STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145384	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Village Care Center	400 South Station Road Glen Carbon, IL 62034

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32874 Based on record review, interview, and observation the facility failed to prevent skin breakdown for 2 of 4 residents, (R1 and R10) reviewed for pressure ulcers in a sample of 30. Findings include: 1. R10 was admitted on [DATE] with diagnosis of, in part, Parkinsonism, Alzeimer's disease, and cerebral atherosclerosis. R10's Care Plan dated 12/11/24, documented she is at risk for altered skin integrity r/t disease processes, incontinence, increased weakness, changes in mobility, fair/poor appetite. It is difficult to get her to off load heels because of her cognitive status, she does not comprehend why it must be done. Difficult to get her to keep heel protectors or pressure reducing boots on as well. 11/5/24; deep tissue injury (DTI) on left heel; provide assist with repositioning as needed; continue to provide assist with incontinence care and with changing incontinence (inc) briefs when needed, keep skin clean and dry. Low air loss (LAL) mattress with bolsters on bed. Float heels when in bed to offset pressure. Apply heel protectors as often as resident will allow. Pressure reducing cushion in reclining chair; weekly skin check to assess for possible alterations in skin integrity; check heels also; help keep R10 clean, dry every shift and prn. R10's Progress Notes dated 11/16/24 documents, while helping CNA toilet resident, nurse noticed 7cm x 8cm pressure ulcer to right buttock with shearing of skin pressure reducing pad applied to reclining chair, no complaints of (c/o) pain or discomfort. R10's record fails to document any additional measure or treatment for Pressure ulcer to right buttock. R10's skin assessment dated [DATE], documented R10 at moderate risk for skin breakdown. R10's skin assessment dated [DATE], documentsed R10 moderate risk for skin breakdown. On 2/5/2024 at 1:10PM, V17, Licensed Practical Nurse (LPN) stated R10 did have an open area on her buttock, but it had been resolved. The Facility Wound summary report dated 8/1/2024 -1/31/2025 fails to document any type of wound or pressure area to 10's buttocks. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R10's care plan fails to document pressure sore to right buttock or any type of interventions for right buttock. On 2/6/25 at 9:50 AM, during transfer to the toilet R10's buttock region was red and had darkened discoloration to the coccyx On 2/6/25 at 9:55 AM, V17 stated she looked at R10's buttocks and it definitely had redness, darkened discoloration with hardened areas and that this was new for her. V17 stated R10 did not have any concerns previously with her coccyx. V17 stated she would monitor R10's skin and notify hospice of her findings. 50908 2.R1 was admitted to the facility on [DATE] with diagnosis of, in part, unspecified severe protein-calorie malnutrition, edema and pain. R1's Minimum Data Set (MDS) dated [DATE] documented she is moderately cognitively impaired and is dependent on staff for putting on/taking off footwear, toileting hygiene, bathing self and all transfers. R1's Care Plan dated 11/20/24 documented she is at risk for altered skin integrity due to decreased mobility, incontinence, weakness; on hospice at this time secondary to (s/t) protein/calorie malnutrition diagnosis (dx); has an ulcer on lateral right foot/heel and right foot/bunion area; refer to Medication Administration Record (MAR) for treatment to right outer heel and lateral right foot wounds; monitor for any signs of healing progress; check Right foot wound dressings every shift to assure placement. R1's care plan continued to document R1 having a problem with Activities of Daily Living (ADL)s Functional Status/Rehabilitation Potential, R1's ability to safely perform daily care tasks has changed related to (r/t) changes in condition, weakness. R1 is on hospice at this and needs more help with her care now. Pressure reducing boots discontinued because R1 keeps trying to 'fix' them on her feet causing falls. When R1 is in her wheelchair (w/c) her feet are not resting on any hard surfaces due to the calf rests on leg rests. When R1 is in bed, she is to have gripper socks on with her heels floated. Provide assist with bed mobility as needed; assist with transfer with mechanical lift and using 2 staff assist; W/C used for mobility, she needs some assist with locomotion; assist with dressing tasks; assist with toileting/incontinence care as needed; assist with showers; assist with grooming; bilateral Knee-High compression hose on in morning, off at hour of sleep for edema. R1 had a Braden Scale for Predicting Pressure Sore Risk completed on 8/2/24 scoring her to be a mild risk and again on 11/8/24 scoring her to be a moderate risk. There were no other documented Braden Assessments completed upon discovering pressure ulcers on R1. R1's wound documentation details that she had a coccyx pressure ulcer identified on 9/4/24 and was unstageable with moderate amounts of drainage, the Right top of foot medial right foot (bunion area) wound was identified on 10/18/24 and her Right top of foot lateral wound was identified on 10/24/24; all facility acquired pressure ulcers. R1's wound care orders on 11/3/24, documented the following cleanse open area to right outer foot with wound cleanser then apply wound gel and cover with foam daily and prn; Right lateral foot wound: cleanse with wound cleanser, apply wound gel and absorbent dressing. Change daily and prn. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/4/2025 at 10:59 AM, V9, License Practical Nurse (LPN), performed wound care. V9 was observed sitting in wheelchair with feet dangling with compression stockings and socks in place. V9 removed the sock to R1's right foot revealing dried yellow drainage to the wound to the inner right foot next to bunion and outer right side of the foot. V9 attempted to remove the stocking and noted that the stocking was dried to the wound on the inner and outer aspect of the right foot. Upon removal of the stocking, observed open wounds and no dressings in place. During the removal of her stocking, R1 was grimacing and stated it is painful when her bunion is being touched. V9 stated he had no concerns with R1's wounds at this time other than there not being a dressing in place. R1's Progress Notes on 8/8/24 at 2:52 PM documented, New order for bilat Knee-high compression hose for edema, on in (morning) AM, off at (hour of sleep) HS. Tolerated well. Two assist for transfers. As needed (PRN) Norco given this AM for right lower extremity (RLE) pain, helpful. Feeds self with set-up. Continues routine nebulizer. R1's Progress Notes on 9/01/2024 11:42 PM documented, Took meds as ordered, including nebs treatment. Confused, she wandered some this afternoon, trying to go to main dining room (MDR) early and then to leave during supper. She took her meds and went to bed early. Certified Nursing Assistant (CNA) reported that her bottom looked bad, so we checked it out together late this evening. I noted large areas of redness on coccyx and sacrum most of which blanche, although not strongly. There are apparently two very small open areas to coccyx area. Foam dressing applied over area. Hospice should be notified with possible request for sacral foam dressing. Staff reports that she is usually continent during the day but very incontinent overnight. She does try to turn herself while in bed at night but sits on her bottom all day. R1's Progress Notes on 9/04/2024 at 1:43 PM documented, Hospice called to provide low air loss mattress related to (r/t) 1.5-centimeter (cm) by (x) 2 cm unstageable wound to coccyx area. Slough area noted. Wound gel and foam dressing applied to region. Tolerated well. R1's Progress Notes on 9/08/2024 2:29 PM documented, CNA notified writer that resident has red areas to feet. Noted 0.5 cm x 0.2 cm red blanchable area to right bunion region, 1 cm x 0.5 cm red blanchable are to right dorsal foot, also 1cm x 0.6 cm red blanchable region to left inner heel. Patient (Pt) has less edema to (bilateral lower extremity) BLE from diuretic therapy and compression hose. Shoes are not too tight with compression hose and shoes, does occasionally wear fuzzy thick socks with the compression hose. Order for skin prep every (q) shift to bilateral (bilat) feet and heel protector boots in bed. Power of Attorney (POA) updated about status of feet, also pt had removed right hearing aid after lunch for the second time and hearing aid dropped on the floor during transfer from chair to bed during transfer. Hearing aid pieces put in container for pick-up for POA. Coccyx wound dressing changed, nickel size amount of serosang drainage (drng). Continues wound gel and foam dressing. Patient (Pt) is on low air loss mattress now for bed and has wheelchair and recliner seat pads. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/6/25 at 12:37 PM, V3, Director of Nursing (DON), stated she expects wound dressings to stay in place especially if it is draining. V3 stated she would find it very hard for a resident to completely remove a dressing from under a compression stocking. V3 stated after a pressure ulcer is found, she expects the nurse to measure and clean it, notify the doctor and get orders, consult the wound nurse and notify the family. V3 stated she does not know why the nurse for R10 documented her having a pressure ulcer to her buttock or why nothing else was documented on it further. V3 stated the facility has daily meetings, including the wound nurse, to discuss a resident's change in skin condition and assess their situations then but we do not document them. The facility's Pressure Ulcer Prevention and Treatment Policy and Procedure documented, It is their objective to provide nursing standards for accurate assessment, prevention, treatment, and implementation of protocols including documentation to help manage residents at any level of risk for skin breakdown. To cleanse, inspect and protect all residents' skin. The policy continued to document any new areas identified will be assessed and documented in the Electronic Medical Record (EMR) by the licensed nurse using observation Skin Integrity Condition, progress note and/or other assessments as appropriate. Physician will be notified of the change in the resident's condition.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44556 Based on observation, interview, and record review, the facility failed ensure timely and complete incontinent care was done for 4 of 4 residents (R3, R4, R41, and R52) reviewed for incontinent care in a sample of 30. Findings Include: 1. R3's Face Sheet, current admitted [DATE], documented R3 has diagnoses of but not limited to Urinary tract infection, Unspecified urinary incontinence, Full incontinence of feces, and Severe sepsis with septic shock. R3's Minimum Data Set (MDS), dated [DATE], documented R3 is severely cognitively impaired and is dependent on staff for toileting hygiene, bed mobility, and transfers. R3's Care Plan, last review date of 11/18/2024, documented R3 has been incontinent of bowel and bladder, and she doesn't know when she is wet or soiled. R3 needs assistance from staff for toileting and peri care. R3 has progressing dementia and Multiple Sclerosis (MS). Interventions include but are not limited to report signs of UTI (acute confusion, urgency, frequency, bladder spasms, nocturia, burning, pain/difficulty urinating, nausea, emesis, chills, fever, low back/flank pain, malaise, foul odor, concentrated urine, blood in urine) and provide incontinence care after each incontinent episode. Check/change incontinent briefs approximately every 2 hours and as needed. Apply moisture barrier to skin after giving peri care. Monitor for signs of potential skin breakdown. R3's Physician's Orders, dated 12/20/24, documented Certified Nursing Assistant (CNA) may apply moisture barrier after each incontinent episode. Every shift; Days 7:00-3:00, Evenings 3:00-11:00, and Nights 11:00-7:00. On 02/05/25 at 01:41 PM, V29, CNA and V30, CNA transferred R3 back to be via mechanical lift. No hand hygiene was done prior to V29 and V30 applying their gloves. With the same gloves V29 and V30 unfastened R3's incontinent brief. They rolled R3 onto her left side. R3's incontinent brief was wet with urine her buttocks were red and had indentations from where the elastic on the incontinent brief had been. V29 then took a disposable wipe and cleansed R3's gluteal fold and when she was done, she was done with the wipes she threw the wipes onto the floor. She then took another wipe with the same gloves and cleansed R3's right buttocks, placed the wipe in the brief and tucked the brief under R3. V29 and V30 then assisted R3 onto her back with no hand hygiene or glove change done before V29 took another wipe from the pack and cleansed down the right and left crease by the pubic area on R3. V29 then took another disposable wipe and cleansed R3's outer labia. She did not separate the outer labia and cleanse the inner labia. V29 and V30 then assisted R3 onto her right side and V29 cleansed R3 left buttocks. R3 was then placed on her back and her incontinent brief was fastened. V29 and V30 did not clean all areas of incontinence and they did not dry any of the areas. No barrier cream was applied prior to placing R3's clean incontinent brief. V29 and V30 did not do any glove changes or hand hygiene during the incontinent care. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/06/25 at 12:27 PM, V2, Director of Nursing (DON) stated she would expect the CNAs to do incontinent care correctly and to follow the policy. She would expect them to wash all areas wet with urine and to change their gloves and use hand gel when going from dirty to clean. V2 stated she expects the CNAs to check and change the residents at least every two hours and changed if the resident is suspected to be soiled. On 02/06/25 at 12:50 PM, V1 Administrator said she would expect the staff to follow the policy and do what is supposed to be done when it comes to incontinent care and all areas of incontinence to be cleaned. She said she would the staff to do hand hygiene appropriately when doing incontinent care. 32874 2. On 2/5/2024 at 1:16PM incontinent care observed. V25, CNA and V26 CNA both sanitized hand prior to donning gloves. R52 on back in bed. V25 removed adult diaper. Diaper saturated with urine and diaper dark yellow in color and strong smell of urine. V25 stated she is a heavy wetter I changed her earlier.V25 then removed gloves sanitized hands and donned new glove. With disposable washcloth cleanses right groin, then new cloth and left groin new cloth the separated labia and cleanse. V25 did not cleanse inner thighs or dry R52. V25 and V26 then turned R52 to left side and V25, removed gloves sanitized hands and cleans buttock and rectal area, removed gloves and sanitized hand and donned gloves applied barrier cream. Placed adult diaper under R52 then tuned to right side and secured diaper. Did not dry R52 or cleanse right buttocks. R52's Care plan dated revised 11/8/2024 documents R52 episodes of incontinence, and needs assistance with incontinence care. R52's care plan documents intervention dated 11/7/2024: Provide incontinence care after incontinent episodes. R52's face sheet dated 10/31/2024 documents in part R52 has a history of Urinary Tract Infection (UTI) and urinary retention R52's Brief Interview Mental Status (BIMS) dated 12/5/2024 documents R52 has severe cognitive impairment. 42108 3. R4's Care Plan, dated 12/31/2024, documents that Problem: I am incontinent of b/b R/T (related to) weakness, disease progression. I need assist with changing inc briefs , hygiene, skin care. Unable to retain new information for bladder re-training s/t dementia dx (diagnosis) and cognitive loss. 2/10/2024 Approach: Provide incontinence care after each incontinent episode. Check/change my incontinence briefs approx (approximately) every 2hrs (hours) and prn (as needed). R4's MDS, dated [DATE], documents that R4 is severely impaired, always incontinent of bowel and bladder and dependent on staff for toileting. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/5/2025 at 10:05 AM observed V27, CNA, and V28, CNA, perform incontinent care. R4 was incontinent of urine. V27 and V28 opened the heavily urine soiled incontinent brief and V27 rolled the incontinent brief beneath R4. V27 then took a wipe and cleansed R4's groin and vaginal area, V27 and V28 then assisted R4 onto her right side. V28 then using wipes cleansed R4's entire left buttock and partial right. V27 and V28 then applied the clean incontinent brief. V27 and V28 did not cleanse R4's entire right buttock and inner thighs. 4. R41's Care Plan, dated 1/23/2025, Problem: Senior is incontinent of B/B (bowel/bladder). Needs assist with inc (incontinent) care. Unable to care for herself. She is unaware of when she is wet/soiled. Approach: Provide incontinence care after each incontinent episode. Apply moisture barrier to skin after inc episodes. Assist with changing inc briefs. as needed. R41's Minimum Data Set (MDS), dated [DATE], documents that R41 is severely cognitively impaired, frequently incontinent of urine and bowel and dependent on staff for toileting. On 2/5/2025 at 9:00 AM V27 and V28 provided incontinent care. R41 was heavily incontinent of urine. V27 and V28 assisted R41 into the bed using a mechanical lift. V27 opened the incontinent brief and pushed it beneath R41. V28 then opened right side of the soiled brief, pulled it from between R41's legs. V27 and V28 assisted R41 onto her left side and removed the heavily urine soiled incontinent brief. V28 then removed wipes from package and wiped between R41's buttocks. V28 then applied the clean incontinent brief and placed the cover on top of R41. V28 did not cleanse R41's vaginal area, inner thighs and buttocks. V28 did not apply barrier after incontinent care. The facility's Perineal Care/Catheter Policy & Procedure, dated 2/28/2024, documents Policy: The following procedure should be followed when cleansing the external genitalia and surrounding area. Procedure: 3.) Steps for female residents: a. Position the resident to lie on her back b. use one hand to retract the labia and with the other hand wash front to back. c. Use a separate section of the cleansing cloth for each wipe in a downward motion. d. Cleanse the urethral to the vagina orifice, then wash the labia. e. Cleanse the perineum. f. Place the resident on her side and cleanse the rectal area and buttock from front to back.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44556 Based on observation, interview, and record review, the facility failed to label food items in the refrigerator with use by dates and dispose of outdated food items in the refrigerator. This failure has the potential to affect all 52 residents residing at the facility. Findings include: On 02/03/24 at 8:06 AM, The initial tour of the kitchen was completed. During inspection of the walk-in refrigerator, it contained the following items: 1. A metal container of Chopped bacon, a metal container of diced tomatoes, a metal container of chopped onions, a metal container of shredded cheese, a metal container of cut up eggs, a metal container of pickle spears, and a metal container of shredded lettuce all of them covered with cling wrap with perpetration (prep) date of 2/2 and no date listed on the use by section. 2. Sliced ham in a meatal container, covered with cling, with a prep date of 1/27 and no date listed on the use by section. 3. Half a ham wrapped in cling wrap with a prep date of 1/24 and a use by date of 1/31. 4. There was a plastic container of tropical fruit covered with cling wrap and there was writing on the top in marker with a prep date of 2/2 and there is no use by date. 5. A plastic container of red and orange Jello covered with plastic wrap and the date of 1/22 written on the plastic wrap and no use by date. 6. There was a pitcher of red and pink juice and two pitchers of tea with the prep date of 2/2 and no use by date. 7. A gallon of milk with about a 1/4 left in the jug with no open date on the jug. On 02/03/25 at 08:15 AM, The walk-in freezer was inspected and contained the following items: 8. A metal pan containing spaghetti sauce was covered with plastic wrap that wasn't secured and the date of 1/13 and no use by date. 9. A metal container of polish sausages covered with cling wrap and dated 1/28 written with a marker, and no use by date. 10. A container of broccoli covered in cling wrap dated 1/30 written with marker and use by date. 11. A container with meat loaf written on the cling wrap dated 1/22 and no use by date. The meat loaf was noted to have freezer burn on it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	12. A container covered with cling wrap with pork roast and the date 1/27 written on it with a marker and no use by date. 13. Plastic container of soup covered with cling wrap; date of 1/28 wrote on it with a marker and no use by date noted. On 02/05/25 at 09:30 AM, V7 Dietary Manager said she has educated her staff on the proper labeling of food. She said she would expect when they open something for them to label it with an open date and an out date so they will know when it's not good anymore. On 02/06/25 at 12:50 PM, V1 Administrator stated she would expect the food to be labeled and dated appropriately. The facility's safe storage of food policy, issue date of 08/08/24, documented Standard: All time/temperature control for safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA (Food and Drug Administration) Food Code.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 44556 Based on observation, interview, and record review, the facility failed perform proper hand hygiene and glove changes were done during incontinent care and failed to sanitize glucometer between residents during medication pass for 4 of 4 residents (R3, R15, R14, R35) reviewed for infection control in a sample of 30. Findings include: 1. On 02/05/25 at 01:41 PM, V29, Certified Nursing Assistant (CNA) and V30, CNA transferred R3 back to be via mechanical lift with no issues noted. No hand hygiene was done prior to glove placement to put R3 to bed. With the same gloves V29 and V30 unfastened R3's incontinent brief. R3's incontinent brief was wet with urine her buttocks were red and had indentations from where the elastic on the incontinent brief had been. V29 then took a disposable wipe and cleansed R3's gluteal fold and there was a smear of bowel movement (BM) on the wipe. When she was done with the wipes she threw the wipes onto the floor. She then took another wipe with the same gloves and cleansed R3's right buttocks, V29 and V30 then assisted R3 onto her back with no hand hygiene or glove change done before V29 took another wipe from the pack and cleansed R3's pubic area. V29 then took another disposable wipe and cleansed R3's outer labia. She did not separate the outer labia and cleanse the inner labia. V29 and V30 then assisted R3 onto her right side and V29 cleansed R3 left buttocks. R3 was then placed on her back and her incontinent brief was fastened. V29 and V30 did not do any glove changes or hand hygiene during the incontinent care. On 02/05/25 at 01:41 PM, V2, Director of Nursing (DON) said she would expect the CNAs to change their gloves and use hand gel when appropriate. On 02/06/25 at 12:50 PM, V1 Administrator she would expect the staff to follow the policy and do what is supposed to be done when it comes to incontinent care and all areas of incontinence to be cleaned. She said she would the staff to do hand hygiene appropriately when doing incontinent care. 2. On 2/4/2024 at 9:00AM V13, CNA donned gloves ,V13 CNA did not sanitize hands prior to donning gloves prior to entering R15's room Sign on wall pocket attached to R15's door documents, stop contact precautions, everyone must: clean their hands, including before entering and when leaving the room. R15's physician orders dated 2/3/2025 documents contact isolation due to nausea vomiting and diarrhea. 42108 3. On 2/4/2025 at 8:00 AM V8, Registered Nurse, applied a gown, gloves and a N95. V8 then entered R14 room and placed the glucometer on the overbed table without a barrier. V8 then performed a fingerstick and placed the glucometer back on the table without a barrier. V8 then discarded the used strip and placed it in the trash along with the used PPE. V8 then placed the glucometer in his pocket and left the room. V8 then removed the glucometer from his pocket and placed it in the top drawer of the medication cart. V8 did not cleanse the glucometer. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145384	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Village Care Center	400 South Station Road Glen Carbon, IL 62034

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/4/2025 at 8:00 AM V8 stated that R14 was on contact isolation for a stomach virus and that R14 was having vomiting and diarrhea. On 2/4/2025 at 8:11 AM The Sign on door of R14's door documents CONTACT PRECAUTIONS EVERYONE MUST: Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. On 2/4/2025 at 11:41 AM V8 applied gloves, removed glucometer from the top of the cart, applied strip. V8 then entered R35's room and performed R35's Fingerstick blood sugar (FSBS) with 317 results. V8 then removed the strip and placed the glucometer on top of the medication cart without a barrier. V8 removed gloves and applied alcohol gel. V8 did not clean or sanitize the glucometer. On 2/4/2025 at 11:47 AM V8 applied gloves, removed uncleaned glucometer from top of cart applied strip and performed R14's Fingerstick blood sugar (FSBS) in the doorway of her room. V8 then removed the strip and placed the glucometer in the top drawer of the cart. V8 removed gloves and applied alcohol gel. V8 did not clean or sanitize the glucometer. On 2/3/25 at 11:33 AM, V9, LPN, stated the facility uses disinfecting wipes with a contact time of 2 minutes for the glucometers. On 2/6/2025 at 12:20 PM V1, Administrator, provided a list of residents who receive fingerstick on 400 Hall R3, R35, R14. On 2/6/2025 at 12:35 PM V2, Director of Nurse, stated that the multi dose vial expiration date is different when opened. V2 stated that the nurse is to place an open date and this date is what they go by for expiration date. V2 stated that the glucometer is to be clean after each use with the wipes. The facility's Infection Control Policy, dated 2/28/24, documents Infection Control - Hand Hygiene Policy: (Facility) recognizes proper hand hygiene to be one of the most important elements of an effective infection control program and one of the best ways to prevent the spread of infection and illness. (facility) will follow the C.D.C. (Center for Disease Control) guidelines regarding hand hygiene. Perform hand hygiene: Before and after providing resident care including bathing, oral care, incontinence care, catheter care and any direct contact with the resident (such as taking a blood pressure/pulse, transferring the resident, etc.). Before and after assisting a resident with toileting. After contact with body fluids or excretions or mucous membranes. After handling soiled or used linens, bedpans, catheters and urinals. It also documents Infection Control Standard Precautions Standard precautions apply to all residents, regardless of their diagnosis or presumed infectious status. It continues f. Resident care equipment should not be used for the care of another resident until it has been cleaned and disinfected.