STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155022	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF SHELBYVILLE	2309 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00422534, IN00427915, IN00427968 and IN00428299. Complaint IN00422534 - No deficiencies related to the allegations are cited. Complaint IN00427915 - Federal/state deficiencies related to the allegations are cited at F676, F695 and F697. Complaint IN00427968 - No deficiencies related to the allegations are cited. Complaint IN00428299 - No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey dates: February 19, 20, 21 and 22, 2024 Facility number: 000009 Provider number: 155022 AIM number: 100274760 Census Bed Type: SNF/NF: 68 Total: 68 Census Payor Type: Medicare: 5 Medicaid: 45 Other: 18 Total: 68 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1	F 0000	**Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.** **We respectfully request paper compliance for this survey.**	

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

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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	Quality review completed on February 29, 2024			
F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including			

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	(i) Speech, (ii) Language, (iii) Other functional communication systems. Based on interview and record review, the facility failed to ensure a resident's preference for frequency of bathing was honored on a regular basis for 1 of 4 residents reviewed for bathing. (Resident B) Findings include: The clinical record of Resident B was reviewed on 2-20-24 at 9:42 a.m. Her diagnoses included, but were not limited to chronic obstructive pulmonary (lung) disease (COPD), dementia, diabetes, chronic respiratory failure, unspecified heart failure, fibromyalgia, chronic atrial fibrillation, high blood pressure and glaucoma. Her most recent Minimum Data Set analysis, dated 1-8-24, indicated she is moderately cognitively impaired, requires a walker or wheelchair for mobility and requires substantial assistance with bathing. In an interview on 2-20-24 at 1:41 p.m., with Resident B, she indicated she prefers to receive bedbaths as opposed to a shower or tub bath and is scheduled for Tuesdays and Friday evenings. She indicated in recent weeks, this has only happened once a week with her last bedbath one week ago. A review of Resident B's bathing records for January and February, 2024 were reviewed. It indicated she was scheduled for bathing on Tuesday and Friday evenings. In January, it indicated she did not receive a bedbath on 3 of 4 Fridays, specifically 1-5-24, 1-12-24 or 1-26-24. In February, it indicated she did not receive a bedbath on 1 of 3 Fridays, specifically 2-16-24.	F 0676	**F676 Activities Daily Living (ADLs)/Mntn Abilities** **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident B had the potential to be affected by the alleged allegation, but no adverse effects were noted. An audit was conducted on resident Bs bathing preferences and documentation. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents residing in the facility have potential to be affected by the alleged deficient practice. 100% audit of CNA assignment sheets for residents residing in the facility was completed. If a resident was found to not have preferences documented on CNA assignment sheet staff were educated and preference was put into place. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not occur?**	03/20/2024

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	A care plan for activities of daily living (ADL) "self-care performance deficit," initiated on 1-27-22, and revised most recently on 7-31-23, failed to identify specific bathing needs for Resident B or her preference for bedbaths twice weekly. It identified various care needs, such as eating, dressing, toileting, oral care and sleep location preference,and included level of assistance required, varying from limited to extensive assistance. This Federal tag relates to Complaint IN00427915. 3.1-38(a)(2)(A) 3.1-38(b)(2)		The DON or designee will educate staff regarding resident preferences and documentation when bath is given. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Don or designee will do bathing documentation audits five times weekly for two weeks, biweekly for six weeks, and weekly for four months to ensure bathing preference is being conducted. Any identified trends will be corrected upon discovery, documented on facility QA tool and reported during QA committee meeting overseen by the HFA. The QA tool will be utilized for 6 months.	
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 therapy	F 0695	**F695 Respiratory/Tracheostomy Care and Suctioning**	03/20/2024

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	supplies were maintained in a clean and hygienic manner for 1 of 3 residents reviewed for oxygen therapy services. (Resident F) Findings include: During a care observation on 2-21-24 at 3:30 p.m., Resident F was observed receiving supplemental oxygen via a nasal cannula at 3 liters per minute. Her oxygen concentrator (machine delivering supplemental oxygen) was observed to have oxygen tubing without any identifier as to the date the tubing was replaced. Additionally, there was not a storage bag for oxygen tubing for the concentrator. Her portable oxygen tank tubing had an identifier to indicate it had been most recently changed on 2-18-24, and had a storage bag for the oxygen tubing. This was verified by CNA 4, who was present at that time, due to care provision to Resident F. A review of Resident F's physician orders, dated 1-28-24, indicated, "Change O2 [oxygen] tubing and bag weekly and date every day shift every Sun [Sunday]." She was physician-ordered to receive supplemental oxygen at 3 liters per minute continuously, as of 1-23-24. A review of Resident F's February, 2024, treatment administration record indicated facility staff had signed off to indicate the weekly oxygen tubing and bag change had been conducted on 2-4-24, 2-11-24 and 2-18-24. In an interview on 2-22-24 at 12:45 p.m., with the Director of Nursing, she indicated she could not locate a specific policy or procedure for the frequency of changing the oxygen tubing. She added it is her expectation that staff will follow the physician orders to change the oxygen tubing and		**What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident F, had the potential to be affected by the alleged deficit practice, but no adverse affects were noted. Resident F had no identifier or bag for the oxygen concentrator. The portable oxygen tank tubing did have an identifier and a storage bag. It was documented in the TAR and had been signed off that the tubing and bag had been changed the same date that the portable oxygen tank bag and tubing had been changed. The tubing and the storage bag were changed and dated immediately upon notification. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All Residents residing in the facility that receive oxygen therapy have the potential to be affected by the alleged deficient practice. All residents who receive oxygen therapy were reviewed and if found to not have an identifier on the tubing or a bag for the tubing it was replaced. **What measures will be put into place or what systemic**	

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	supply bags at least every 7 days and as needed. She indicated the facility's contracted oxygen company assumes responsibility for replacement of the oxygen concentrator's filters on an annual basis or as needed. Staff are to monitor the oxygen settings for any resident receiving supplemental oxygen therapy. This Federal tag relates to Complaint IN00427915. 3.1-47(a)(6)		**changes you will make to ensure the deficient practice does not occur?** The DON or designee will educate the nursing staff regarding the physician order to change and date the storage bags and oxygen tubing weekly. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** All residents receiving oxygen therapy will be reviewed weekly for three months and bimonthly for three months to ensure storage bags and tubing have been changed and have proper identifiers. Any identified trends will be corrected upon discovery, documented on facility QA tool and reported during QA committee meeting overseen by the HFA. The QA tool will be utilized for 6 months.	
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 interview and record review, the facility	F 0697	**F697 Pain Management**	03/20/2024

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	failed to ensure 1 of 4 residents reviewed for pain medication received pain medications as ordered by their physician. (Resident B) Findings include: In an interview on 2-20-24 at 1:41 p.m., with Resident B, she indicated her primary concern is getting her pain medication as ordered. She indicated it is ordered routinely at 6:00 a.m., 2:00 p.m., and 10:00 p.m., and also has an as needed order for the same medication that she can receive one tablet every 12 hours as needed for pain. She indicated some staff give her pain medication too early and some administer it late, which can make it hard to keep her pain at bay. The clinical record of Resident B was reviewed on 2-20-24 at 9:42 a.m. Her diagnoses included, but were not limited to, chronic obstructive pulmonary (lung) disease (COPD), dementia, diabetes, chronic respiratory failure, unspecified heart failure, fibromyalgia, chronic atrial fibrillation, high blood pressure and glaucoma. Her most recent Minimum Data Set analysis, dated 1-8-24, indicated she is moderately cognitively impaired, requires a walker or wheelchair for mobility and receives scheduled and as needed (PRN) pain medications. A review of Resident B's narcotic pain medications orders were as follows: -Norco Oral Tablet 5-325 milligram (mg) (Hydrocodone-Acetaminophen), give 1 tablet by mouth every 12 hours as needed for moderate to severe pain was ordered on 2-1-24. -Norco Oral Tablet 5-325 mg (Hydrocodone-Acetaminophen), give 1 tablet by mouth three times a day at 6:00 a.m., 2:00 p.m. and 10:00 p.m., effective 2-1-24. This was a time		**What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident B had the potential to be affected by the alleged deficient practice, but no adverse effects were noted. As noted by the surveyor's notes in the 2567, citing the documentation within the MAR(Medication Administration Record), the resident received all required dosages on time. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents with routine narcotic pain management have the potential to be affected by the alleged deficit practice. Narcotic sheets and MAR were audited and nursing staff educated on need to give pain medication within doctor order parameters if found to be out of parameters. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not occur?** Staff who administer medications educated on narcotic count sheets matching the MAR, but the facility does not use the narcotic count	

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	change order from the previous administration times of 7:00 a.m., 3:00 p.m. and 11:00 p.m. A review of Resident B's January and February, 2024 narcotic logs for her Norco and her medication administration records (MAR) revealed the following: -The routinely scheduled Norco was ordered to be administered at 7:00 a.m., 3:00 p.m., 11:00 p.m. during the month of January. -1-5-24, the 7:00 a.m. dose was given late at 8:30 a.m., but documented on the MAR as given at the scheduled time. -1-5-24, the 11:00 p.m. dose was given early at 9:00 p.m., but documented on the MAR as given at the scheduled time. -1-8-24, the 11:00 p.m. dose was given late on 1-9-24 at 12:06 a.m., but documented on the MAR as given at the scheduled time. -The routinely scheduled Norco administration time was changed on 2-1-24 to 6:00 a.m., 2:00 p.m., and 10:00 p.m. -2-3-24, the 6:00 a.m. and 2:00 p.m. doses were not documented on the narcotic log, but were documented on the MAR as given at the scheduled time. -2-9-24, the 6:00 a.m. dose was not documented on the narcotic log, but was documented on the MAR as given at the scheduled time. -2-17-24 and 2-18-24, the 10:00 p.m. dose was administered too early at 8:00 p.m., but were documented on MAR as given at the scheduled time. Resident B's care plans for "pain/discomfort r/t [related to] osteoporosis and chronic left knee pain and fibromyalgia," was initiated on 1-27-21, and most recently revised on 5-9-23, indicated as an intervention, "Administer pain medication per MD order."		sheets for Medication Administration times. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** DON or designee will audit narcotic pain medication sheets for accuracy five times weekly for two weeks, biweekly for six weeks, and weekly for four months. Any identified trends will be corrected upon discovery, documented on facility QA tool and reported during QA committee meeting overseen by the HFA. The QA tool will be utilized for 6 months. The facility respectfully requests to IDR this finding. As noted within the 2567 the facility's Medication Administration Record (MAR) showed the medication was administered appropriately per the physician's order. The surveyor's findings noted issues with the timing documented on internal narcotic logs. The facility has never intended, nor implied, that the narcotic logs were meant to show the administration time of the medication. These logs are used in order to remain in compliance with F755 Section D. regarding the recording of and reconciliation of controlled medications. The facility's MAR,	

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	On 2-21-24 at 1:15 p.m., the Director of Nursing provided an undated copy of a policy entitled, "Medication Administration." This policy indicated, "Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection...Administer within appropriate time frame prior to or after scheduled times unless otherwise ordered by physician." In an interview with the Direction of Nursing on 2-22-24 at 8:40 a.m., she clarified the medication administration policy, referring to "appropriate time frame." She indicated this means within one hour before or one hour after the scheduled administration time. This Federal tag relates to Complaint IN00427915. 3.1-37(a)		in definition by its name, records the timing and administration of the medication to the resident.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and			

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	permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure an insulin pen was properly labeled for use for 1 of 4 residents observed during 1 of 2 medication pass observations with 3 staff members with 4 residents. (Resident H, LPN 3) Findings include: During a medication pass observation on 2-19-24 at 7:41 p.m., LPN 3 was observed to obtain a Lispro (type of insulin) Kwikpen from the medication cart. There were no directions for use on the pen and LPN 3 was unable to locate the pen's bag with the label directions for use. Additionally, there was not a date identified in which the insulin pen had been opened. LPN 3 indicated insulin pens should include the date it was opened and should be kept in the bag it was dispensed in as the bag contains the directions for use. LPN 3 attempted to locate another Lispro Kwikpen, but failed to find one, but she was able to obtain an equivalent insulin from the facility's emergency drug kit. At 8:07 p.m., LPN 3 administered 6 units of Humalog insulin subcutaneously (under the skin) for Resident H's blood glucose level of 266. The physician's order	F 0761	**F761 Label/Store Drugs and Biologics** **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident H had the potential to be affected by this alleged deficient practice, but no adverse effects noted as LPN 3 properly administered another medication. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents with insulin orders had the potential to be affected, but no adverse effects noted. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice**	03/20/2024

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	for the insulin, dated 2-12-24, indicated, "Insulin Lispro (1 Unit Dial) 100 UNIT/ML Solution pen-injector Inject as per sliding scale: of 0 - 150 = 0; 151 - 200 = 2; 201 - 250 = 4; 251 - 300 = 6; 301 - 350 = 8; 351 - 400 = 10, subcutaneously four times a day for Diabetes Mellitus." On 2-21-24 at 1:15 p.m., the Director of Nursing provided a copy of a policy entitled, "Infection Control - Blood Glucose Machine Safe Injection Practices to Prevent Resident Transmission of Bloodborne Pathogens." This policy had a revision date of 10-20-22, and was indicated to the current policy utilized by the facility. This policy indicated, "Prepare insulin in medication area using the insulin assigned to the individual resident and check the label contains the resident name, date opened and is within the expiration guidelines." 3.1-25(j)(5) 3.1-25(j)(6)		**does not occur?** Staff administering medication educated on importance of insulin being properly labeled. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** DON or designee will audit insulin pens weekly for four weeks and biweekly for five months. Any identified trends will be corrected upon discovery, documented on facility QA tool and reported during QA committee meeting overseen by the HFA. The QA tool will be utilized for 6 months.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:			

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	§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155022	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview and record review, the facility failed to ensure facility staff appropriately sanitized a glucometer (testing machine for blood sugar levels) utilized for multiple residents. (Resident H and QMA 2) Findings include: During 1 of 2 medication pass observations with 3 staff members with 4 residents, QMA 2 was observed to obtain a blood sugar level for Resident H on 2-19-24 at 7:33 p.m. Upon completion of the procedure, QMA 2 was observed to use an alcohol wipe to cleanse the glucometer. She indicated this is how she normally cleans the glucometers after using them. LPN 3 intervened at this time and indicated the facility's policy does not utilize alcohol wipes to sanitize the glucometer, but utilizes a bleach solution product to clean and sanitize the glucometer and to leave it wrapped in the bleach solution product to keep it wet for a designated amount of time. LPN 3 was observed to obtain a bleach solution container from the medication cart and demonstrated to the QMA how to sanitize the	F 0880	**F880 Infection Prevention & Control** **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident H had the potential to be affected by this alleged deficient practice, but no adverse effects noted. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents with insulin orders had the potential to be affected, but no adverse effects noted. **What measures will be put into place or what systemic changes you will make to**	03/20/2024

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	glucometer. In interviews conducted on 2-22-24 with QMA 5, QMA 6 and QMA 7, each indicated the facility provides annual, or more often, training on diabetic care, including glucometer use and how to sanitize the glucometer after each use with the bleach solution product. Each QMA indicated all 3 medication carts in the building has a glucometer and is used to check blood sugars to more than one resident. A review of Resident H's physician orders indicated she was ordered, effective 10-19-23, for blood sugar testing at bedtime for diabetes mellitus with result parameters of notifying the physician for results less than 70 or greater than 350. Resident H's results were elevated at 266. In an interview with the Director of Nursing (DON) on 2-22-24 at 10:50 a.m., she provided a listing of 16 of 65 current residents who currently have physician orders to receiving blood glucose testing. She indicated there are currently no residents she is aware of with any type of bloodborne pathogen or diagnoses. She indicated the facility does not have any specific policies or procedures regarding to how to sanitize the glucometer, but provided a copy of the manufacturer's recommendations for disinfecting the glucometer with a product containing a bleach disinfectant. The DON provided documentation of QMA 2's annual training record which identified her most recent documented "diabetic testing" education occurred March, 2023. On 2-21-24 at 1:15 p.m., the DON provided a copy of a policy entitled, "Infection Control - Blood Glucose Machine Safe Injection Practices to		**ensure the deficient practice does not occur?** QMA 2 reeducated and provided guidance on the diabetic testing. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** DON or designee will randomly audit a glucometer cleaning five times weekly for two weeks, biweekly for six weeks, and weekly for six months. Any identified trends will be corrected upon discovery, documented on facility QA tool and reported during QA committee meeting overseen by the HFA. The QA tool will be utilized for 6 months.	

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	Prevent Resident Transmission of Bloodborne Pathogens." This policy had a revision date of 10-20-22, and was indicated to the current policy utilized by the facility. This policy indicated, "It is the policy of this facility to prevent the spread of infections and bloodborne pathogens when using blood glucose testing devices...Clean and disinfect blood glucose machine environmental surface with an EPA approved germicide before and after testing the resident's blood glucose and between each resident use..." 3.1-18(b)(2) 3.1-18(b)(4)			