STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155484	A. Building B. Wing	12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southwood Healthcare Center	2222 Margaret Ave Terre Haute, IN 47802

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 34525 Based on interview and record review, the facility failed to ensure adequate nurse staffing for 5 of 6 units schedules reviewed (units 100, 200 A, 200 B, 400, and 500). Findings include: 1. During an interview, on 12/31/24 at 9:25 a.m., Resident K indicated there were sometimes when she had not been given her insulin. She understood that the nurses were human and were really busy, but she was a Registered Nurse in her career and knows that insulin needs to be given as ordered. She would never refuse any of her insulin, it was too important for her to have it. Resident K's record was reviewed on 12/31/24 at 8:29 a.m. The profile indicated the resident resided on the 400 unit of the facility. Her diagnoses included, but were not limited to, type 2 diabetes mellitus (a chronic disease that occurs when the body doesn't produce enough insulin [a hormone that regulates blood sugar levels] or doesn't use it properly, resulting in high blood sugar levels) with hyperglycemia (high blood sugar). A significant change Minimum Data Set (MDS) assessment, dated 10/28/24, indicated the resident had moderate cognitive deficit and required insulin injections (medication that is used to take the place of insulin that is normally produced by the body). A care plan, with a revised date of 2/14/24, indicated the resident was at risk for complications due to diabetes. Interventions included, but were not limited to, administer medications per medical provider's orders. A physician's order, dated 4/16/24, indicated to administer 30 units of Glargine insulin (used to control blood sugars in persons with diabetes) subcutaneous (SQ-under the skin) every evening at 9:00 p.m., for type 2 diabetes. A physician's order, dated 4/17/24, indicated to administer 10 units of Lispro insulin (used to control blood sugars in persons with diabetes) subcutaneous (SQ-under the skin) before meals on 7:30 a.m., 11:30 a.m., and 4:30 p.m., for type 2 diabetes. Review of the daily 400 unit nursing staff schedule, for 12/10/24 through 12/28/24, indicated the following: (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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. The 12/10/24 400 unit schedule lacked documentation of any nurse or Qualified Medication Aide (QMA) scheduled for the day shift (6:00 a.m., to 2:30 p.m.). Review of the December 2024 medication administration record (MAR) lacked documentation that Resident K's 7:30 a.m., and 11:30 a.m., doses of Lispro insulin had been administered on 12/10/24, and lacked documentation of any refusal by the resident. b. The 12/20/24 400 unit schedule lacked documentation of any nurse or QMA scheduled for the day shift and the evening shift. Review of the December 2024 MAR lacked documentation that Resident K's 4:30 p.m., dose of Lispro insulin and the 9:00 p.m., dose of Glargine insulin had been administered on 12/20/24, and lacked documentation of any refusal by the resident. c. The 12/25/24 400 unit schedule indicated LPN 14 was assigned to the 400 unit on the day shift. The 400 unit schedule lacked documentation that any nurse or QMA had been scheduled for the evening shift. Review of the December 2024 MAR lacked documentation that Resident K's 11:30 a.m., dose of Lispro insulin had been administered on 12/25/24, and lacked documentation of any refusal by the resident. d. The 12/27/24 400 unit schedule indicated that QMA 11 was assigned to the hall on the evening shift. LPN 8 was to cover the hall until 6:00 p.m. The schedule lacked documentation of any nurse assigned to cover the hall after 6:00 p.m. Review of the December 2024 MAR lacked documentation that Resident K's 4:30 p.m., dose of Lispro insulin and the 9:00 p.m., dose of Glargine insulin had been administered on 12/27/24, and lacked documentation of any refusal by the resident. e. The 12/28/24 400 unit schedule lacked documentation of any nurse or QMA scheduled for the evening shift. Review of the December 2024 MAR lacked documentation that Resident K's 4:30 p.m., 9:00 p.m., dose of Glargine insulin had been administered on 12/28/24, and lacked documentation of any refusal by the resident. During an interview, on 12/31/24 at 10:46 a.m., the Regional Director of Clinical Operations (RDCO) indicated she believed the nurses were administering the insulin medications but had failed to document on the MAR that they were given. 35317 2. During an interview, on 12/31/24 at 10:52 a.m., Resident F indicated there were times when she was not given her insulin medications, and she missed doses. The resident indicated she had noticed it had happened more often on the evening shift. (continued on next page)

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident F's record was reviewed on 12/30/24 at 1:10 p.m. The profile indicated the resident's diagnosis included, but were not limited to, systemic lupus erythematosus (an illness that occurs when the immune system attacks healthy tissue and organs) and diabetes mellitus (a group of diseases that result in too much sugar in the blood). A quarterly Minimum Data Set (MDS) assessment, dated 11/8/24 indicated the resident was cognitively intact and was on insulin medication. A care plan, dated 10/7/20, indicated the resident had diabetes mellitus and had potential for complications. Interventions included, but were not limited to, diabetes medication as ordered by doctor and educate regarding medications and importance of compliance. Review of daily staffing sheets for December 10 through December 28, 2024, indicated the following: a. On 12/10/24 Qualified Medication Aide (QMA) 11 was assigned to work on the 2A unit from 2-10:30 p.m., which Resident F resided on. Licensed Practical Nurse (LPN) 8 was assigned to cover QMA until 6 p.m. Review of December Medication Administration Record (MAR) indicated the record lacked documentation of Fiasp (insulin medication) was administered to Resident F on 12/10/24 at 4:30 p.m. and Exenatide (insulin medication) at 4:00 p.m. The record also lacked documentation of the resident's refusal. b. On 12/13/24 a former QMA was assigned to work the 2A unit from 2-10:30 p.m., which Resident F resided on. The record lacked which nurse was covering the QMA for the evening shift. Review of December MAR indicated the record lacked documentation of Fiasp was administered to Resident F on 12/13/24 at 4:30 p.m., Exenatide at 4:00 p.m., and Basaglar (insulin medication) at 9:00 p.m. The record also lacked documentation of the resident's refusal. c. On 12/25/24 QMA 12 was assigned to work on the 2A unit from 6-10 p.m., which Resident F resided on. The record lacked which nurse was to cover the QMA from 6-10 p.m. Review of December MAR indicated the record lacked documentation of an accu check (used by people with diabetes to monitor their blood glucose (known as blood sugar) levels) was obtained on 12/25/24 at 9:00 p.m. , or Basaglar was administered at 9:00 p.m. The record also lacked documentation of the resident's refusal. d. On 12/27/24 QMA 10 was assigned to work on the 2A unit from 2-6:30 p.m. LPN 8 covered QMA until 6:30 p.m. Review of December MAR indicated the record lacked documentation of Exenatide being administered at 4:00 p.m. and Fiasp on 12/27/24 at 9:00 p.m. The record also lacked documentation of the resident's refusal. e. On 12/28/24 QMA 12 was assigned to work on the 2A unit from 6-10:30 p.m. The record lacked which nurse was assigned to cover the QMA'a for the evening shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of December MAR indicated the record lacked documentation of an accu check being obtained on 12/28/24 at 4:30 p.m., Exenatide being administered at 4:00 p.m., Fiasp at 4:30 p.m., and Basaglar at 9:00 p.m. The record also lacked documentation of the resident's refusal. During an interview, on 12/31/24 at 9:44 a.m., Registered Nurse (RN) 3 indicated staff had to look at the daily staffing schedule to see what hall they were working on and if they were covering QMA's. RN 3 indicated to a new employee the schedule can be a little confusing to understand, but she was used to it. During a confidential interview, on 12/31/24 at 10:00 a.m., the employee indicated there had been times when she would have to cover the whole building due to only QMA'a and her being scheduled. She indicated she was able to get her work completed but it could be difficult. During an interview, on 12/31/24 at 11:14 a.m., the Regional Director of Clinical Operations (RDCO) indicated she thought the nurses were administering the insulin medications but forgot to document on the MAR that they were given. She indicated the management team had been aware of the documentation issues and they were re-educating the nursing staff. The cooperation did employee QMA's and they could perform the accu checks but they were not able to administer the insulin medications, and they had to be administered by the nurse. 48226 3. On 12/28/24 at 5:22 p.m., during observation. The posted schedule indicated that Licensed Practical Nurse (LPN) 8 was working on the 100 unit. Qualified Medication Aide (QMA) 10 was working on 200-B hall from 2 p.m. to 6:30 p.m., QMA 12 was scheduled to work on 200 A hall and 200 B hall from 6:30 p.m. to 10:30 p.m., QMA 15 was working on 500 hall. LPN 8 was working on the 600 hall and 200 B Hall. The schedule lacked documentation of a nurse covering the 400 unit. On 12/28/24 at 5:25 p.m., LPN 8 indicated she was scheduled on 100 unit and overseeing the QMA's on all of the units except 600 unit. She indicated she was very overwhelmed because a resident had fallen on another hall, and she was trying to send the resident to the hospital and still oversee the QMA's. She indicated the facility often had QMA's scheduled, and one nurse oversaw them on all of the halls except 600 hall. She indicated a nurse was scheduled for the 600 hall. On 12/28/24 at 5:51 p.m., during a phone interview Resident B indicated at times there was only one nurse and two aides for the whole building. She indicated this was more prevalent on the weekends. On 12/30/24 at 2:49 p.m., during interview LPN 8 indicated she covers 400 and 500 hall and when she worked there was always a nurse on 600 hall. She indicated she covered 3 halls plus worked on 100 hall. On 12/31/24 at 10:00 a.m., during an interview Certified Nurse Aide (CNA) 9 indicated she found her assignment on the assignment board each day and it indicated what hall she was scheduled to work on. On 12/31/24 at 10:07 a.m., during an interview LPN 14 indicated she understood the daily schedule, but the new people did not understand it and she had to explain to them where they were working. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/31/24 at 10:00 a.m., a review of the daily nursing schedules the following was indicated. a. On 12/10/24 on 2:00 p.m., to 10:00 p.m., shift LPN 8 was scheduled to work on 100 hall and overseeing 400 hall, 500 hall and 200 A hall till 6:00 p.m. LPN 17 was assigned to work from 6:00 p.m. to 10:00 p.m. on 600 hall and 200 B hall. QMA 11 was scheduled to work on 500 hall and 200 A hall. The record lacked evidence of nurse coverage for 200 B hall before 6:00 p.m., or coverage for 200 A hall, 400 hall and 500 hall after 6:00 p.m. b. On 12/13/24 on 2:00 p.m., to 10:00 p.m., shift. LPN 8 was scheduled to work on 100 hall, 400 hall and 500 hall. LPN 16 was scheduled to work 600 hall, part of 200 B hall and oversee 200 A hall. QMA 12 was scheduled to work on 500 hall and part of 200 A hall. c. On 12/20/24 on 2:00 p.m., to 10:00 p.m., shift. LPN 14 was scheduled to work on 100 hall till 3:15 p.m., LPN 8 was scheduled to work on 100 hall from 8:30 p.m., to 10:30 p.m. LPN 17 was scheduled to work on 200 A hall and 200 B hall and oversee 600 hall. QMA 18 was scheduled to work on 200 B hall and 600 hall. QMA 11 was scheduled to work on 500 hall. The record lacked evidence of nurse coverage for 400 hall or nurse coverage for 100 hall from 3:15 p.m. to 8:30 p.m. d. On 12/27/24 on 2:00 p.m., to 10:00 p.m., shift. LPN 8 was scheduled to work 100 hall and oversee 200 A hall, 400 hall and 500 hall till 6:00 p.m. LPN 17 was scheduled to work at 6:00 p.m., on 200 A hall and 200 B hall. LPN 16 was scheduled to work 600 hall. QMA 11 was scheduled to work on 400 hall and 500 hall. The record lacked evidence of a nurse overseeing 400 hall and 500 hall after 6:00 p.m. e. On 12/27/24 on 2:00 p.m., to 10:00 p.m., shift. LPN 8 was scheduled to work 100 hall. LPN 16 was scheduled to work 200 B hall and 600 hall. QMA 15 was scheduled to work on 500 hall. The record lacked evidence of nurse coverage for 400 hall and lacked an LPN overseeing 200 A and 500 hall. On 12/31/24 at 2:00 p.m., the Regional Director of Clinical Operations indicated if a nurse was scheduled to work on 100 hall and had to oversee the QMA's. The nurse would not be assigned to work a cart so the nurse would be free to administer insulins and other medications for the QMA's. She indicated the facility did not have a policy for staffing. This citation relates to Complaint IN00449502. 3.1-17(a)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35317 Based on record reviews, and interviews, the facility failed to ensure inulin medications were administered as ordered for 3 of 3 residents reviewed for insulin medications (Residents F, K, and H). Findings include: 1. Resident F's record was reviewed on 12/30/24 at 1:10 p.m. The profile indicated the resident's diagnosis included, but were not limited to, systemic lupus erythematosus (an illness that occurs when the immune system attacks healthy tissue and organs) and diabetes mellitus (a group of diseases that result in too much sugar in the blood). A quarterly Minimum Data Set (MDS) assessment, dated 11/8/24 indicated the resident was cognitively intact and was on insulin medication. A care plan, dated 10/7/20, indicated the resident had diabetes mellitus and had potential for complications. Interventions included, but were not limited to, diabetes medication as ordered by doctor and educate regarding medications and importance of compliance. a. A physician order, dated 4/6/24, indicated to administer Fiasp (insulin medication) 100 unit/ml (milliliter). Inject 20 units subcutaneously (under the skin) before meals. Review of December 2024 Medication Administration Record (MAR), indicated that the record lacked documentation Resident F received the Fiasp insulin injection on 12/10/24 at 4:30 p.m., 12/13/24 at 4:30 p.m. , 12/19/24 at 11:30 a.m., 12/27/24 at 4:30 p.m., and 12/28/24 at 4:30 p.m. b. A physician order, dated 9/8/22, indicated to administer Exenatide (insulin medication) 10mcg (microgram)/0.4ml. Inject 10 mcg subcutaneously two times a day. Review of December 2024 MAR, indicated that the record lacked documentation Resident F received Exenatide injection on 12/10/24 at 4:00 p.m., 12/13/24 at 4:00 p.m., 12/27/24 at 4:00 p.m., and 12/28/24 at 4:00 p.m. c. A physician order, dated 3/1/24, indicated to administer Basaglar (insulin medication) 100 unit/ml. Inject 50 units subcutaneously every morning and at bedtime. Review of December 2024 MAR, indicated that the record lacked documentation Resident F received Basaglar injection on 12/13/24 at 9:00 p.m., 12/25/24 at 9:00 p.m., and 12/28/24 at 9:00 p.m. d. A physician order, dated 10/9/24, indicated to obtain accu checks (used by people with diabetes to monitor their blood glucose (known as blood sugar) levels) before meals and at bedtime. Review of December 2024 MAR, indicated that the record lacked documentation Resident had her accu check completed on 12/19/24 at 7:30 a.m., 11:30 a.m., 12/25/24 at 9:00 p.m., and 12/28/24 at 4:30 p.m. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 12/31/24 at 10:52 a.m., Resident F indicated there were times when she was not given her insulin medications, and she missed doses. The resident indicated she had noticed it had happened more often on evening shift. During an interview, on 12/31/24 at 11:14 a.m., the Regional Director of Clinical Operations (RDCO) indicated she thought the nurses were administering the insulin medications but forgot to document on the MAR that they were given. She indicated the management team had been aware of the documentation issues and they were re-educating the nursing staff. The cooperation did employee Qualified Medication Aides (QMA) and they could perform the accu checks but they were not able to administer the insulin medications, and they had to be administered by the nurse. 34525 2. Resident K's record was reviewed on 12/31/24 at 8:29 a.m. The profile indicated the resident's diagnoses included, but were not limited to, type 2 diabetes mellitus (a chronic disease that occurs when the body doesn't produce enough insulin [a hormone that regulates blood sugar levels] or doesn't use it properly, resulting in high blood sugar levels) with hyperglycemia (high blood sugar). A significant change Minimum Data Set (MDS) assessment, dated 10/28/24, indicated the resident had moderate cognitive deficit and required insulin injections (medication that is used to take the place of insulin that is normally produced by the body). A care plan, with a revised date of 2/14/24, indicated the resident was at risk for complications due to diabetes. Interventions included, but were not limited to, administer medications per medical provider's orders. a. A physician's order, dated 4/16/24, indicated to administer 30 units of Glargine insulin (used to control blood sugars in persons with diabetes) subcutaneous (SQ-under the skin) every evening at 9:00 p.m., for type 2 diabetes. Review of the December 2024 medication administration record (MAR) lacked documentation that the Glargine insulin had been administered on 12/20/24, 12/27/24, and 12/28/24, and lacked any documentation of a refusal by the resident. b. A physician's order, dated 4/17/24, indicated to administer 10 units of Lispro insulin (used to control blood sugars in persons with diabetes) SQ before meals on 7:30 a.m., 11:30 a.m., and 4:30 p.m., for type 2 diabetes. Review of the December 2024 MAR lacked documentation that the Lispro insulin had been administered on the 7:30 a.m., dose on 12/10/24, the 11:30 a.m., dose on 12/10/24, the 4:30 p.m., dose on 12/20/24, the 11:30 a.m., dose on 12/25/24, and the 11:30 a.m., dose on 11/27/24, and lacked any documentation of a refusal by the resident. During an interview, on 12/31/24 at 10:46 a.m., the Regional Director of Clinical Operations (RDCO) indicated she believed the nurses were administering the insulin medications but had failed to document on the MAR that they were given. 48226 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 12/28/24 at 5:22 p.m., during observation and staff interview. The posted schedule indicated there were 2 Licensed Practical Nurses (LPN) scheduled, and 3 Qualified Medication Aide's (QMA) scheduled. On 12/28/24 at 5:25 p.m., LPN 8 indicated she was scheduled on 100 hall and scheduled to oersee the QMA's on all of the halls except 600 hall. She indicated she was very overwhelmed because a resident had fallen on another hall, and she was trying to send the resident to the hospital and still oversee the QMA's. She indicated the facility often has QMA's scheduled, and one nurse oversees them on all of the halls except 600 hall. She indicated a nurse is scheduled for the 600 hall. On 12/28/24 at 5:30 p.m., during interview with QMA 15, she indicated she was working on the 400 and 500 hall with 2 Certified Nurse Aide's (CNA). The employee indicated she tells the nurse if there is an issue on the hall and if medications need to be administered by the nurse. On 12/28/24 at 5:51 p.m., during a phone interview with Resident B. The resident indicated she was diabetic and was taking insulin. She indicated staff refused to administer her insulin till after she ate, though her blood sugar was not low. Resident B indicated residents told her they did not receive their insulin more often when a QMA instead of a nurse was scheduled on the hall. On 12/28/24 at 6:00 p.m., during interview LPN 16 indicated she was working on the 600 hall and was covering the QMA on 200 B hall. She indicated at times it is a challenge to oversee several halls. On 12/30/24 at 10:32 a.m., during interview QMA 7 indicated she was not allowed to administer insulin. The nurse overseeing her administered the insulin. She indicated she checked the residents blood sugar level with a glucometer (a small, portable device that measures the amount of glucose (sugar) in the blood) and reported the results to the nurse. She indicated she entered the blood sugar results into the residents Medication Administration Record (MAR). On 12/30/24 at 10:38 a.m., during interview Registered Nurse (RN) 3 indicated she oversees the QMA's at times and obtains the residents blood sugar and administers insulin for residents who are assigned a QMA. On 12/30/24 at 2:49 p.m., during interview LPN 8 indicated the QMA had to come to her to tell her what the blood glucose readings were. She told the QMA to write them on paper then she went to the halls and administered insulin. She indicated she was able to administer insulin within the prescribed administration time. She indicated the QMA could enter the blood glucose reading, but the nurse must administer and sign off the insulin after it was administered. LPN 8 indicated when she administered insulin she signed it off in the MAR at the same time. On 12/30/24 at 2:00 p.m., the medical record of Resident H was reviewed. The resident was admitted to the facility on [DATE]. There had been no hospitalization s since admission. Diagnosis included but were not limited to, chronic obstructive pulmonary disease, (a group of diseases that cause airflow blockage and breathing-related problems) COPD, type 2 diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), anxiety disorder (a feeling of fear, dread, and uneasiness. It might cause you to sweat, feel restless and tense, and have a rapid heartbeat. It can be a normal reaction to stress), congestive heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs). (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician orders included but not limited to. a. A physician order dated 11/24/23, indicated to administer Lantus insulin100 units/milliliter solution. Inject 50 unit subcutaneously (under the skin) two times a day for diabetes. On 12/13/24 the record lacked documentation the resident received Lantus insulin at 8:00 p.m., on 12/20/24 at 8:00 p.m., and on 12/28/24 at 8:00 p.m. b. A physician order dated 11/21/24, indicated to administer Lispro insulin inject 22 unit subcutaneously before meals for diabetic. Review of the December Medication Administration Record (MAR) indicated the record lacked documentation the resident received Lispro insulin on 12/10/24 at 4:30 p.m., on 12/13/24 at 4:30 p.m., and 12/27/24 at 4:30 p.m. c. A physician order dated 10/2/24, indicated to obtain blood sugar levels before meals and at bedtime for DM (diabetes mellitus) A quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated the resident was cognitively intact and required minimal assistance for activities of daily living (ADL) care. A care plan dated 10/7/24 indicated the Resident had diabetes mellitus and had potential for complications. Interventions included but not limited to. Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. On 12/31/24 at 9:49 a.m., during interview, Resident H indicated she did not remember if she had not been administered insulin. She indicated she had refused her insulin a few times if her blood sugar was too low. On 12/31/24 at 11:49 a.m., the Regional Director of Clinical Operations RDCO provided an undated document, titled, Injectable Medication Administration, dated, 09/2018 and indicated it was the policy currently being used by the facility. The policy indicated, .Document administration site used, and any unusual reactions. Notify the physician of reactions occur .16. Document the injection on the MAR along with the site used On 12/31/24 at 11:53 a.m., the Regional Director of Clinical Operations RDCO provided a document, titled, Qualified Medication Aide Scope of Practice, and indicated it was the policy currently being used by the facility. The policy indicated, .15. Conduct finger stick blood glucose testing (specific to the glucose meter used), reporting result to the licensed nurse This citation relates to Complaint IN00449477. 3.1-48(c)(2)