning. Norfolk County also provides corporate orientation in which some of the related topics addressed are workplace bullying and harassment including a video addressing unconscious bias, and respecting others.

Norview Lodge understands the importance of providing education to all staff on the complex topics of equity, inclusion, diversity, anti-racism and Indigenous Health and is in the planning stages of such training programs.

As listed in the Service Accountability Agreement (SAA), Norview Lodge must provide service in French, submit the appropriate French language reports and post documents in both English and in French.

PATIENT/CLIENT/RESIDENT EXPERIENCE

Norview Lodge takes this category very serious as this is where there is an opportunity to make a positive change for our Residents and families.

There are already questions asked on satisfaction surveys as well as consistent interaction with Residents both daily and at Multi-teams/Care Conferences. These survey questions are used in proactive plans to enhance the care needs identified by the Residents as well as by family members to created action plans. In addition, Resident council meetings provides an interaction with Residents to find out their experiences, level of satisfaction and future needs.

When this information is received, many of the programs and interactions have tailored outcomes to achieve what is needed to enhance the Resident experience.
Our leadership team is provided with specific and related questions from the surveys as well as individual meetings (Resident, family council and Multi-Teams) to respond with outcomes. Norview Lodge has a very in-depth. Response process that also incorporates direct follow up even if it is a phone call if that is what is requested.

Regular rounds, audits and inspections are conducted by members of the Leadership Team and applicable staff of their respective areas and responsibilities. Dining room, Health and Safety, Infection Control and Personal Safety Device Audits are conducted as required to continue to go over items and support staff, Residents and family needs.

PROVIDER EXPERIENCE

Norview Lodge is part of Norfolk County and although that brings many benefits, these are difficult times for all LTCHs. While recruitment has taken on many required changes and needs, Norview Lodge continues to do the best possible job to ensure staff feel educated and prepared for their start at Norview Lodge. Candidates are interviewed where they are given the opportunity to request workplace accommodation, as required. If successful, staff are then verbally offered the position where the conversation begins with a mutually agreed start date. This allows the candidate to ensure a significant length of time is provided for notice to their current employer as well as if they need to make a medical appointment or arrange items for home life that can be achieved. Recruitment, along with staff onboarding is now completed electronically, allowing for a reduction of paper however causing an increased dependence on technology for Norview Lodge, Norfolk County and the potential new employees.

When the staff are officially on boarded, they are provided in writing with enhanced direction of what is needed and the steps with time provided for this process. Staff orientation includes a complete first day of training usually with a coworker to go over all pertinent policies for both safety and Resident needs. Then the on-floor orientation begins, staff are partnered with a coworker for their appropriate number of shifts, as required for orientation. This allows the staff members to be orientated to different areas of the home as well as the different shifts that they will be required to work.

Norfolk County has found multiple ways to recognize staff. Staff appreciation events continued to happen recognizing significant years of service. This also came with inviting a guest, receiving a certificate and a gift card of different denominations (for certain years of service) as well as a very delicious meal (take-out in or take-out) for both the employee and their guest, which has also been extended to recent retirees.

We are constantly hiring but there are so many long-term care homes recruiting. The positions must be exactly what the individuals are expecting, or they just continue to move on. Norview is very fortunate as we are a municipal home which allows a very respectful compensation package to all staff. In addition, Norview Lodge has a wonderful reputation within the community as well as surrounding areas. Many applicants come from within the community, but also other staff have been coming to Norview from surrounding locations. This has helped with our recruitment.

One of our main concerns is staff burn out along with recruitment and retention of staff. When it comes to staff burn out, we must adapt and find new, positive ways to address as previous methods are no longer applicable. The ability to remain flexible within the collective agreement was helpful as vacations were adapted to provide an opportunity for staff to have time off, which has helped. Norview lodge is also hiring more staff to assist with staff being required to work less weekends in a row.

Norview Lodge has always maintained the best approach possible for staff when it comes to items like shift switch flexibility. For example, some staff have reduced shifts or an increased break between their shift rotation switchovers.

In 2023, Norview Lodge hired an estimated 78 new staff with 25 staff who secured full-time due to direct care requirements and 53

staff left due to retirement, resignation, or termination.

SAFETY

Whenever there is a near miss and/or actual incident that involves a Resident or staff member, these situations are reviewed by applicable staff and the Leadership Team to develop an action plan to reduce the risk and hopefully prevent any future recurrence.

All assessments that are conducted including Skin and Wound, Falls and Pain, provide an area of focus and potential improvement or at least action plans to assist for treatments moving forward. Other assessments require a review and potentially discussed outcomes at a committee meeting, such as Pharmacy and Therapeutics and Infection Prevention and Control (IPAC), where some of the information requires a more detailed discussion and analysis to happen.

Each CIS is reviewed and signed off. When the CIS is submitted, the analysis has begun to look for further development, and any potential improvements.

Staff have been educated in the category of risk management assessments. What this does is allow staff to have the ability to use critical thinking to look at a situation and make the best possible judgement to create a safe culture for staff, visitors, families and Residents.

POPULATION HEALTH APPROACH

Norfolk County does participle in the Associated Ontario Health Team by being involved in the executive leadership group. As Norfolk County operates the Public Health unit for both Haldimand and Norfolk Counties, there is a very diverse approach to providing all our health-related services, which include Norview Lodge.

The General Manager of Health and Social Services oversees the complete division including all associated departments of Health and Social Services. The Medical Officer of Health for both counties as well as Norview Lodge are departments of the Health and Social Service division, which means we have a very quick access to public health for consultation and advice for IPAC measures as well as a shared information system for IPAC trends.

In addition, hospital and community or shared health services information is easily accessible. Some examples of additional community groups include the Alzheimer's society who provide staff training and support and Senior Support Services offer transportation services. Norview Lodge' s Administrator sits on the Dementia Committee for Brant, Brantford Ontario Health Team, and the Regional Administrator group through AdvantAge Ontario.

SIGN-OFF

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on

March 27th, 2024

Amy Martin

Amy Martin, Mayor Board Chair / Licensee or delegate

Bill Nolan

Bill Nolan, Administrator /Executive Director

Caitlyn Stefan, Quality Committee Chair or delegate

Other leadership as appropriate

Access and Flow | Efficient | Priority Indicator

	Last Year		This Year	
Indicator #4 Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Norview Lodge)	**2.97** **Performance (2023/24)**	**2** **Target (2023/24)**	**11.79** **Performance (2024/25)**	**2.90** **Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

"#1. Provide education and awareness to Registered Staff on the benefits and approaches to preventing ED transfers. #2. Modify the standardized tracking tool for all ED transfers. #3. Revise the Resident Information Package to include information on in-house treatments and services that can be provided in-house with the focus on the benefits and approaches to preventing ED transfers."

Process measure

- **#1. Total number of Registered staff who have received the education. #2. The CQI Lead or designate will utilize the tracking tool for monitoring ED transfers. #3. All new Resident admissions will be given the updated Resident Information package by the Social Work at the time of admission.**

Target for process measure

- **#1. 100% of the Registered Staff will have received the education on ED transfers by October 31, 2023. #2. 100% of all ED transfers will be documented on the tracking tool and reviewed at Medical Advisory meetings. #3. By June 1, 2023, all new Resident admissions will receive the updated Resident Information package.**

Lessons Learned

Education to Registered Staff was not implemented as other educational opportunities took priority such as MST initiatives and IPAC education.
We have moved this forward into 2024-2025 QIP initiatives.
The tracking tool for ED visits was effective in aiding the home to review reasons and specifics around each Resident transfer to hospital. The review was completed monthly by the Manager of Nursing and Personal Care and then presented quarterly at Medical Advisory meetings.
The implementation of the inclusion and exclusion criteria related to Potentially Avoidable ED Visits provided efficient tracking. The home had a decrease in ED transfers from 7.39 rate per 100 Residents/LTC home Resident in 2022 to 2.9 rate per 100 Residents/LTC home Residents in 2023.
The Resident Information Package was updated to include in house treatments and assessments, and it provides the family with the information on what services/medical interventions the home can provide to prevent unnecessary transfers to hospital.
All new Resident admissions to the home, received the Resident Information Package with the new updated information regarding in house services/medical interventions.

Experience | Patient-centred | Priority Indicator

	Last Year		This Year	
Indicator #3 Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Norview Lodge)	**97.78** **Performance (2023/24)**	**100** **Target (2023/24)**	**CB** **Performance (2024/25)**	**100** **Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

To add this to the monthly billings to increase the knowledge and ability of Residents and family members for encouragement to complete the Resident Surveys.

Process measure

- While the Survey is uploaded and available for completion, have the Social Service Worker and home area staff perform a secondary reminder. The Social Service Worker will also be going to the home areas to assist those Residents who are not technologically savvy and assist with either electronic or paper-version completion.

Target for process measure

- Increase our number of completed Surveys by 10%

Lessons Learned

The Resident surveys were included in Resident billings, and we saw an increase in Resident survey completion.
Residents who had a CPS score of 0-2 and above completed the Resident survey and if the Resident was not able to complete, then the Family completed the Family Survey.
This change idea was effective as we had
97% Resident participation based on CPS score of 0-2, complete the Resident satisfaction survey. This was an increase from 88 % Resident participation in 2022. The home utilized staff (CQI Lead/Social Worker) to reach out to the Residents who were not able to independently complete the survey and assist them.

54 Families/POA completed the Family Satisfaction Survey in 2023. This is an increase from 38 Families/POA in 2022.

Indicator #2	Last Year		This Year	
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (Norview Lodge)	**60** Performance (2023/24)	**90** Target (2023/24)	**100** Performance (2024/25)	**100** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

"#1. To add this to the monthly billings to increase the knowledge and ability of Residents and family members for encouragement to complete the Resident Surveys. '#2. Improve Resident and Family participation in the annual satisfaction surveys '#3. Residents with a CPS score of 2 or below will complete the annual satisfaction survey and the POA / Substitute Decision Maker will complete it for Residents with a CPS score of 3 or above."

Process measure

- "#1. While the Survey is uploaded and available for completion, have the Social Worker and home area staff perform a secondary reminder. The Social Worker will also be going to the home areas to assist those Residents who are not technologically savvy and assist with either electronic or paper-version completion. '#2. Percentage of Residents who have completed the annual survey. '#3. Percentage of POA / Substitute Decision makers who have completed the annual survey."

Target for process measure

- "#1 & #2. Increase the percentage of Residents who complete the annual survey to 90% #3. Increase the percentage of POAs / Substitute Decision Makers who complete the annual survey to 90%."

Lessons Learned

The Resident surveys were included in Resident billings, paper copies and access via internet/electronic surveys starting in April 2023. This change idea was effective in increasing the number of surveys that were completed and
Resident survey participation was 88% in 2022, including Residents with CPS score of 0-2. Resident survey participation was 97% in 2023, including Resident with CPS score of 0-2. Family/POA Surveys completed in 2022 was 38 and 54 were completed in 2023.

Safety | Safe | Priority Indicator

	Last Year		This Year	
Indicator #1 Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Norview Lodge)	**31.24** **Performance (2023/24)**	**30** **Target (2023/24)**	**36.06** **Performance (2024/25)**	**NA** **Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

#1. Complete GPA Certification and/or GPA Recharged training with all current staff. #2. Initiate the ongoing review of anti-psychotic medication usage with each Resident at a their Three-Month Medication Review.

Process measure

- #1. Percentage of staff who have completed GPA (full course) and percentage of staff who have completed GPA Recharged. #2. 100% of Residents who are on anti-psychotic medication will be reviewed by the Physician / Nurse Practitioner on their Three-Month Medication Review.

Target for process measure

- #1. To complete 6 training sessions with 12 staff per session for a total of 72 staff complete GPA Recharged from all departments by October 31, 2023. #2. 100% of Residents who are prescribed anti-psychotic medication will receive a Three-Month Medication Review of their medications to determine the potential for reducing the dosage and/or discontinuing any of the anti-psychotic medication.

Lessons Learned

GPA recertification took place and we had 74 staff complete GPA Recharged. Staff who attended the education were given additional tools and strategies in dealing with Residents who displayed responsive behaviors.
The home currently has 74 % of the staff that have completed, GPA, GPA Recharged and Crisis Intervention.
Quarterly Resident Medication Reviews are completed by Physician/Nurse Practitioner. At these reviews, attention was focused on anti-psychotic medication as we saw this change idea was effective.
We did see a reduction from Quarter 3 (Oct-December 2022) from 37.7 % of Residents on inappropriate anti-psychotic usage to 30.9% in Q2 (July-September 2023)

Access and Flow

Measure - Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	O	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 1st 2022 to September 30th 2023 (Q3 to the end of the following Q2)	11.79	2.90	To maintain number of ED transfers at current performance.	

Change Ideas

Change Idea #1 **Provide education and awareness to Registered Staff/Resident/Families about what can be managed in house. 2. Utilize the ED transfer data, to assist the home in reasons that contribute to ED transfers.**

Methods	Process measures	Target for process measure	Comments
1. Provide continuous education for Staff/Residents/Family about what treatments and services can be provided in house - Addition of Nurse Practitioner to team, which provides an additional accessibility for assessment in home rather than transferring to hospital for assessment. 2. Continue to track ED visits on Tracking Tool – details surrounding visit are input into tracking tool to monitor characteristics of each ED visit and review	1. Number of ED Visits	Maintain number of ED transfers at status quo	

Equity

Measure - Dimension: Equitable

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	CB	50.00	This is a new initiative and no staff have been trained yet.	

Change Ideas

Change Idea #1 1.Provision of in house education to Staff related to equity, diversity, inclusion and antiracism education

Methods	Process measures	Target for process measure	Comments
Focus on Management Team and Registered Staff to complete relevant education focused on equity, diversity, inclusion and antiracism.	1. Number of Staff who have received education	1. As this will be an introduction of new education – current performance is 0% 2. Target is to increase number of educated Management and Registered Staff to 50%. 3. To complete training sessions with 68 staff by October 31, 2024 of the Management Team and Registered Staff.	

Experience

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	O	% / LTC home residents	In house data, NHCAHPS survey / Most recent consecutive 12-month period	100.00	100.00	To increase positive percentage of respondents to 100%	

Change Ideas

Change Idea #1 1. Increase awareness on how Residents can give feedback and provide their input on the care and services they receive 2. Provide more opportunities for Residents to provide feedback and input on their care

Methods	Process measures	Target for process measure	Comments
1. Resident Satisfaction Survey has been revised this year with updated questions and comment section added to each question to encourage Resident feedback. Survey continues this year to be available electronically as well as paper copies. 2. CQI Lead to attend monthly Resident Council Meetings and quarterly Family Council Meetings to discuss changes, ask for feedback/ideas/suggestions from councils. 3. Creation of Information Poster for Resident Home Areas that outlines who to direct Questions/Concerns/Suggestions to for Residents/Family Members 4. Continue to provide education on Resident Rights and Resident Centered Care for all Staff through Surge Learning Annually.	1. Number of Surveys 2. Number of Residents Completing Surveys 3. Number of POA/SDM completing Surveys	1. Increase number of Residents responding positively to "What number would you use to rate how well the staff listen to you?" to 100%?	Total Surveys Initiated: 62 Total LTCH Beds: 179

Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	O	% / LTC home residents	In house data, interRAI survey / Most recent consecutive 12-month period	CB	100.00	To increase positive percentage of residents to 100%	

Change Ideas

Change Idea #1 **1. Provide more opportunities for Residents to give feedback and input on their care. 2. Send out Surveys with monthly billings to increase knowledge and ability of Residents and family members and encouragement to complete Surveys.**

Methods	Process measures	Target for process measure	Comments
1. Resident Satisfaction Survey has been revised this year with updated questions and comment section added to each question to encourage Resident feedback. Survey continues this year to be available electronically as well as paper copies. 2. Creation of Information Poster for Resident Home Areas that outlines who to direct Questions/Concerns/Suggestions to for Residents/Family Members 3. CQI Lead to attend monthly Resident Council Meetings and quarterly Family Council Meetings to discuss changes, ask for feedback/ideas/suggestions from councils. 4. CQI Lead to continue to assist Residents in completion of Surveys	1. Number of Surveys 2. Number of Residents Completing Surveys 3. Number of POA/SDM completing Surveys	1. Increase number of residents who responded positively to the statement "I can express my opinion without fear of consequences" to 100%.	

Safety

Measure - Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	O	% / LTC home residents	CIHI CCRS / July 2023– September 2023 (Q2 2023/24), with rolling 4-quarter average	17.33	16.00	To reduce the number of residents who fell.	

Change Ideas

Change Idea #1 1. Review details surrounding all Falls (time, place, repetitive falls) – Revision of Fall interventions as needed 2. Annual Training for all Staff (Surge Learning) 3. Post Fall Investigation/Post Fall Assessment by Registered Staff

Methods	Process measures	Target for process measure	Comments
1. Maintain Fall Prevention Management Program – All Falls will be reviewed at Quarterly Falls Committee Meetings to discuss Circumstances Surrounding Falls, Fall Prevention Items in Place and Next Steps/Suggestions to prevent future falls. 2. Creation of New Falls Committee Review Progress Note to document discussions at Falls Committee Meeting. 3. Review process for Post Fall Huddle with Registered Nursing Staff, Review what is involved with Post Fall Investigation Process. 4. Revision of Post Fall Progress Note.	1. Number of Falls occurring in whole Home	1. 100% of Falls reviewed Quarterly at Falls Committee Meeting 2. 100% of Falls reviewed by unit staff to identify contributing factors/fall prevention items in place/need for new/altered Fall prevention items 3. Number of Falls will decrease by 1.2%.	

Measure - Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Pressure Ulcers-Percentage of LTC Home Residents who developed a Stage 2 or higher pressure ulcer.	C	% / LTC home residents	CIHI CCRS / 2022-2023	3.90	2.90	Reduction in new stage 2 or higher pressure ulcers by 1%.	

Change Ideas

Change Idea #1 **New Skin and Woung Application to be implemented in Point Click Care-Education for Registered Staff on how to use application. 2. Education for all Staff on Skin Care/Repositioning for pressure ulcer prevention. 3. Wound Care Nurse continues to complete rounds and assessments of wounds weekly.**

Methods	Process measures	Target for process measure	Comments
1. Implementation of New Skin and Wound Application in Point Click Care. 2. Yearly Education on about Skin Care and Repositioning, Prevention of Pressure Ulcers for all Nursing Staff 3. Wound Care Nurse to complete rounds weekly for monitoring of High Risk Wounds	1. Number of Registered Staff Trained on using the Skin and Wound Application 2. Number of Nursing Staff receiving training on pressure ulcer prevention	1. 100% of Registered staff feel comfortable using Skin and Wound Application to ensure information is accurate 2. 100% of all nursing staff will receive training on pressure ulcer prevention	

Measure - Dimension: Safe

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
End of Life Care Discussions	C	% / LTC home residents	Local data collection / October 1, 2023 to January 31, 2024	0.00	100.00	100% of New Admissions	

Change Ideas

Change Idea #1 Creation of a Goals of Care Discussion Progress Note. 2. Continue to use End of Life Care Plan templates within Point Click Care.

Methods	Process measures	Target for process measure	Comments
1. Goals of Care Discussion Progress Note created to document Resident Goals of Care – Discussion beginning on Admission and reviewed during Annual Multi Team Meeting and on an as needed basis. 2. Continue to use EOL Care Plan Templates within PCC to individualize Resident End of Life Care.	1. Number of Residents/POA/SDM who have had Goals of Care Discussions documented in Resident chart. 2. Number of Residents receiving End of Life Care that have had EOL Care Plan initiated.	1. Goal that 100% of New Admissions will have this implemented and working toward whole home documentation in Goals of Care Discussions progress notes. 2. Goal that 100% of Residents receiving End of Life Care will have Care Plan in place.	