

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/20/2025
NAME OF PROVIDER OR SUPPLIER  Westridge Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  125 W Margaret Ave Terre Haute, IN 47802	

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)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>35317</p> <p>Based on interview and record review, the facility failed to ensure residents were provided showers/bed baths as preferred for 2 of 3 reviewed for choices (Residents 41 and 40).</p> <p>Findings include:</p> <p>1. During an interview, on 3/17/25 at 9:29 a.m., Resident 41 indicated he had requested to receive two complete bed baths twice a week, but it was a challenge to receive the bed baths because of the facility not having enough staff. He indicated the bed baths were scheduled to occur on Monday and Thursday evening, but they were not getting done twice a week as requested. Resident 41 would sometimes only receive a washcloth from staff to wash his face and armpits and that was all he would get washed because he was unable to complete the task himself.</p> <p>Resident 41's record was reviewed on 3/18/25 at 10:50 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 12/3/24, indicated the resident was cognitively intact and required 1 to 2 staff assistance with activities of daily living (basic tasks that individuals perform to maintain their health and well-being).</p> <p>Review of daily preference assessment, dated 8/29/24, indicated Resident 41 prefers bed baths two times a week in the evenings.</p> <p>Review of the scheduled showers/bed baths for the 200 hall, indicated Resident 41 was to receive a bed bath on Monday and Thursday from 2-4 p.m.</p> <p>Review of point of care (when healthcare services are provided) documentation, indicated the resident received a bed bath on 3/17/25, 3/10/25, 3/6/25, 2/24/25, 2/18/25. The record lacked documentation of a bed bath being completed on 3/13/25, 3/3/25, 2/27/25, and 2/20/25. In the last 30 days the resident didn't receive 4 of his scheduled bed baths.</p> <p>During an interview, 3/19/25 at 8:36 a.m., Certified Nurse's Aide (CNA) 6 indicated Resident 41 doesn't refuse his bed baths and was something he wanted to make sure he received as scheduled. The CNA indicated there were times she would have to stay past her scheduled shift to help the next shift get their showers/bed baths completed. There were times it was a challenge to get all tasks completed due to staffing.</p> <p>(continued on next page)</p>

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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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on 3/19/25 at 2:07 p.m., the Administrator indicated Resident received his scheduled bed baths but was unable to provide documentation of the bed baths being completed by staff.</p> <p>48226</p> <p>2. On 3/16/25 at 2:21 p.m., during initial observation and interview Resident 40 indicated he did not receive regular showers. He indicated he was scheduled for two showers per week in the evenings but did not always receive them.</p> <p>On 3/17/24 at 11:00 a.m., Resident 40 record was reviewed. The most recent quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact and required 1 staff member for assistance with bathing and toileting.</p> <p>Review of the residents care plan dated 11/6/23, indicated the resident daily preferences were very important to him and he preferred to have two showers per week in the evening.</p> <p>A care plan dated 4/10/23, indicated the resident sometimes rejects care. Intervention included but not limited to attempt to determine the immediate cause for rejection. Seek solution if able. The medical record lacked documentation of resident refusals to take offered showers.</p> <p>On 3/18/25 at 1:44 p.m., during interview with Certified Nurse Aide (CNA)10., she indicated the residents are given showers at least two days a week and some are three days a week. She indicated the CNA's record of the shower on a document referred to as a shower sheet. Once it is filled out they turn the shower sheet into the Director of Nursing (DON) for review. She indicated blank shower sheet forms are kept in the nurses station, file cabinet. She indicated if the resident refused a shower they would complete a behavior sheet and a shower sheet, staple them together and report to the DON. She indicated Resident 40 was scheduled for two showers a week to be administered in the evenings. The CNA demonstrated the shower schedule was in the CNA record book and indicated the schedule is updated as needed.</p> <p>Review of the shower schedule indicated the resident was scheduled to be administered a shower on Mondays and Thursdays in the evening.</p> <p>On 3/18/25 at 2:26 p.m., during interview, CNA 9 indicated each resident is to receive two showers a week on the day or evening shift. And the shower schedule for each resident is in the CNA book. If a resident refused a shower, she would report it to the nurse and would complete a shower sheet. If the resident refused to take a shower she would record the refusal on a behavior sheet and a shower sheet. If the resident refused to sign the shower sheet she would record that as well. She would turn the behavior sheet and shower sheet into the DON.</p> <p>On 3/18/25 at 1:00 p.m., the DON provided several copies of CNA assignment sheet. The document indicated Resident 40 had refused some of the scheduled showers. The CNA assignment sheet was not part of the resident's medical record. The point of care record, part of the resident's medical record, lacked documentation indicating the resident had refused showers.</p> <p>(continued on next page)</p>

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/18/25 at 1:30 p.m., the point of care documentation which was recorded by the CNA and was part of the medical record was reviewed. From December 1, 2024 to March 17, 2025 the resident was scheduled to receive a total of 30 showers. The record indicated the resident received 17 showers. From January 12 to 18, 2025 and March 16 to 18, 2025 the record lacked documentation of showers being administered.</p> <p>On 3/18/25 at 3:00 p.m., during interview the DON indicated if a resident refused a shower the staff would ask again and then they would ask the nurse to talk to the resident. She indicated if a resident refused to take a shower they do not have the resident sign a shower sheet. She indicated they have used shower sheets, but they use the CNA assignment sheet now and also document in the medical record. She indicated at times the staff would fill out a behavior sheet if the resident refused a shower, but many of the residents do not take regular showers. She indicated the residents should receive a minimum of 2 showers a week. The DON could not recall the last time the facility used shower sheets. I asked for a copy of any shower sheets they had used for Resident 40. The facility failed to provide requested documentation.</p> <p>On 3/19/25 at 9:34 a.m., during interview, CNA 3 indicated there were times when they did not have staff to administer showers. This had occurred mostly on the evening shift. She indicated she was not aware if Resident 40 had ever refused a shower.</p> <p>On 3/19/25 at 9:38 a.m., during interview Resident 40 indicated he had never refused a shower when it was offered.</p> <p>On 3/19/25 at 2:00 p.m., during an interview, the Administrator indicated Resident 40 had received several showers from the Occupational Therapist. The Administrator provided a document, dated 3/12/25, and indicated it was documentation of occupational therapy providing showers for the resident. The document lacked evidence of administration of a shower. She did not know if the staff could document a refusal in the resident's electronic record. The occupational therapy staff recorded showers they administered in their records.</p> <p>On 3/20/2025 at 11:54 a.m., the Regional Nurse Consultant provided a document, titled, Resident Rights, dated 9/17, and indicated it was the policy currently being used by the facility. The policy indicated, . This facility shall treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life . This facility shall provide equal access to quality of care regardless of diagnosis, severity of condition, or payment source</p> <p>3.1-3(u)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>35317</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure expired medications were disposed of for 1 of 2 medication carts and 1 of 2 medication storage rooms reviewed (Residents 36 and 26).</p> <p>Findings include:</p> <p>1. On 3/19/25 at 09:35 a.m., the south hall medication cart contained two expired insulin (medication used to lower blood sugar) vials with an open date of 2/6/25. The insulin vials contained labels that indicated they were for Resident 36.</p> <p>During an interview, on 3/19/25 at 09:37 a.m., Qualified Medication Aide (QMA) 7 indicated insulin was good for 30 days once opened. The insulin vials in the cart should have been discarded.</p> <p>Resident 36's record was reviewed on 3/19/25 at 10:06 a.m. The profile indicated the resident diagnosis included, but were not limited to, type 2 diabetes mellitus with hyperglycemia (occurs when the body either doesn't produce enough insulin or its cells don't respond properly to insulin, leading to a buildup of glucose [simple sugar] in the blood stream).</p> <p>A physician order, dated 2/5/25, indicated to administer Humalog (insulin medication) solution 100 unit/ml (milliliter). Inject 12 units subcutaneously (under the skin) three times daily.</p> <p>A physician order, dated 2/5/25, indicated to administer Lantus (insulin medication) solution 100 unit/ml. Inject 24 units subcutaneously at bedtime.</p> <p>2. On 3/19/25 at 9:51 a.m., the north hall medication storage room contained an expired insulin pen (contains insulin in a cartridge that is administered into subcutaneous tissue through fine, replaceable needle) with an open date of 1/14/25, it was in the refrigerator, and it contained a label that indicated it was for Resident 26.</p> <p>During an interview, on 3/19/25 at 9:52 a.m., Qualified Medication Aide (QMA) 8 indicated insulin was good for 28 days once opened. She indicated she was unsure why the insulin pen was in the refrigerator and why it wasn't discarded.</p> <p>Resident 26's record was reviewed on 3/19/25 at 10:10 a.m. The profile indicated the resident diagnosis included, but were not limited to, type 2 diabetes mellitus without complications (a state where the body doesn't produce enough insulin or doesn't use it properly, leading to high blood sugar).</p> <p>A physician order, dated 12/11/24 with a discontinued date of 1/10/25, indicated to administer Humalog kwikPen 100 unit/ml. Inject 45 units subcutaneously twice a day.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/19/25 at 11:27 a.m., the Cooperate Nurse Consultant provided a document, dated 9/2017, titled, Medication Expiration, and indicated it was the policy currently being used by the facility. The policy indicated, .d. Multiple dose injections, such as insulin will expire 28 days after opening unless otherwise noted by manufacturer. 2. Facility staff shall date the label of any multi-use vial the first accessed and access the vial in a dedicated medication preparation area: If a multi-dose vial has been opened or accessed .the vial should be dated and discarded within 28 days unless the manufacturers specifies a different .date for the opened vial</p> <p>3.1-25(o)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>48226</p> <p>Based on observation and interview, the facility failed to label and date refrigerated and frozen food items, so it is used by its use-by date, frozen, or discarded, and the facility failed to prevent possible contamination of food in the refrigerator from water dripping onto food items for 2 of 2 kitchen observations.</p> <p>Findings include:</p> <p>On 3/16/25 at 10:05 a.m., during initial kitchen observation of refrigerated foods with Employee 11. The main refrigerator was observed with tomatoes in a clear plastic container date labeled with an opened date of 2/24. Two clear containers with lettuce inside with an opened date of 2/24. The tops of both containers were covered in water which was dripping down onto covered container of chicken noodle soup on the second shelf. The bottom of the refrigerator also had water on it and boxed food items were wet.</p> <p>On 3/16/25 at 10:10 a.m., an observation of freezer found an undated bag of frozen tater tots, two packages of undated frozen pie shells, two undated cakes, and four undated frozen pies.</p> <p>On 3/16/25 at 10:15 a.m., during interview employee 11 indicated the tots were from last night. She removed the item from the freezer and wrote a date on the bag.</p> <p>On 3/19/25 at 11:10 a.m., during second dietary kitchen observation with Employee 12. The refrigerator noted to have standing water on the top shelf of sealed food items. When moved, water spilled down inside of refrigerator and onto the floor. Boxes on the shelves were wet. Food items inside boxes were sealed.</p> <p>On 3/19/25 at 11:05 a.m., during interview the Dietary Manager indicated he did not know where the water in the refrigerator was from.</p> <p>On 3/18/2025 at 11:48 a.m., the Administrator provided a document titled, Magnolia Health Systems storage guidelines for Refrigerator/freezer/dry storeroom, dated 3/2017, and indicated it was the policy currently being used by the facility. The policy indicated, .Angel food cake 6-12 months, Pie Shells 12 months freezer, Shredded lettuce (opened) 3 days: reseal tightly, Tomatoes 3 days</p> <p>3.1-21(i)(1)</p> <p>3.1-21(i)(3)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>34525</p> <p>Based on record review and interview, the facility failed to ensure documentation of the facility contact with the hospital prior to a resident transfer was completed timely for 1 of 4 residents reviewed for hospitalization (Resident 31).</p> <p>Findings include:</p> <p>Resident 31's record was reviewed on 3/17/25 at 2:31 p.m. The profile indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD- a group of lung diseases that cause ongoing inflammation and damage to the airways and air sacs in the lungs), cerebral infarction (a condition where brain tissue dies due to a lack of blood flow caused by a blockage in a blood vessel), and late-onset Alzheimer's disease (a common form of dementia that starts after the age of 65. It can cause memory and cognition issues, impaired judgment, and other symptoms as it progresses).</p> <p>A 5-day Minimum Data Set (MDS) assessment, dated 2/4/25, indicated the resident had moderate cognitive deficit, was totally dependent with all activities of daily living (ADLs-fundamental tasks essential for independent living, including basic self-care and mobility, like bathing, dressing, eating, and toileting), and required continuous oxygen (O2).</p> <p>The census indicated that the resident had been hospitalized from 3/9/25 to 3/13/25.</p> <p>The initial review of the record lacked documentation of facility contact with the hospital emergency room (ER) to provide a report of the transfer.</p> <p>During a follow-up review of the resident's record, on 3/18/25 at 2:10 p.m., a late entry progress note, dated 3/18/25 at 1:48 p.m. for 3/9/25, indicated the family and ER had been notified. At the same time the Corporate Nurse Consultant indicated it was dated a late entry on 3/18/25, because the note had just been placed in the record. The note had been added as a plan of correction after it was discovered that there had not been a note written at the time of the transfer.</p> <p>On 3/18/25 at 3:40 p.m., the Administrator provided a document, dated 10/2014, titled, Charting and Documentation, and indicated it was the policy currently being used by the facility. The policy indicated, . Policy: Nurse's notes shall be written on each resident .and shall address the resident's conditions .entries shall be dependent on individual residents' needs and any pertinent change in condition .Document significant information</p> <p>3.1-50(a)(1)</p> <p>3.1-50(a)(2)</p> <p>3.1-50(h)(5)(F)</p> <p>3.1-50(i)</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>35317</p> <p>Based on observation, record review, and interview, the facility failed to ensure proper handling of the glucometer (small portable machine that's used to measure how much glucose [type of sugar] is in the blood) meter during 2 of 2 blood glucose monitoring opportunities (Residents 42 and 35).</p> <p>Findings include:</p> <p>1. During a blood glucose monitoring observation, on 3/19/25 at 11:11 a.m., the Qualified Medication Aide (QMA) 7 entered Resident 42's room and placed the glucometer onto her side table, no barrier placed under the meter. The QMA returned the glucometer to a resident specific black case and placed it back in the medication cart.</p> <p>Resident 42's record was reviewed on 3/19/25 at 1:10 p.m. The profile indicated the resident diagnosis included, but were not limited to, type 2 diabetes mellitus with hyperglycemia (occurs when the body either doesn't produce enough insulin or its cells don't respond properly to insulin, leading to a buildup of glucose [simple sugar] in the blood stream).</p> <p>2. During a blood glucose monitoring observation, on 3/19/25 at 11:17 a.m., QMA 7 entered Resident 35's room and placed the glucometer onto her side table, no barrier placed under the meter. The QMA returned the glucometer to a resident specific black case and placed it back in the medication cart.</p> <p>During an interview, on 3/19/25 at 11:17 a.m., QMA 7 indicated the night shift nurses clean the glucometers, but she also cleans the machines at the end of her shift daily.</p> <p>Resident 26's record was reviewed on 3/19/25 at 1:20 p.m. The profile indicated the resident diagnosis included, but were not limited to, type 2 diabetes mellitus without complications (a state where the body doesn't produce enough insulin or doesn't use it properly, leading to high blood sugar).</p> <p>During an interview, on 3/20/25 at 9:11 a.m., QMA 10 indicated a paper towel should be placed under the glucometer as a barrier when placing the glucometer on a surface. She indicated this was to prevent any cross contamination.</p> <p>On 3/19/25 at 1:30 p.m., the Cooperate Nurse Consultant provided a document, dated 10/2014, titled, Blood Glucose Measurement, Evencare G2, and indicated it was the policy currently being used by the facility. The policy indicated, .1. Select the resident specific meter/case to be utilized. Place a clean paper towl on the bedside table or stand. Place the close case on the paper towel</p> <p>3.1-18(a)</p>		