STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075230	A. Building B. Wing	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ledgecrest Health Care Center	154 Kensington Rd Kensington, CT 06037

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, and facility policy for 3 of 4 sampled residents (Resident #3, #15, #33) reviewed for the facility Water Management Plan, the facility failed to ensure a comprehensive Resident Care Plan that included a potential exposure to Legionella (a bacteria that causes Legionnaires Disease) and for the only sampled resident (Resident #47) reviewed for communication, the facility failed to develop a baseline Resident Care Plan identifying the need for a translator. The findings include: The facility tested positive for the presence of Legionella on 12/29/25. 1 Resident #3 's diagnoses included high blood pressure, seizure disorder, paraplegia, muscle weakness, and depression. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #3 was cognitively intact and required assistance for eating and maximum assistance for bathing, mobility, and self-care. The Resident Care Plan dated 3/18/26 failed to identify potential for exposure to Legionella. 2. Resident #15's diagnoses included dementia, high cholesterol, anemia, high blood pressure, and depression. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #15 was severely cognitively impaired and required maximum assistance for personal hygiene, bathing, and was independent with mobility. The Resident Care Plan dated 3/19/26 failed to identify potential for exposure to Legionella. 3. Resident #33's diagnoses included high blood pressure, dementia, Alzheimer's disease, and depression. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #33 was severely cognitively impaired and was independent with eating, bathing, personal care, and mobility. The Resident Care Plan dated 2/3/26 failed to identify potential for exposure to Legionella. Interview and record review with the Infection Prevention Nurse (RN #3) on 4/13/26 at 1:26 PM identified that Residents #3, #15, and #33 were not care planned to identify a potential Legionella exposure. RN #3 identified that staff were aware of a potential Legionella exposure and they were (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mitigating the risks by using bottled water. She acknowledged that new staff or agency staff might not be aware of the potential for exposure to Legionella if not documented in the resident's chart. Review of the Legionnaires Disease policy directed., in part, the facility should monitor and treat residents appropriately for potential exposure to Legionnaires Disease. Subsequent to surveyor inquiry all Resident Care Plans were updated to reflect monitoring for signs and symptoms of Legionella. 4. Resident #47 's diagnoses included sepsis, calculus of the gallbladder with chronic cholecystitis without obstruction and generalized anxiety. The admission Nursing assessment dated [DATE] identified Resident #47 had a Brief Interview for Mental Status score of 8, indicating moderate cognitive impairment, required substantial maximal assistance with bed mobility, dressing, and personal hygiene, and was dependent on staff for toileting. The admission Nursing Assessment failed to identify that Resident #47 was Spanish only speaking and required a translator to communicate. Review of the Baseline Resident Care Plan dated 4/10/26 failed to identify the need of an interpreter on all shifts due to being able to communicate only in Spanish. The Occupational Therapy and Physical Therapy Evaluations, and Speech /Language Therapy screen, all dated 4/10/26 failed to identify Resident #47 was Spanish speaking only, required a translator to communicate, and failed to identify alternatives for staff to use to communicate such as a picture board or the availability of a translator as needed. Interview and clinical record review with Social Worker (SW) #1 on 4/14/26 at 9:45 AM indicated the resident spoke only Spanish and that she had communicated with Resident #47 through a family member, or if no family was available, a Spanish speaking staff member. Review of the baseline Resident Care Plan failed to identify Resident #47 only spoke and understood Spanish and failed to identify an alternate means to communicate with the resident. SW #1 stated Resident #47 should have had a communication Resident Care Plan, and that she would be entering one into the resident's clinical record. The Resident Care Plan dated 4/14/26 (5 days after admission), identified Resident #47 was Spanish speaking and required a translator with interventions to promote communication. Review of the Resident Assessment Instrument Manual (RAI) dated October 2023 directed, in part, within 48 hours of admission to the facility, the facility must develop and implement a Baseline Care Plan for the resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of care (42 CFR 483.21(a)). A review of the Resident's Rights policy directed, in part, you have the right to be treated with consideration, respect, full recognition of your dignity and individuality. You have the right to receive care and services with reasonable accommodation of your individual needs and preferences.

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 1 of 2 sampled residents (Resident #47) reviewed for dignity, the facility failed to ensure toileting for a dependent resident was provided in a dignified manner. The findings include:Resident #47 ?s diagnoses included sepsis, calculus of the gallbladder with chronic cholecystitis without obstruction and generalized anxiety.The admission Nursing assessment dated [DATE] identified Resident #47 had a Brief Interview for Mental Status score of 8, indicating moderately cognitively impaired, required substantial maximal assistance with bed mobility, dressing, personal hygiene, was dependent on staff for toileting, and had episodes of both continence and incontinence. Resident #47 was Spanish speaking and required an interpreter for communication. The Resident Care Plan dated 4/10/26 identified Resident #47 needed staff assistance with Activities of Daily Living, assistive devices: wheelchair, and walker. Interventions included to assist as needed to meet toileting needs, incontinent care per policy, keeping commonly used/needed items within reach, Physical and Occupational Therapy as ordered, transfers per physician orders.A review of the Accident/Incident Report dated 4/10/26 identified a family member reported on 4/9/26 at 3:30 PM to Social Worker #1 (SW) that staff told Resident #47 to stay in bed for voiding.A review of NA #1's statement dated 4/9/26 indicated she asked NA #1 to assist with translating since Resident #47 was Spanish speaking only. NA #1 asked Resident #47 if he/she needed anything or if he/she wanted to use the bathroom. Resident #47 replied he/she did not want to go to the bathroom because of recent surgery, and he/she was in pain. NA #2 reassured Resident #47 not to worry that if he/she needed to, he/she could use the incontinent product he/she was wearing. NA #1 indicated she explained to Resident #47 how to use the call bell, and the NA would assist and change him/her as needed.A review of the Director of Nursing investigation dated 4/15/26 identified that a family member reported a concern that Resident #47 was instructed by staff to go in his/her brief. An investigation was immediately initiated. In the context of Resident #47 expressing discomfort and hesitation to move, NA #1 reassured Resident #47 if he/she experienced urgency and could not wait, staff would promptly assist with hygiene care and ensure he/she was cleaned and changed. This was intended to reduce anxiety given Resident #47's post operative status and new admission, not to discourage toileting or to replace assistance with the bathroom. The facility was not able to substantiate the allegation of neglect.Interview with Social Worker #1 on 4/14/26 at 9:45 AM identified that Resident #47 was Spanish speaking and a family member or a Spanish speaking staff member was able to translate. The family member came to her on Friday 4/9/26 very unhappy that the NA told Resident #47 to void in bed. SW #1 went to the Director of Nursing, and she took over the investigation.An interview with NA #2 on 4/14/26 at 12:53 PM indicated nothing happened on Friday 4/9/26 with Resident #47. When asked about the statement NA #1 had written, the phone disconnected. A reinterview was attempted but NA #1 did not answer the phone.An Interview with the Director of Nursing (DON) and Regional Nurse (RN #4) on 4/14/26 at 1:37 PM identified the Social Worker came to the DON with concerns from a family member identifying the staff had told Resident #47 to void in bed. Resident #47 was upset because the staff told him/her to void in bed. The family member engaged the call bell and the staff came, took Resident #47 to the bathroom, and he/she voided. NA #2 was assigned to Resident #47, NA #1 (who translated) was not assigned to the resident. Review of NA #1's statement identified that NA #1 had written she instructed Resident #47 to void in his/her incontinent product. The DON and RN #4 indicated instructing Resident #47 to void in his/her diaper was not appropriate. Additionally, NA #1 failed to notify the nurse that Resident #47 was having pain, and this was why Resident #47 did not want to get up to use the bathroom. The DON indicated that Resident #47 was continent with incontinence and retention and had a urology follow up.An interview with NA #2 was (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attempted but not obtained.A review of the Resident's Rights policy directed, in part, you have the right to be treated with consideration, respect, full recognition of your dignity and individuality. You have the right to receive care and services with reasonable accommodation of your individual needs and preferences, except when your health or safety or the health or safety of others would be endangered by such accommodation

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility policy and interviews for 2 of 2 sampled residents (Resident #3 and Resident #31) reviewed for activities, the facility failed to ensure activity preferences were provided. The findings include:1.Resident #3?s diagnoses included generalized muscle weakness, paraplegia, anxiety, and depression.An annual Recreation assessment dated [DATE] at 3:55 PM identified that it was very important for Resident #3 to do his/her favorite activities, be around animals such as pets, to keep up with the news, and get some fresh air.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #3 had a Brief Interview for Mental Status of 15 indicating intact cognition and required maximum assistance for dressing, oral hygiene and set up assistance for eating. The Resident Care Plan dated 12/16/25 identified Resident #3 would engage in activities of their own choosing. Interventions included offering a calendar of activities, encouraging the resident to attend activities of his/her choice, offering materials for in-room activities, and the Recreation Director would provide a weekly 1:1 visit to determine interests and offer support and encouragement. Interview with Resident #3 on 4/10/26 at 12:35 PM identified that the only activity he/she engaged in was self-propelling around the facility in his/her wheelchair 80 to 100 times per day. Additionally, Resident #3 indicated that there were no activities of interest for residents who were younger than the majority of residents in the facility.Review of the recreation participation documentation from 3/1/26 to 4/14/26 identified Resident #3 had participated in 3 out of 45 recreational opportunities, and the 3 activities attended consisted of a weekly 1:1 visit with the Recreation Director. Resident #3's participation record failed to identify the Recreation Director had visited the resident weekly (per the Resident Care Plan) as 2 of the 5 visits were missing. Further, the recreation participation documentation failed to indicate Resident #3's choices, that were identified during the annual Recreation Assessment on 12/15/25 as being very important to him/her were attempted or provided including contact with animals/pets, news, and being taken outside for fresh air, anytime during the remaining 42 days.2. Resident #31's diagnoses included muscle weakness, overactive bladder, diabetes, depression, and anxiety.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #31 had a Brief Interview for Mental Status of 15 indicating intact cognition and was independent for dressing, oral hygiene and required set up assistance for eating.The Resident Care Plan dated 1/21/26 identified Resident #31 would need leisure and diversional activities to adjust to their new environment in the facility. Interventions included offering a calendar of activities, encouraging the resident to attend activities of their choice, offering materials for in room activities, and the Recreation Director would provide a weekly 1:1 visit to determine interests and offer support and encouragement.Interview with Resident #31 on 4/10/26 at 12:40 PM identified that the facility did not provide activities he/she was interested in such as photography and sign language courses. Resident #31 stated he/she was bored. Although the facility had provided a tablet there were so many blocks it was difficult to use.An annual Recreation assessment dated [DATE] at 12:08 PM identified that it was very important for Resident #31 to do their favorite activities, be around animals such as pets, to keep up with the news, do things with groups of people and to get some fresh air.Interview and clinical record review with Social Worker #1 on 4/14/26 at 9:49 AM identified that available resident activities included word find games, exercising, social gatherings, and outside and picnicking when it was nice. Review of Resident #3 and Resident #31's Resident Care Plans failed to identify individualized preferences for recreational activities. Social Worker #1 indicated that it was the responsibility of the Recreation Director to personalize Resident #3 and Resident #31's Resident Care Plans to include recreational activity preferences and ensure residents received the activities of their choice.Interview and review of Resident #3 and Resident #31's clinical records on 4/14/26 at 10:05 AM with the Recreation Director failed to identify that residents' personal preferences had been added to the Resident Care Plans. The (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Recreation Director stated that she was unaware that it was her responsibility to individualize the Resident Care Plans to include residents preferred recreational activities. Resident #3's recreational preference included being able to go outside in his/her wheelchair, but that would be difficult due to a lack of available staff to accompany the resident. Although Resident #31 preferred and had been previously provided with 4 tablets, the tablets had broken and there were no further recreational activities that had been offered to him/her. A review of individualized participation records for Resident #3 and Resident #31 was attempted; however, the Recreation Director concluded the interview stating she had to get to her next activity.Review of the Care Plan policy dated 10/30/20 directed, in part, a comprehensive plan of care based on the identified needs, strengths, and preferences will be developed for each resident by the Interdisciplinary Team which includes social work and recreation.Although requested, a facility policy for Activities was not provided.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility documentation, facility policy and interviews for the only sampled resident (Resident #3) reviewed for positioning and mobility, the facility failed to ensure a custom wheelchair was regularly reviewed per the facility policy and physician orders. The findings included:Resident #3 ?s diagnoses included paraplegia, generalized osteoarthritis and muscle weakness.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #3 had a Brief Interview for Mental Status score of 15, indicating no cognitive impairment and was totally dependent on staff for dressing, toileting, bed mobility, and transfers, had a functional limitation in range of motion with impairment on both sides of the lower extremities, used a wheelchair independently, and was at risk for pressure ulcer development.The Resident Care Plan dated 4/1/26 identified Activities of Daily Living (ADLs) needing staff assistance with ADLs due to quadriplegia, assistive devices used a wheelchair required a total mechanical lift. Interventions included assisting as needed to meet toileting needs, incontinent care per policy, side rails per physician's orders to assist with bed mobility, transfers per physician's orders.Physician's orders effective 2/1/26 through 4/14/26 directed to transfer the resident from bed to the motorized wheelchair with a mechanical lift, offer to transfer out of bed after morning care, offer to transfer back to bed after lunch or by resident request, schedule was subject to change per resident tolerance, 24-hour positioning plan in place, and to complete custom wheelchair nursing review on the 15th of each month on the 7:00 AM to 3:00 PM shift.Observations of Resident #3 throughout the survey on 4/10, 4/13, 4/14, and 4/15/26 identified daily placement in his/her CWC.A review of the 24-hour positioning plan for Resident #3 identified to offer to transfer out of bed to the custom wheelchair after morning care. Please offer to transfer back to bed after lunch meal or by request. Schedule was subject to change per Resident #3 tolerance with transfer bed to wheelchair as needed. The 24-hour positioning plan failed to identify times or time frames within the 24-hour time period to be out of bed in the custom wheelchair, back to bed or any specific positions in or out of bed.A review of the undated initial quarterly Rehab Review for Custom Wheelchair (CWC) and 24-hour Positioning Plan identified Resident #3 would transfer out of bed to a CWC daily via mechanical lift with the assistance of 2 staff members and would remain in the CWC as tolerated with repositioning per policies and return to bed via mechanical lift with assistance of 2 staff members for rest periods with repositioning every 2 hours. Initial positioning on return to bed should be supine. Transfer to CWC via mechanical lift with assistance from 2 staff members refer to 24-hour positioning plan. Education for the CWC was noted as having been provided on 9/11/23.Although an annual Rehab Review dated 2/6/26 identified there were no health issues related to the use of the CWC, the facility was compliant with the CWC and continued to be appropriate without recommendations or modifications, the clinical record failed to reflect the facility had followed their policy for quarterly rehabilitation documentation for a CWC and was missing quarterly Rehabilitation Reviews for 7/2024, 10/2024, 1/2025, 4/2025, 7/2025, and 10/2025.Review of the clinical record, monthly Custom Wheelchair nursing review failed to include nursing documentation was completed on 1/15/25, 2/15/25, 3/15/25, 4/15/25, 5/15/25, 6/15/25, 9/15/25, 12/15/25, and 2/15/26, per the physician order, for the use of Resident #3's CWC.Interview and clinical record review with the Director of Rehabilitation on 4/14/26 at 10:01 AM identified Resident #3's 24-hour Custom Wheelchair (CWC) positioning plan per the Physical Therapy Discharge summary dated [DATE] identified staff would be educated and compliant with Resident #3's 24-hour positioning plan to maintain skin integrity and promote quality of life and interaction with the environment. The CWC positioning plan did not include specific times for Resident #3 to be out of bed in the CWC and specific times to go back to bed. The Director of Rehabilitation indicated that this was the way the plan was to be written and Resident #3 knew how to tilt the CWC and reposition him/herself. She indicated that the positioning plan was based on Resident #3's preferences. The (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Rehabilitation indicated that facility policy directed the Rehabilitation Department to conduct quarterly CWC reviews and although Nursing Department was to conduct monthly CWC nursing reviews, the nurses often missed documentation.Review of the Custom Wheelchair policy dated December 2008 directed, in part, Licensed staff were responsible for monthly notes, and overall compliance, PT/OT were responsible for quarterly notes, see custom wheelchair notebook for specific instructions on unit, daily documentation on positioning in flowsheets needed to be completed by NA daily.Sec. 17-134d-46. Customized wheelchairs in nursing facilities as defined in 42 USC 1396r(a), as amended from time to time, directed in part, the 24 hour positioning plan shall describe periods of time when the patient shall be seated in the customized wheelchair and shall also describe a time schedule for the patient to be therapeutically positioned in bed, on mats or with other pieces of adaptive equipment. The positioning plan shall take into account the patient's ability to be seated in a customized wheelchair for limited or extended periods of time, depending on the circumstances of the patient. Emphasis must be placed on seating the patient in a customized wheelchair at mealtime. The positioning plan must be modified, as needed, depending on the circumstances of the patient in order to promote enhanced psychosocial functioning made possible by seating in a customized wheelchair for longer periods of time as the patient develops increased physical capacity for being adaptively seated. The 24-hour positioning plan adopted by the attending physician must indicate the name and title of the individual responsible for overseeing implementation.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, facility record review and policy review for 1 of 1 medication rooms reviewed, the facility failed to ensure emergency stock controlled (narcotic) medications were not expired and were not administered past the labeled expiration date. The findings include:Observation and interview with the supervising Registered Nurse (RN) #1 on 4/10/26 at 11:30 AM identified that emergency stock, controlled medications were counted daily at change of shift; however, the process did not include verification of medication expiration dates. A review of the emergency stock medications with RN #1 identified the following:Hydrocodone Bitartrate and Acetaminophen 5/325 mg tablets (opioid pain reliever): 20 tablets with an expiration date of 6/2025 and 24 tablets with an expiration date of 9/2025Alprazolam 0.25 mg (antiˆanxiety medication) 12 tablets with an expiration date of 11/2025The Controlled Substance Disposition Record (used to identify distribution of narcotic medications) identified the expired Alprazolam 0.25 mg was administered 15 times past the labeled expiration date in the timeframe of 11/22/25 through 3/19/26 as follows: Resident #6 was administered expired Alprazolam 0.25 mg 2 timesResident #15 was administered expired Alprazolam 0.25 mg 6 timesResident #36 was administered expired Alprazolam 0.25 mg 6 timesResident #49 was administered expired Alprazolam 0.25 mg 1 timeInterview with RN #1 identified it was the responsibility of all nurses to check expiration dates prior to dispensing so expired medications were not administered but could not explain why the expired medications were not removed from stock or why they had been administered after their labeled expiration dates.Subsequent to surveyor inquiry, RN #1 removed the 44 expired Hydrocodone Bitartrate and Acetaminophen 5/325 mg tablets and 12 Alprazolam 0.25 mg tablets from the emergency stock.Interview with the Director of Nursing Services (DNS) on 4/13/26 at 12:24 PM identified that it was the responsibility of the DNS, the nursing staff, and the pharmacy to remove expired medications. Additionally, the DNS stated she just reordered them, but was unable to explain why the expired medications were dispensed and remained in use. Interview with Pharmacist #1 on 4/14/26 at 9:25 AM identified that expiration dates for emergency controlled stock were checked by the pharmacy before the medications were sent to the facility. Pharmacist #1 stated once delivered from the pharmacy it became the responsibility of the nursing staff to check to see if a medication was expired prior to dispensing to the residents. Further, administering expired Alprazolam could result in the medication not producing its intended effect (to calm a person experiencing anxiety).Review of the Medication Storage in the Facility Policy dated 1/26 directed in part that outdated, contaminated, or deteriorated medications are immediately removed from stock, and disposed of according to the procedures for medication destruction and reordered from the pharmacy.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, facility documentation review and policy review for 2 of 2 sampled residents (Resident #6 and Resident #22) reviewed for the Infection Control program, the facility failed to follow the manufacturer's guidelines for disinfecting and cleaning a multi-use glucometer (blood device used to measure blood sugar levels). The findings include:1.Resident #6's diagnoses included type 2 diabetes mellitus, depression and hypertension.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #40 had a Brief Interview of Mental Status of 15 indicating intact cognition, and was independent for eating, dressing and toileting.The Resident Care Plan dated 2/8/26 identified Resident #6 had diabetes, was at risk for hyperglycemia and/or hypoglycemia, and increased risk for complications. Interventions included finger sticks (blood glucose monitoring) as ordered and as needed and to check the blood sugar if complaints of hunger, sweating, confusion, dizziness, increased thirst, nausea or vomiting, abdominal discomfort or changes to mental status were present.A physician's order dated 3/27/26 directed to obtain a blood sugar check every Tuesday and Friday at 6:30 AM for type 2 diabetes mellitus.2. Resident #22's diagnoses included type 2 diabetes mellitus, congestive heart failure, and end stage renal disease.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #22 had a Brief Interview of Mental Status of 13 indicating intact cognition and was independent for eating, dressing, and toileting.The Resident Care Plan dated 4/9/26 identified Resident #22 had diabetes, was at risk for hyperglycemia and/or hypoglycemia, and increased risk for complications. Interventions included finger sticks (blood glucose monitoring) as ordered and as needed and to check the blood sugar if complaints of hunger, sweating, confusion, dizziness, increased thirst, nausea or vomiting, abdominal discomfort or changes to mental status were present.A physician's order in effect on 4/14/26 directed to administer Insulin Lispro Subcutaneous Solution Pen Injector 100 unit/ml before meals per sliding scale according to the blood sugar reading. What were the hours of checks?Observation, interview, and facility documentation review with Licensed Practical Nurse (LPN) #2 on 4/14/26 at 6:07 AM identified LPN #2 cleansed the glucometer with an alcohol prep pad to prior to obtaining Resident #6's blood glucose level. After obtaining Resident #6's blood glucose level, LPN #2 again cleansed the glucometer with a new alcohol prep pad indicating this was facility policy and proceeded to obtain Resident #22's blood glucose level. LPN #2 explained that the facility directed the use of alcohol prep pads to disinfect the glucometer between residents with particular emphasis on the test strip port. On review of the facility cleaning and disinfecting policy with LPN #2, it was identified that CaviWipes (hard surface cleaner and disinfectant) were required to be used per the manufacturer guidelines. LPN #2 indicated that she was unaware of this, did not use CaviWipes, and didn't know if CaviWipes were even available in the facility.Interview and facility documentation review with the Director of Nurses (DNS) on 4/14/26 at 7:04 AM identified that the facility's policy requires multiˆuse glucometers to be cleaned and disinfected with Medline Micro-kill One wipes (EPAˆregistered, oneˆstep disinfectant wipes intended for hard, nonˆporous surfaces in healthcare settings) stating alcohol wipes were not appropriate for cleaning and disinfecting the glucometers. Additionally, review of the glucometer user's guide with the DNS showed that, per manufacturer guidelines, CaviWipes or other EPAˆregistered disinfectant wipes must be used to clean and disinfect the meter prior to use and between each patient.Review of the Point of Care Blood Glucose Testing Policy directed, in part, to clean and disinfect the glucometer with germicidal wipes and allow the glucometer to remain wet for the amount of minutes directed per manufacturer recommendations prior to performing the blood glucose test. Additionally, clean and disinfect the glucometer with germicidal wipes and allow the glucometer to remain wet for the number of minutes as per manufacturer recommendations after performing the blood glucose test.