STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115508	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cherokee Center for Nursing and Healing LLC	150 Hospital Circle NW Canton, GA 30114

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 25619 Based on staff interview, record review, and review of facility policy, the facility failed to coordinate with the proper State-designated authority to ensure residents with a mental disorder, intellectual disability or related condition had the opportunity to receive care and services appropriate to their needs for one (1) of one (1) resident reviewed for Level I and Level II Pre-Admission Screening and Record Review (PASARR); Resident (R) #43. Findings include: Review of facility's policy titled, Resident Assessment-Coordination with PASARR Program, with a reviewed/revised date of December 2024, noted the Policy Explanation and Compliance Guidelines to be: 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. a. PASARR Level I-initial pre-screening that is completed prior to admission. i Negative Level I Screen-permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. ii Positive Level I Screen-necessitates a PASARR Level II evaluation prior to admission. b. PASARR Level II-a comprehensive evaluation by the appropriate state-designated authority (cannot be completed by the facility) that determines whether the individual has MD (mental disorder), ID (intellectual disability) or related condition, determines the appropriate setting for the individual and recommends any specialized services and/or rehabilitative services the individual needs. 2. The facility will only admit individuals with a mental disorder or intellectual disability who the State mental health or intellectual disability authority has determined as appropriate for admission. 3. A record of the pre-screening shall be maintained in the resident's medical record. 4. Exceptions to the preadmission screening program include those individuals who: a. Are readmitted directly from a hospital. b. Are admitted directly from a hospital, required nursing facility services for the condition for which the individual received care in the hospital, and has been certified by the attending physician before admission that the individual is likely to require less than 30 days of nursing facility services. 5. If a resident who was not screened due to an exception above and the resident remains in the facility longer than 30 days: a. The facility must screen the individual using the State's Level I screening process and refer any resident who has or may have MD, ID or a related condition to the appropriate state-designated authority for Level II PASARR evaluation and determination. b. The Level II resident review must be completed within 40 calendar days of admission. 6. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority. 7. Recommendations, such as any specialized services, for a PASARR Level II determination and/or PASARR evaluation report will be incorporated into the resident's assessment, care planning and transitions of care. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record for R#43 revealed diagnoses including but limited to parainfluenza virus pneumonia; bipolar disorder, current episode mixed, severe, with psychotic features; hypoxemia; type II diabetes mellitus; depression, unspecified; congestive heart failure; hypothyroidism; hypertension; hyperlipidemia; dysphagia; and cognitive communication deficit. Review of the Level I PASARR for R#43 revealed a completion date of 2/28/25. The Level I PASARR for R#43 did not identify a diagnosis of bipolar disorder. A Level II PASARR could not be located in the medical record for R#43, who had a diagnosis of a mental disorder and could have potentially qualified for Level II services while residing in the facility. Review of the Hospital Discharge Document for R#43 revealed a list of diagnoses that included bipolar disorder, dated 2/21/25, which was in their record prior the completion of the Level I PASARR on 2/28/25 which was prior to admission to the facility. The facility also failed to ensure the Level I PASARR screening was completed accurately by outside resources before being admitted to the facility by failing to recognize the Level I PASARR did not contain documentation of R#43's diagnosis of bipolar disorder. Review of R#43's Level I PASARR application, revealed a certification date of 2/26/25. The application asked the question, Does the individual applying for admission, directly from a hospital discharge, require NF (Nursing Facility) services for the condition received while in the hospital and whose attending physician has certified that the NF stay is likely to require less that 30 days? The answer was marked NO. Review of the Physician's Recommendation Concerning Nursing Facility Care or Intermediate Care for the Mentally Retarded (Georgia Form DMA-6) document, signed by the physician on 2/26/25, noted the Length of Time Care Needed to be temporary, but the area for the estimated length of time was left blank. On 3/12/25 at 12:30 p.m., during an interview with the Social Services Director (SSD), he stated the Admissions Coordinator (AC) was the person responsible for Level I PASARR Screening. The SSD confirmed R#43's medical record did not contain notes for discharge planning, nor a projected discharge date . The SSD confirmed R#43 would be moving to a semi-private room when Medicare Part A services ended on 3/13/25. The SSD stated he had not received a referral for PASARR Level II services for R#43. He stated if the PASARR Level I Screening Tool was inaccurate, the AC would be the person responsible to complete an updated Level I PASARR Screening. On 3/12/25 at 3:30 p.m., during an interview with the AC, she stated the hospital would complete the Level I PASARR screening. After reviewing all of the documentation for the Level I screening for R#43, the AC confirmed the information was inaccurate. She confirmed the diagnosis of bipolar disorder had been marked as no when R#43 did have a diagnosis of bipolar disorder. The AC also confirmed that even though the physician had marked R#43's admission as temporary, the physician failed to indicate the estimated length of stay, which could have been longer than 30 days. The AC stated that since the length of stay was left blank and the diagnosis of bipolar disorder had been marked as no, she would need to complete a new Level 1 PASARR for R#43. The AC confirmed she had failed to note the length of stay was blank, and the diagnosis of bipolar disorder marked no was incorrect when she reviewed R#43's Level I PASARR package prior to her being admitted to the facility.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28734 Based on observations, staff interview, record review, and policy review, the facility failed to implement a comprehensive person-centered care plan for each resident in order to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being for one (1) of 21 sampled residents. Resident #50 sustained a fall from his/her bed and 2. The facility failed to implement a care plan for oxygen therapy as ordered for one (1) of 19 sampled residents, Resident (R)#40 This deficient practice had the potential to put R#40 at risk for medical complications. Findings include: A review of facility policy titled, Care Plans, Comprehensive Person-Centered, dated 12/22 revealed, Policy Statement - A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 1. Review of Resident (R)#50's Admission Record revealed the facility admitted him on 3/31/22. A review of the Quarterly Minimum Data Set (MDS), Section I (Active Diagnoses), dated 1/20/25 revealed R#50 had the following diagnoses: stroke, anemia, coronary artery disease, heart failure, hypertension (HTN), diabetes mellitus (DM), aphasia, hemiplegia or hemiparesis, generalized muscle weakness, chronic respiratory failure, dysphagia, gastrostomy status, muscle spasm, and intracranial abscess and granuloma. A review of the MDS Section C (Cognitive Patterns) revealed a Brief Interview for Mental Status (BIMS) score of nine and the resident was interviewable. Continued review of MDS Section H (Bladder and Bowel) revealed the resident was always incontinent of urine, and frequently incontinent of bowel. Review of Section GG (Functional Abilities and Goals) of the MDS revealed R#50 was dependent and the Helper does ALL the effort. Resident does none of the effort to complete the activity. Or, the assistance of two (2) or more helpers is required for the resident to complete the activity, for the following; roll left and right, toileting hygiene, upper body dressing, lower body dressing, and personal hygiene. Review of the Functional Limitation in Range of Motion revealed the resident had impairments on both sides of their upper and lower extremities. A review of R#50's care plan stated, Focus - I have an activities of daily living (ADL) self-care performance deficit and impaired mobility r/t [related to] muscle weakness s/p [status post] hospitalization related to CVA [cerebrovascular accident]. Interventions - I require extensive assistance to total assist of [two] 2 people for bed mobility, dated 5/9/22, and Focus - [Resident] at risk for fall. Interventions - Re-educate staff on positioning resident with [two] 2 staff members, dated 3/1/25. In review of the document titled, Post Fall Evaluation, dated 3/1/25 at 9:01 a.m. it was revealed R#50 sustained a witnessed fall per Certified Nursing Assistant (CNA) DD. An interview with Licensed Practical Nurse (LPN) DD on 3/14/25 at 10:39 a.m. revealed a care plan was developed for each resident so staff could provide the proper care to each resident because each resident was different. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nurses (DON) on 3/14/25 at 11:30 a.m. revealed a care plan for each individual resident was developed by the facility, and the care plan was patient specific. She revealed there could be a negative resident outcome if the care of plan was not followed. The DON stated the root cause of R#50's fall was determined to be improper bed mobility related to the resident's behavior, and that there was only one CNA who provided the resident's bed mobility when there should have been two staff that assisted. Cross-refer to 689 2. Review of the clinical electronic record for R#40, revealed he was admitted to the facility on [DATE] with diagnoses that included, but not limited to, other pulmonary embolism without acute cor pulmonale, anxiety disorder, depression and heart failure. Review of R#40's most recent MDS assessment, dated 1/31/2025, revealed a BIMS assessment with a score of nine, which indicated the resident had moderately impaired cognition. Review of R#40's Physician Orders revealed oxygen (O2) therapy-nasal cannula (NC) at a rate of two liters per minute (LPM) via NC to maintain oxygen saturation (O2 Sat) above 92%. Review of the Care Plan for R#40, initiated on 10/28/2024 and target date of 4/28/2025, revealed that the resident was not assessed for oxygen therapy. Observation and interview, on 3/11/2025 at 1:21 pm, with the Director of Nursing (DON), confirmed that R#40's O2 concentrator setting was on 5 LPM. The DON checked R40's medical orders in the facility's electronic records and confirmed that the physician order was for two LPM. Interview on 3/13/2025, at 10:14 a.m., the Registered Respiratory Therapist (RRT) confirmed R#40's O2 concentrator (machine that delivers oxygen) should be set to 2 LPM, delivered via NC. The RRT reported there should be a care plan for the O2 prescription for 2 LPM O2 via NC to maintain O2 Sat above 92%. Interview on 3/13/2025, at 12:24 p.m., the MDS Coordinator confirmed the O2 at 2 LPM was not updated to R#40's Care Plan on 2/25/2025 when it was prescribed by the physician. Interview on 3/14/2025, at 11:02 a.m., the DON revealed the expectation was for the care plan to be updated within 48-72 hours with changes. Cross-refer to 695

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 28734 Based on staff interviews, record review, and policy review, the facility failed to ensure that each resident received adequate supervision to prevent accidents for one of three sampled residents. Resident (R)#50 sustained a fall from a rollover from his/her bed to the floor during activities of daily living (ADL) care. Findings include: A review of the policy titled, Fall Prevention Program dated 6/2023 stated, Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. An observation of R#50 on 3/13/25 at 4:19 p.m., revealed the resident to be alert, and awake and lying in a low bed. During an attempted interview with the resident, the resident could not be fully understood. He appeared clean, and without odor. A pump that delivered enteral feeding directly into R#50's gastrointestinal tract was observed to be at the bedside. A review of R#50's Admission Record revealed the facility admitted him on 3/31/22. A review of the Quarterly Minimum Data Set (MDS), Section I (Active Diagnoses), dated 1/20/25 revealed R#50 had the following diagnoses, but not limited to: stroke, anemia, coronary artery disease, heart failure, hypertension (HTN), diabetes mellitus (DM), aphasia, hemiplegia or hemiparesis, generalized muscle weakness, chronic respiratory failure, dysphagia, gastrostomy status, muscle spasm, and intracranial abscess and granuloma. A review of the MDS Section C (Cognitive Patterns) revealed a Brief Interview for Mental Status (BIMS) score of nine and the resident was interviewable. Continued review of MDS Section H (Bowel and Bladder) revealed the resident was always incontinent of urine, and frequently incontinent of bowel. Review of Section GG (Functional Abilities and Goals) of the MDS revealed R#50 was dependent - Helper does ALL the effort. Resident does none of the effort to complete the activity. Or, the assistance of two or more helpers is required for the resident to complete the activity, for the following: roll left and right, toileting hygiene, upper body dressing, lower body dressing, and personal hygiene. Review of the Functional Limitation in Range of Motion revealed the resident had impairments on both sides of their upper and lower extremities. A review of R#50's care plan stated, Focus - I have an ADL [activities of daily living] self-care performance deficit and impaired mobility r/t [related to] muscle weakness s/p [status post] hospitalization related to CVA [cerebrovascular accident]. Interventions - I require extensive assistance to total assist of [two] 2 people for bed mobility, dated 5/9/22, and Focus - [Resident] at risk for fall. Interventions - Re-educate staff on positioning resident with [two] 2 staff members, dated 3/1/25. In review of the document titled, Post Fall Evaluation, dated 3/1/25 at 9:01 a.m., it was revealed R#50 sustained a witnessed fall per a Certified Nursing Assistant (CNA) DD. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of CNA's staff file revealed she had received training on fall prevention on 1/24/25. In an interview with the Director of Nurses (DON), on 3/14/25 at 9:02 a.m., she revealed that only one CNA had turned the resident to his/her side while in the bed, when the resident kicked out his/her foot, and rolled out of the bed. The DON stated a root cause analysis had been completed on the fall; however, the report was secured, and the surveyor was not able to review the report. The DON did state that the root cause investigation revealed the resident had a fall from the bed due to improper bed mobility related to the resident's behavior. An interview with Licensed Practical Nurse (LPN) BB on 3/14/25 at 10:39 a.m. revealed that it usually took two staff to turn R#50 because of how the resident laid; it was easier on him, and easier on the staff. The nurse continued to state new nurse aides were trained upon hire, and during their orientation on how they were to care for and turn residents. She stated that staff had access to the care plan task through the computer. She revealed she usually ran off a census report for the CNAs and made rounds with them in order to review all aspects of the resident's care. An interview with CNA EE on 3/14/25 at 11:14 a.m. revealed all CNAs were trained upon hire in regard to resident safety, and staff received updates on the residents through communication with the nurses. She revealed it was the facility expectations that staff did walking rounds at the beginning and at the end of their shift. The CNA continued to state it was generally just her that turned R#50 and took care of him. A request was made to the facility for R#50 Kardex during the time of the fall, however, it was not provided. An interview with CNA EE could not be conducted as the CNA was on leave from the facility.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 37650 Based on observations, staff and resident interviews, record review, and facility policy review, the facility failed to ensure that one (1) out of 11 residents receiving oxygen (O2) therapy was administered the therapy in accordance with the physician orders. This deficient practice had the potential to put Resident (R)40 at risk for medical complications. Findings include: Review of the facility's policy titled, Oxygen Administration, undated, outlined the purpose of this procedure was to provide guidelines for safe oxygen administration. Under the section Preparation, outlined the following procedure: 2. Review the resident's care plan to assess any special needs of the resident. Equipment and Supplies outlined that a humidifier bottle would be necessary when performing oxygen administration. Review of the clinical electronic record for R#40, revealed he was admitted to the facility with diagnoses that included, but not limited to, other pulmonary embolism without acute cor pulmonale, anxiety disorder, depression and heart failure. Review of R#40's most recent Minimum Data Set (MDS) assessment, dated 1/31/2025, revealed a Brief Interview for Mental Status (BIMS) with a score of nine (9), which indicated the resident had moderately impaired cognition. Review of R#40's Physician Orders, revealed oxygen therapy-nasal cannula (NC) at a rate of two liters per minute (LPM) via NC to maintain oxygen saturation (O2 Sat) above 92%. Observation on 3/11/2025, at 1:14 p.m., revealed R#40's concentrator (O2) flow meter set on 5 LPM delivered via NC with an empty humidifier bottle connected to it. Interview on 3/11/2025, at 1:21 p.m., the Director of Nursing (DON) confirmed that the resident's O2 setting was on 5 LPM. The DON checked the resident's medical orders in the facility's electronic records and confirmed that the physician order was 2 LPM. The DON revealed the nurses who worked on the 11:00 p.m. to 7:00 a.m. shift were responsible for ensuring the O2 concentrator was set on the correct O2 setting and the humidifier bottle was full. Interview on 3/13/2025, at 10:14 a.m., the Registered Respiratory Therapist (RRT) confirmed R#40's O2 concentrator should be set to 2 LPM O2, delivered via NC. The RRT reported that there should be a Care Plan for the O2 prescription for 2 LPM O2 via NC to maintain O2 Sat above 92%. Cross- refer to F656

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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** 26054 Based on observations, staff interviews, record review, and facility policy review, the facility failed to ensure staff: sanitized or washed hands before donning and after doffing gloves, did not stack a medication cup containing liquid medication on top of a medication cup containing pills, and applied gloves before removing a germicidal wipe to clean the glucometer (device that reads blood glugose) after checking a resident's blood sugar. This affected two (2) of five (5) residents, Resident (R)#34 and R#18, observed during medication pass. Findings include: A review of the facility's policy titled, Personal Protective Equipment with a Date Reviewed/Revised of January 2025, revealed the following: Policy: This facility promotes appropriate use of personal protective equipment to prevent the transmission of pathogens to residents, visitors, and other staff. Definitions: Personal protective equipment, or PPE, . It includes gloves, . Policy Explanation and Compliance Guidelines 4. Indications/considerations for PPE (Personal Protective Equipment) use: a. Gloves: . ii. Perform hand hygiene before donning gloves and after removal. Gloves are not a substitute for hand hygiene . iv. Change gloves and perform hand hygiene between clean and dirty tasks . A review of the facility's policy titled, Blood Glucose Monitoring with a Date Reviewed/Revised of February 2025, revealed the following: .Policy Explanation and Compliance Guidelines: . 3. The nurse will abide by the infection control practices of cleaning and disinfection of the glucometer as per the manufacturer's instructions and in accordance with the facility's glucometer disinfection policy. 4 .the nurse is responsible for cleaning and disinfection of the machine between residents following the manufacturer's instructions and in accordance with the facility's glucometer disinfection policy . A review of the facility's policy titled Medication Administration, undated, revealed the following: . Purpose To provide a safe, effective medication administration process . A review of the facility's Infection Prevention and Control Program Description undated, revealed the following as a major activity of the program: .3. Implementation of Control Measures and Precautions which includes basics such as hand hygiene, Standard and Transmission Based Precautions (including the use of personal protective equipment (PPE), cleaning/disinfecting equipment and measures to protect persons . from communicable disease or infections . A review of R#34's Admission Record, revealed the resident was initially admitted to the facility on [DATE] and readmitted on [DATE]. A review of R#34's diagnoses included, but were not limited to: chronic obstructive pulmonary disease, congestive heart failure, muscle weakness, chest pain, atherosclerotic heart disease, malignant neoplasm of prostate, orthostatic hypotension, gastro-esophageal reflux disease without esophagitis, bilateral primary osteoarthritis of hip and essential hypertension. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R#34's current Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 2/13/25, revealed R#34's Brief Interview for Mental Status (BIMS) score was 15, which indicated the resident's cognition was intact. On 3/12/25 at 9:40 a.m., during medication pass, the following was observed: Licensed Practical Nurse (LPN) BB sanitized her hands and obtained R#34's vital signs. LPN BB exited the resident's room, sanitized her hands, and dispensed R#34's medication. LPN BB poured 90 milliliters (ml) of chocolate supplement into a cup. LPN BB then dispensed the following medications into a medication cup: Breztri-Aerosphere inhaler, aspirin 81 milligrams (mg), azithromycin 500 mg, Bumex 2 mg, cetirizine 10 mg, cholecalciferol 125 mcg (microgram), clopidogrel bisulfate 75 mg, divalproex sodium 500 mg, iron 325 mg, midodrine hcl (hydrochloride) 5 mg, montelukast sodium 10 mg, omega 3 1000 mg, pantoprazole sodium 40 mg, prednisone 10 mg, roflumilast 500 micrograms (mcg), spiralactone 25 mg, and hydrocodone 5/325 mg. LPN BB poured Enulose 15 ml into a separate medication cup. LPN BB sanitized her hands, poured water into an empty cup and sat the cup containing the water on top of the medication cart. LPN BB stacked the medication cup containing the Enulose on top of the medication cup containing the pills. LPN BB picked up the stacked medication cups, the inhaler, the cup containing the water and the cup containing the supplement and entered R#34's room. LPN BB administered the medications to R#34. On 3/12/25 at 10:12 a.m., the surveyor asked LPN BB should medication cups that contained medications be stacked. LPN BB replied she did not think they should, but that was what she had done. LPN BB also stated that it could be a contamination issue regarding stacked medication cups. A review of R#18's Admission Record revealed the resident was admitted on [DATE]. A review of R#18's diagnoses included: Type 2 diabetes, acute kidney failure, hyperkalemia, and essential (primary) hypertension, A review of R#18's current MDS with an ARD of 3/4/25, revealed R#34's BIMS score was 12, which indicated the resident's cognition was intact. On 3/13/25 at 11:05 a.m., during medication pass, the following was observed: LPN CC sanitized her hands and dispensed the following medications: Arginaid one packet, acarbose 50 mg, and humalog injection 100 unit/ml. LPN CC mixed the Arginaid packet with six (6) ounces of water. LPN CC sanitized her hands, gathered supplies to obtained R#18's blood sugar, alcohol prep, tissue, and entered R#18's room. LPN CC applied gloves and proceeded to obtain R#18's blood sugar. LPN CC did not sanitize or wash her hands before applying gloves. After obtaining R#18's blood sugar, LPN CC removed her gloves and exited the resident's room. LPN CC did not sanitize or wash her hands after removing her gloves. LPN proceeded to discard the trash removed from R#18's room, obtained a germicidal wipe and cleaned the glucometer. LPN CC did not apply gloves before obtaining the germicidal wipe used to clean the glucometer. On 3/13/25 at 11:30 a.m., the surveyor asked what should be done before applying gloves and after gloves are removed. LPN CC replied that she should sanitize or wash hands. The surveyor asked what should be applied prior to obtaining a germicidal wipe to clean the glucometer. LPN CC replied to wear gloves, but that was not what she had done. Also, LPN CC stated she did not sanitize or wash hands prior to putting her gloves on or after removing her gloves when she checked R#18's blood sugar. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/14/2025 at 9:12 a.m., during an interview with the Director of Nursing (DON), the surveyor asked what the expectations of staff regarding hand hygiene were before donning (putting on) and after doffing (taking off) gloves. The DON stated to sanitize hands if not visibly soiled and if visibly soiled, staff should wash their hands. The surveyor asked what the expectations were for staff regarding stacking medication cups on top of one another containing medications. The DON stated medication cups should not be stacked, and staff should use Styrofoam trays that are in the medication cart. The surveyor asked what the expectations were for staff regarding hand hygiene when using a germicidal wipe to clean a glucometer. The DON stated staff should sanitize hands, apply gloves, clean the machine, allow the machine to dry, remove gloves, and sanitize hands.