STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275120	A. BUILDING ______ B. WING ______	C 11/24/2021

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F 000	INITIAL COMMENTS	F 000		

A Recertification survey was completed by the Department of Health and Human Services, Office of Inspector General, Certification Bureau, on 11/24/21. Facility Reported Incidents were investigated during the survey.

The facility census on entrance was 60.

DEFICIENCIES CITED:
Refer to FORM CMS-2567; Event ID: 2S4M11 for findings.
Deficient Practices were cited for a Facility Reported Incident with Intake Number: #MT51592

DEFICIENCIES NOT CITED:
Refer to FORM CMS-2567; Event ID: K8L311 for findings.

Deficient practices were NOT cited for the complaint with Intake number: MT51219

Deficient Practices were NOT cited for Facility Reported Incident with Intake Number: MT50998

Glossary:

D/C	discontinued
EHR	electronic health record
PCV13 (PCV13)	Pneumococcal conjugate vaccination
PPE	personal protective equipment
PPSV23	Pneumococcal polysaccharide (PPSV23) vaccination
Q	every

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/16/2021

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.

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F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a safe and secure environment with sufficient supervision to prevent elopement for 1 resident (#32) of 3 sampled residents, which resulted in a hospitalization for the resident. Findings Include: Review of a Facility Reported Incident, dated 10/7/21, showed resident #32 eloped from the facility on 10/7/21 at 11:40 a.m., and was found on 10/8/21 at 9:28 a.m., at his son in-law's home, asleep on the couch. Resident #32 was taken to the hospital by police and admitted for dehydration and altered mental status. The Facility Reported Incident included documentation showed the resident was missing for 18 hours, and did not show resident #32 had altered mental status or dehydration at time of the elopement. Resident #32 returned to the facility on 10/12/21. Review of resident #32's Elopement Risk Assessment, dated 9/29/21, showed the resident had eloped from a the previous facility, less than 30 days prior to admission to current facility. The document also showed a care plan intervention of "needs monitored by staff, wander guard ordered and placed."	F 689	1. Resident #32 was reassessed on 11/22/2021. This assessment identified that he is at high risk for elopement. He currently resides on the locked dementia unit to provide him with a secure environment. His care plan has been updated to identify that he is an elopement risk, and it provides direction to reduce his elopement potential. The staff visually monitor his location due to limited size of the unit. He is re-directed to a location/activity of his choice if he is loitering and is noted to be near doors. He is easily directed and is safe in this environment. 2. All current residents have been re-assessed by the interdisciplinary team. The assessments were reviewed by the Interdisciplinary team, which included nursing, social services and activities. The elopement assessments were completed within the last 90 days for all individual residents and each resident’s potential for elopement was identified. The IDT team developed and updated care plans to direct staff on how to	12/23/21

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F 689 Continued From page 2

Review of an un-titled and un-dated facility document showed, "Patio door was locked. [Staff member] was told she could let the residents out on patio if she stayed with them. The fence was down at the time. [Staff member] took residents out on the patio; however, did not lock the door again after she brought them in." The document showed after reviewing the cameras, resident #32 stood in the activities room by a pillar and walked out to the patio when he saw no staff was watching. He sat on a patio chair for a while then walked off the patio as the fence/gate was down.

Review of a un-titled and un-dated facility document showed, "Floor staff had witnessed [Resident #32] standing in the Activity room near a pillar ... Staff were not checking residents as frequently as needed ..."

Review of resident #32's [Entity Name] report, dated October 2021, showed an order for, "Wander guard in place for safety-please check function and placement q shift every shift for elopement risk," start date 9/30/21 and D/C date 10/12/21. Documentation for shift checks on 10/1/21, 10/3/21 and 10/6/21 were not present on the [Entity Name] report. A second order showed "Wander guard in place for safety- please check function and placement q shift. Wander guard expiration date 4/2024. Every shift for elopement risk," start date 10/12/21 and D/C date 11/22/21. Documentation for shift checks on 10/14/21, 10/18/21, and 10/20/21 were not present on the [Entity Name] report.

During an interview on 11/23/21 at 12:42 p.m., staff member E stated there were cameras at the doors, and a main screen was located at the

F 689

prevent elopements for each individual resident, wander guards were added to care plans. The residents that were identified at risk had wander guards placed on their body and the care plans were adjusted to direct the staff on how to prevent elopements for each resident. Going forward, residents will be assessed or re-assessed for elopement risk upon admission, quarterly, annually and or with significant changes. The residents with moderate dementia or have a history or wandering/eloping are automatically at risk. The facility has wander guard system and doors alarm when residents wearing a wander guard bracelet attempt to leave, the doors will alarm.

3. The staff (to include nursing, social services, activities, housekeeping, business office, laundry and dietary) will be educated by the Vice President of Operations on or before 12/20/2021 on the required assessments, the elopement policy, and steps to take to prevent elopements and what steps to take if an elopement should occur. The center has developed an elopement binder that will be reviewed weekly by the Social Services Director or designee to ensure it is updated. At the care plan meetings, the residents being discussed will have their elopement risk reviewed to ensure the IDT agrees with the rick factors. Care plans for individual residents will be reviewed and updated as deemed necessary. The wander guard alarms are checked daily by the nursing staff or manager on duty for each individual

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Continued From page 3

nurse's station. The cameras could also be accessed by cell phone or other facility computers. The screens at the nurse's station are not monitored.

During an interview on 11/23/21 at 12:54 p.m., staff member F stated the fence was down on the non-smoking area, and there was a delay with the fencing company in putting it back up. Staff member F stated the door to the smoking patio contained an alarm, and a lock with a code for entry, and exit. Staff member F said the door on the non-smoking patio door did not have an alarm and was locked with a key. Staff member F said resident #32 was discovered missing when the nurse went into his room for the afternoon med pass at 2:10 p.m., and found his lunch tray had not been touched. A code pink was then called and a search by staff was initiated. Staff member F stated resident #32 was initially admitted for the secured unit. The facility did not have any openings at that time in the secured unit, and the facility placed resident #32 in a non-secured room. Staff member F stated, "The Administrator wanted him taken anyway (accepted for admission), social services wanted a wander guard placed and resident watched closely."

Review of document titled, "Elopement of [Resident #32]" dated 10/8/21, showed the facility did not discover resident #32 was missing for 2.5 hours.

During an observation on 11/23/21 at 1:35 p.m., the smoking door was propped open with a towel, the door alarm was sounding, but couldn't be heard over the noise of the heater running.

During an observation on 11/23/21 at 1:36 p.m.,

F 689

resident using the wander guard system. This audit is documented on a form and the audit review is monitored by the DON or designee five times per week. The doors equipped with the wander guard system are checked daily by the maintenance director or designee. This is documented and review by the Administrator at least five times per week. The staff will be educated on identifying the difference alarm tones and what each alert the staff to.

4. The DON or designee will review to ensure the elopement assessments have been completed, ensuring all MDS's completed have a corelating elopement risk assessment. The assessments that identify residents at risk will trigger a care plan to be completed to reduce the risk of elopement. The DON or designee will review the care plan to identify that the residents at risk are receiving interventions to prevent elopement. Five times per week, the DON or designee will review the daily wand guard report to ensure that the system is working. The Administrator will monitor 5 times per week the door alarms function properly. The DON will audit this weekly for 4 weeks then monthly for 6 months. The Social Services Director will audit the elopement binder weekly to ensure that the residents are risk for elopement are identified in the binder and that the binder is kept up to date. The binder will include a current picture of the resident and the profile for the resident. The information will also be in the medical records and

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F 689	Continued From page 4 the alarm system at the nurse's station was noted to make the same alarm sound for both the door alarm, and the resident call lights. No staff members were present at the nurse's station to hear the door alarm had been activated. Review of facility policy titled "Elopement Risk," with a revision date of March 2019 showed "...6. Following are possible individualized interventions which may include, but are not limited to: a. Account for residents at risk for elopement every 30 minutes..."	F 689	can be printed if necessary. The results of the audits will be shared with the QAPI team beginning 12/20/2021. Results of audits will be discussed by at Quality Assurance Process Improvement meeting to identify trends or additional education needs and will include discussion on the continuation of the audit based on findings. 5. Completion date: 12/23/2021	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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: §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;	F 880		12/23/21

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F 880	Continued From page 5 §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. §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.	F 880		

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F 880	Continued From page 6	F 880		

The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, facility staff failed to sanitize hands between meal tray deliveries to resident rooms, or offer to assist residents to wash their hands, in rooms A12, bed A, A10, bed B, A12, Bed B, A8, bed B; and failed to properly handle soiled linens in room A12. These deficient practices had the potential to spread infectious agents throughout the facility and increase the possibility of infection for residents residing within the facility. Findings include:

1. During an observation on 11/22/21 at 1:20 p.m., bed sheets, a draw sheet (light weight blanket,) hand towels, and washcloths were observed on the floor of room A12, by the closet.

2. During an observation and interview on 11/23/21 at 7:59 a.m., staff member D delivered meal trays to residents on the quarantine hall. She wore a gown, gloves, N95, and face shield. Staff member D delivered a meal tray to room A12, bed A. Staff member D used her gloved hands to move a wheelchair to reach the bedside table to deliver and set up a meal tray. She then assisted staff member C to untie and doff her gown. Without changing gloves or sanitizing her hands, staff member D left the room and picked up another meal tray from the cart and delivered the tray to room A10, bed B. Without doffing the gloves or sanitizing her hands, staff member D continued in this manner as she delivered trays to A12, bed B and A8, bed B, and assisted each resident with minimal tray set up. Staff member D then sanitized hands and donned new gloves.

DIRECTED PLAN OF CORRECTION (DPOC)

This Directed Plan of Correction is required by the Centers for Medicare and Medicaid, and the Montana State Office of Inspector General, Certification Bureau (SA), related to the identification of deficient practice for F880 - Infection Control, cited at the Severity and Scope of E. Corrections are to be completed by the date noted in Criteria Five - the Date of Completion/Compliance (X5 date). At a minimum, the facility will carry out and complete the following plan:

Additions may be made to this DPOC by the facility if identified necessary, but the DPOC (at a minimum) is required to be completed in entirety for the determination of compliance.

1. Criteria One: Corrections

a. The facility administrative team will review/assess the deficient practices identified in the Form CMS-2567 as related to the failure of staff to wash/sanitize hands during the passing of meal trays to residents in their rooms, offering residents assistance with washing their hands before/after meals, and for the safe handling of soiled linens, for infection control prevention and determine contributing factors. On completion, the

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F 880

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Hand hygiene was not offered to any of the residents with delivery of meal trays. Staff member D said, "We were told we didn't have to change the gown a long as we don't touch the resident when we go in the room. I should have probably sanitized my hands." She did not respond when asked about sanitizing residents' hands.

During an interview on 11/23/21 at 11:02 a.m., staff member C said that linens in resident rooms should have been bagged and removed from the rooms. She said that staff should be sanitizing their hands each time they enter or leave a resident's room, and the residents should be offered hand hygiene before meals and after toileting.

Review of the facility policy titled, "Handwashing/Hygiene," last revised Jan 2020, showed,
"5. Hand hygiene needs to be completed:
d... Before donning and after removal of gloves and other PPE
j... Before and after eating or handling food
7... If Residents need assistance with hand hygiene, staff should assist with washing hands after toileting, before meals and use of ABHR [alcohol-based hand rub] or soap and water at other times, as indicated."

Review of the facility policy titled, "Laundry and Linen Policy," last revised March 2019, showed, "... 1. Handling of soiled linen: ... c. All soiled linen will be bagged/placed in laundry containers at the location where used. Soiled laundry will not be sorted or pre-rinsed in the resident/patient care areas. It should never be placed on the floor. If linen touches floor, it will be considered soiled

F 880

facility will plan and implement corrections for the three deficient practice areas, to include who is responsible for the tasks to be completed (by title), and the process which will be carried out to make these corrections.

b. Any and all potential staff members, who will be identified by the facility, specifically to include any staff who will pass meal trays to residents in their rooms, or handle soiled linen, will be educated related to the three failures identified. Training will be documented and completed by a staff member with the knowledge necessary as related to infection control and facility policies/procedures.
c. The residents in room A12 bed A and B, A10 bed B and A8 bed B are cared for following infection control practices. Hands ae washed prior to care and between meal delivery and are assisted to wash their handsand the linens are handled properly.
What was done for identified res idents? Who assessed? When was assessment? What was found and what was done? What have you done?

2. Criteria Two: Identification of Others

The facility will medically assess all residents identified to be in the specific rooms numbers documented on the FORM CMS-2567, to determine if the failure contributed to any negative outcomes for these residents.

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F 880	Continued From page 8 linen and not be used for resident/patient until laundered."	F 880	The facility DON/IP will use the current infection control monitoring system to determine if a spread of infection occurred due to the failures identified. a. The nursing staff will monitor and assess residents when symptoms are noted. The nurses will document in the medical records if symptoms of infection are present. The DON will monitor the progress notes 5 times per week and will take actions if any signs of infections occur. 3. Criteria Three: Systems a. The facility administrative team will review/assess the deficient practices identified in the Form CMS-2567 as related to the three identified failures, for infection control prevention and determine contributing factors. On completion, the facility will plan and implement corrections for the deficient practices, to include who is responsible for the tasks to be completed (by title) and the process which will be carried out to make these corrections. b. Any and all potential staff members, who will be identified by the facility, specifically to include any staff who will potentially pass meal trays, offer handwashing at meals, or handle soiled linen, will be re-educated related to the three failures identified. Training will be documented and completed by a staff member with the knowledge necessary as related to infection control, and the facility	

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F 880	Continued From page 9	F 880	policy and procedures. c. The nursing administrative team will establish a visual monitoring system for the nursing department, as related to infection control, which will cover the three areas of deficient practice. Monitoring (which will include visual observations by the DON and IP) will be no less than weekly for 2 months for each of the three areas of deficient practice identified, then every other week for 2 months. If concerns are identified during the monitoring process, immediate corrections will be implemented by the DON/IP. The monitoring system established will include the gathering of measurable data, which will be passed to the QAPI team upon completion prior to each QAPI meeting for further review and discussion of concerns related to quality deficient practices. Criteria Four: Monitoring a. The nursing administrative team will establish a visual monitoring system for the nursing department, as related to infection control, which will cover the three areas of deficient practice. Monitoring (which will include visual observations by the DON and IP) will be no less than weekly for 2 months for each of the three areas of deficient practice identified, then every other week for 2 months. If concerns are identified during the monitoring process, immediate corrections will be implemented by the	

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F 880	Continued From page 10	F 880	DON/IP. The monitoring system established will include the gathering of measurable data, which will be passed to the QAPI team upon completion prior to each QAPI meeting for further review and discussion of concerns related to quality deficient practices. b. The QAPI team will meet to discuss and review the monitoring results, as provided by the DON/IP, for concerns related to quality deficient practices. The QAPI team will meet no less than weekly for the monitoring review for the first month. After the first month of monitoring, the QAPI team will then meet a minimum of two times a month for 3 months for the reviews of the data provided by the DON/IP. Any and all concerns and corrections for these will be addressed timely by QAPI. c. The QAPI team will meet on or before 12/22/21, to determine if the facility has completed all the necessary corrections for this directed plan of correction, and whether the facility has achieved compliance. This determination will be documented, and provided to the survey team on the revisit survey. d. DON or designee will bring audit results to QAPI on an ongoing basis. Results of audits will be discussed by the Quality Assurance Process Improvement meeting to identify trends or additional education needs and will include discussion on the continuation of the audit based on findings. DON or designee will bring audit results to QAPI. Results of audits will be	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 880	Continued From page 11	F 880	discussed by the Quality Assurance Process Improvement meeting to identify trends or additional education needs and will include discussion on the continuation of the audit based on findings. Criteria Five: Date of Completion - 12/23/21	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.	F 883		12/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275120	A. BUILDING ______ B. WING ______	C 11/24/2021

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PARKVIEW CARE CENTER	**600 S 27TH ST** **BILLINGS, MT 59101**

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F 883	Continued From page 12 §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to educate, offer, administer, or document a declination of the PCV-13 (pneumococcal conjugate vaccine) for 2 (#s 12 and 43) of 5 sampled residents reviewed for pneumococcal vaccination status. This deficient practice had the potential to increase the risk of infection for two residents. Findings include: 1. Review of resident #12's pneumococcal vaccination record, with staff member C in the EHR, showed resident #12 had never received	F 883	1. Resident #43 received the PCV13 vaccine at St. Vincent Healthcare on 1/9/2020. The hospital sent the verification of this vaccination and the documentation of this was placed in the resident's medical record. She also received the PPSV23 on 1/1/2016. She therefore is current according to her primary care provider and there is no deficient practice with this resident. Resident #12 had a document in her medical record that indicated that she	

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F 883	Continued From page 13 the PCV-13 vaccination. Resident #12 had received the PPSV-23 pneumococcal vaccination on 10/1/21. During an interview on 11/23/21 at 12:20 p.m., staff member C stated, "I don't have anything [documented] for the PCV-13. We need to get a PCV-13. I need to get a consent. I dropped the ball on that." 2. Review of resident #43's pneumococcal vaccination record, with staff member C in the EHR, showed resident #43 had never received the PCV-13 vaccination. Resident #43 had received the PPSV-23 on 1/1/16. During an interview on 11/23/21 at 12:31 p.m., staff member C stated, "No, [Resident #43] does not have a PCV-13, and I will have to look further to see why." Review of the facility policy titled, "Pneumococcal Vaccination for Residents Policy," last revised March 2019, showed, "Procedure ... 1. a ... i ... 1. Residents who are uncertain of their vaccination status and have no record of a previous vaccination and residents who have not previously received PCV-13 or PPSV-23 should receive a single dose of PCV-13 followed by a dose of PPSV-23 8 weeks after the PCV-13 dose. 2. Residents who HAVE previously received one dose of the PPSV-23 should receive a dose of PCV-13 one year or more after the last PPSV-23 dose was received ..."	F 883	received her PCV13 on 6/1/2015. This documentation was available to the surveyor at the time of survey. Then she received the PPSV23 on 8/31/2010 and another on 10/1/2019. Therefore, this resident was also current and there are no more vaccines necessary and there was no deficient practice. 2. Any resident that wishes to have pneumococcal vaccinations are at risk for this. Unvaccinated residents will be educated regarding the need for pneumococcal vaccine. The facility will offer and recommend that the resident consent to taking the vaccine, however the resident or responsible party will have the choice to consent to or deny the vaccine. The resident's primary physicians will also be queried about the need for the vaccine for each individual resident. All residents charts have been reviewed and vaccination status is being address as needed and will be completed by 112/28/2021. 3. The ICP and nurses will be educated on the policy for pneumonia vaccines by the DON on or before 12/20/2021. An audit was completed by reviewing vaccination documentation for all residents to determine their vaccination status. Any resident that had no record of the pneumococcal vaccines were educated and offered the vaccine. The residents that have requested the vaccine are now current on the pneumococcal vaccine. Going forward, the resident's vaccination status will be reviewed upon	

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F 883	Continued From page 14	F 883	admission. Any resident needing vaccinated will be educated regarding these vaccines and offered the vaccine to take per their acceptance. Yearly with the influenza vaccine, all unvaccinated residents needing PVC13 or PPSV23 will be offered the vaccine again. The residents will also be able to get these vaccines at any time they wish if the primary medical practitioner provides an order for the vaccine 4. The ICP or IDT care plan team will monitor all new admissions weekly for 8 weeks and then monthly for 12 months and then as needed as determined by the QAPI team. The results of the vaccination status will be reported to the QAPI committee on or before 12/20/2021. Results of audits will be discussed by the Quality Assurance Process Improvement meeting to identify trends or additional education needs and will include discussion on the continuation of the audit based on findings. 5. Completion: 12/23/2021.	