STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185132	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franciscan Health Care Center	3625 Fern Valley Road Louisville, KY 40219

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, record review, and review of facility documentation, the facility failed to ensure necessary care and services (i.e. nail care) were provided for residents unable to carry out their own activities of daily living (ADLs) for 3 of 35 sampled residents, (Resident (R)81, 91, and 100). The findings include:During interview on 09/20/2025 at 1:44 PM, the Division [NAME] President (DVP) stated the facility did not have a policy related to trimming or cleaning residents' nails. The DVP stated the Certified Resident Care Associate's (CRCA) checklist noted the CRCAs were responsible for grooming, which included trimming/cleaning residents' nails who did not have a diagnosis of diabetes.Review of the facility document titled, Job Descriptions, for a Certified Resident Care Associate, revealed staff were to, Assist residents with nail care (i.e., clipping, trimming, and cleaning the finger/toenails. (NOTE: Does not include diabetic residents).1. Record review revealed the Resident Face Sheet noted the facility admitted R!00 on 09/11/2025, with diagnoses that included: cerebral infarction, right lower leg fracture, congestive heart failure (CHF), anxiety, and depression. Continued record review revealed no documented evidence the facility had completed the admission Minimum Data Set (MDS) Assessment for R100. Review of the baseline Care Plan for R100 revealed the facility developed a problem statement initiated on 09/12/2025, noting the resident had a diagnosis of cerebrovascular accident (stroke) and required assistance with his ADL care. Continued review revealed the interventions included for staff to assist the resident with ADL care as needed (initiated 09/12/2025).Observation on 09/15/2025 at 11:07 AM revealed R100 had long fingernails with a black substance under the nail. In interview at the time of the observation R100 stated he had asked staff to trim his fingernails for him, but no one had trimmed them for him. Observation on 09/16/2025 at 9:07 AM; on 09/17/2025 at 1:41 PM; and 09/18/2025 at 10:36 AM, revealed R100 continued to have long, jagged fingernails with a black substance under the nail. In interview on 09/18/2025 at 10:36 AM, R100 stated he wished he could get someone to trim his nails.In interview on 09/19/2025 at 11:55 AM, CRCA 9 stated residents' nail care was provided with showers and as needed. In interview on 09/19/2025 at 12:09 PM, CRCA 10 stated residents were provided nail care when needed. She reported R100's fingernails were long and dirty. the CRCA further stated she had not provided nail care for R100 that week.2. Review of the medical record Resident Face Sheet for R81 revealed the facility admitted the resident on 06/23/2025, with diagnoses that included rheumatoid arthritis and type 2 diabetes mellitus. Review of the Quarterly MDS Assessment, with an Assessment Reference Date (ARD) of 08/20/2025, revealed the facility assessed R81 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. Continued MDS review revealed the facility also assessed R81 to require supervision or touch assistance for personal hygiene.Review of R81's Care Plan revealed the facility developed a problem statement dated 04/23/2025, noting the resident had potential for decline in functional status related to weakness, dementia, and cerebrovascular accident (CVA). Further review revealed an intervention dated 04/23/2025, directing staff to provide nail care on shower days and prn (as needed).Observation on 09/15/2025 at 1:38 PM, revealed R81 had long fingernails with a dark brown/black substance under them. In interview at the time of observation revealed R81 stated he would like to have staff clean and trim his fingernails.Observation on 09/16/2025 at 11:13 AM, revealed R81 continued to have long (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fingernails with the dark substance under them. In interview at the time of observation R81 stated no staff had offered to trim his fingernails. He further stated he would like for his fingernails to be trimmed and cleaned.In interview on 09/17/2025 at 12:10 PM, CRCA12 stated he had not offered to trim R81's fingernails because the nurses were responsible for trimming the fingernails of the diabetic residents. The CRCA reported however, he should have offered to clean R81's fingernails. CRCA 12 further stated R81's fingernails should have been trimmed on his previous shower days by the nurses. In interview on 09/18/2025 at 12:35 PM, CRCA 13 stated R81 was a diabetic, so the nurses were responsible to trim his fingernails.In interview on 09/19/2025 at 1:28 PM, R81 stated he received his showers/baths; however, staff did not trim or clean his fingernails. R81 further stated he did not like to have long, dirty fingernails, but he was not steady enough to trim or clean his own fingernails.In interview on 09/20/2025 at 2:40 PM, Registered Nurse (RN) 3 stated nurses were responsible to trim the diabetic residents' fingernails. RN 3 reported R81 had his shower on Wednesday evenings, and the nurse on that shift should have trimmed the resident's fingernails. The RN stated it was the CRCA's responsibility to trim/clean the non-diabetic residents' fingernails and to clean the diabetic residents' fingernails. RN 3 further stated R81's fingernails were long and dirty and needed to be trimmed.3. Record review revealed the Resident Face Sheet noted the facility admitted R91 on 07/13/2025, with diagnoses that included adult failure to thrive and weakness. Review of the admission MDS Assessment, with an ARD of 07/15/2025, revealed the facility assessed R91 to have a BIMS score of 12 out of 15, indicating moderate cognitive impairment. Continued MDS review revealed the facility additionally assessed R91 to require supervision or touch assistance for personal hygiene.Review of R91's Care Plan revealed the facility developed problems that included a problem statement dated 07/21/2025, noting the resident had impairment in function status related to weakness. Further review revealed the interventions included one dated 07/21/2025, directing staff to provide assistance for R91 as needed with self-care and mobility functional tasks.Observation on 09/15/2025 at 1:46 PM, revealed R91's fingernails were long with a dark substance under them. In interview at the time of observation, R91 stated he had not asked to have his fingernails trimmed or cleaned, but would like to have his nails cleaned and trimmed. He said maybe when the activities assistant had a fingernail day they would ask him and would trim and clean his nails. R91 stated staff had not ever offered to clean or trim fingernails. Observation on 09/16/2025 at 9:00 AM, revealed R91's fingernails remained long with a dark substance under them. In interview at the time of observation, R91 stated there still had been no staff offer to trim/clean his fingernails. Observation on 09/20/2025 at 1:30 PM, R91 was observed to continue to have long, dirty fingernails.In interview on 09/20/2025 at 2:10 PM, CRCA 10 stated she had not offered to trim or clean R91's fingernails. CRCA 10 further stated nurses were responsible for trimming the diabetic residents' fingernails.In interview on 09/20/2025 at 2:20 PM, CRCA 16 stated she could trim and clean the non-diabetic residents' fingernails, but the diabetic residents' fingernails were trimmed by the nurses. CRCA 16 observed R91's fingernails and confirmed the resident's fingernails were long, dirty and needed to be trimmed.In interview on 09/19/2025 at 5:50 PM, Licensed Practical Nurse (LPN)14 stated CRCAs were responsible for trimming/cleaning the residents' fingernails except for the diabetics. LPN 14 further stated the nurses were responsible for trimming the diabetics' fingernails.In interview on 09/19/2025 at 6:44 PM, CRCA 15 stated that she cleaned the residents' fingernails on their shower days or as needed. She further stated she could trim the non-diabetic residents' fingernails, but the nurses were responsible for trimming the diabetic residents' fingernails.In interview on 09/20/2025 at 3:21 PM, the Director of Health Services (DHS) stated she did not have a need to do any audits related to resident care, as she only did audits if a concern was brought to her attention. The DHS said she expected her staff to keep the residents' nails cleaned and trimmed. She further stated the CRCAs could trim and clean the non-diabetic residents' fingernails; however, the nurses were responsible for the diabetic residents nails. In interview on 09/20/2025 at 5:08 PM, the Division [NAME] President (DVP) stated he expected the staff to give the resident a shower, and if they needed their nails cleaned/trimmed, staff were to (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	perform those tasks. The DVP reported the CRCA's checklist noted they were responsible for assisting residents with grooming, which would include trimming/cleaning of the non-diabetic residents' fingernails. He said it was a standard for nurses to care for the diabetic residents' fingernails.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, record review, facility document and policy review, the facility failed to ensure a medication error rate of less than 5 percent (%) or less, with 6 errors out of 30 opportunities, which yielded a medication error rate of 20% involving 4 of 4 residents observed for medication administration out of the total sample of 35 (Residents (R)21, 2, 13, and 15). The findings include:Review of the facility policy titled, Medication Administration-General Guidelines, revised 11/2018, revealed the FIVE RIGHTS for medication administration included the right resident, right drug, right dose, right route, and right time, and those rights were to be applied for each medication being administered. Per review, a triple check of the Five Rights was recommended at three steps in the process of preparation of a medication for administration. Continued review revealed the three steps included checking when the medication was selected; when the dose was removed from the container; and finally just after the dose was prepared and the medication was put away. Review of the policy further revealed medications were to be administered in accordance with written orders of the prescriber; administered within 60 minutes of the scheduled time, except before, with or after meal orders, which were to be administered based on mealtimes.Review of the Instructions for Use Humalog KwikPen, revised 07/2023, revealed to prime the pen before each injection. Per review, priming the KwikPen meant removing any air from the needle and cartridge which might have collected during normal use. Review further revealed priming was also to ensure the Pen was working correctly. In addition, if priming was not performed before each injection, you may get too much or too little insulin.1. Review of R21's physician Orders revealed an order dated 08/29/2025, for insulin lispro insulin pen 100 units (u) per milliliter (ml) eight units subcutaneously (SQ) three times a day for diabetes.Observation, during medication administration, on 09/17/2025 at 11:48 AM, revealed Registered Nurse (RN) 3 failed to prime R21's insulin pen after placing the new needle on the pen and before turning the dose dial to ordered eight units. In interview, at the time of observation, RN 3 stated he did not know that he needed to prime the pen.In interview on 09/17/2025 at 12:07 PM, Licensed Practical Nurse (LPN) 5 stated the insulin pen needed to be primed with two units prior to use.In interview on 09/17/2025 at 12:08 PM, RN 6 stated she primed the insulin pen with five units. However, observation at the time revealed while demonstrating insulin administration, RN 6 failed to prime the needle prior to turning the dose dial to the prescribed dose.In interview on 09/20/2025 at 4:38 PM, the Assistant Director of Health Services (ADHS) stated the insulin pen needle needed to be primed with two units.In interview on 09/20/2025 at 5:08 PM, the Director of Health Services (DHS) stated the insulin pen needle needed to be primed with two units prior to administering the insulin.2. Review of R2's physician's Orders revealed an order dated 04/08/2025, for artificial tears 0.1-0.3% two drops to both eyes four times a day for dry eyes. Continued review also revealed an order dated 10/25/2024, for dorzolamide 2% one drop in the left eye three times a day for glaucoma.Observation during medication administration on 09/17/2025 at 9:19 AM, revealed RN 4 did not administer R2's artificial tears. Further observation revealed RN 4 administered the dorzolamide eye drops in both eyes instead of just the left eye as ordered.In interview on 09/17/2025 at 2:10 PM, RN 4 confirmed she had not given R2 the artificial tears as ordered. She also confirmed she had administered the dorzolamide in both eyes. RN 4 reviewed R2's physician's order, and said she realized she was only supposed to have placed the dorzolamide in the left eye. She reported she should have read the order completely to ensure she was giving the medication as ordered. RN 4 further stated she should have also checked and double checked the medications with the medication administration record (MAR) to ensure she gave all the medications as ordered.3. Review of R13's physician's Orders revealed an order dated 03/21/2025, for dorzolamide-timolol drops 22.3-6.8 milligrams per milliliter, one drop in each eye once a day for glaucoma.Observation during medication administration on 09/17/2025 at 8:58 AM, revealed RN 4 failed to administer R13's the dorzolamide-timolol eye drops as ordered.In interview on 09/17/2025 at 2:10 PM, RN 4 stated she should have checked and double checked the (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications with the MAR to ensure she gave all medications as ordered.In interview on 09/20/2025 at 5:08 PM, the Director of Health Services (DHS) stated when administering medications, the nurse needed to utilize the electronic medication administration record (EMAR). She said the nurse also needed to check the six rights and give medication according to the orders. She further stated the nurses should check and check again.In interview on 09/20/2025 at 5:46 PM, the Division [NAME] President (DVP) stated nurses were to ensure all medications were given as ordered.4. Review of R15's physician's Orders revealed an order dated 07/25/2025, for polyethylene glycol (osmotic laxative) 17 grams by mouth once a day for constipation. Continued review also revealed an order dated 08/25/2025, for Synthroid 25 micrograms (mcg) one tablet once a day at 6:30 AM for hypothyroidism.Observation during medication administration on 09/17/2025 at 8:35 AM, revealed RN 3 administered R15's Synthroid an hour after it was due to be given. Further observation revealed RN 3 failed to administer the polyethylene glycol.In interview on 09/17/2025 at 2:03 PM, RN 3 stated that when giving medications, the nurse should check the label of the medication to the list of medications on the computer and check for the right resident, right medication, right dose, right time, and right route and should check it at least two times. RN #3 confirmed that he did not give the polyethylene glycol and if he went off the time the Synthroid was scheduled to be given, then it would be considered late when he gave it.In interview on 09/17/2025 at 2:10 PM, RN 4 stated if a medication was ordered to be given at a specific time, they had an hour before to an hour after to administer the medication. RN 4 stated therefore, medication due at 6:30 AM could be given from 5:30 AM to 7:30 AM.In interview on 09/20/2025 at 4:21 PM, Nurse Practitioner (NP) 1 stated Synthroid should be given on an empty stomach as that was important for absorption. She further stated it should be given one hour before or three hours after a meal.In interview on 09/20/2025 at 4:38 PM, the Assistant Director of Health Services (ADHS) stated when passing medications, she would check the pill pack with the MAR. She said she would pull out all the medications due to be given and cross reference them with the MAR and read the order on the MAR and the order on the bottle. The ADHS further stated if a medication was due to be administered at 6:30 AM, then it could be given from 5:30 AM to 7:30 AM.In interview on 09/20/2025 at 5:08 PM, the DHS stated when administering medications, the nurse needed to utilize the EMAR, check the rights, and administer medications as ordered. She said the nurses should check and check again. She reported if a medication was due to be administered at 6:30 AM, then they had a half an hour to an hour before or after to give the medication. The DHS said if the resident asked to get a medication later, then they should follow the resident's wishes. She further stated if that continued to happen with a resident, then the nurse should notify the physician.In interview on 09/20/2025 at 5:46 PM, the Division [NAME] President (DVP) stated if residents had a medication ordered, the medication was to be given at the time it was ordered. The DVP further stated they should ensure all medications ordered were given.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, record review, and facility policy review, the facility failed to assess residents for self-administering medications for 1 of 2 residents sampled for accidents, (Resident (R)101), out of the total sample of 35. The findings include:Review of the facility policy titled, Guidelines for Self-Administration of Medications, dated 05/22/2018, revealed in the section designated Procedure, residents requesting to self-medicate or who had self-medication as a part of their plan of care were to be assessed using the observation Self Administration of Medication within the electronic health record (EHR). Per policy review, the results of the assessment were to be presented to the physician for evaluation and an order obtained for self-medication. Continued review revealed the order was to include the type of medication(s) the resident was able to self-medicate. Policy review revealed the resident and/or family/responsible party were to be informed of the results of the assessment and whether the resident had been determined to safely self-administer medications. Further review revealed the policy additionally noted the medication the resident could self-administer was to be kept in a locked drawer in the resident's room. Review also revealed the resident was to maintain the key to the locked drawer, and a key was to be maintained by the licensed nurse and/or QMA (Qualified Medication Aide).Review of the Resident Face Sheet revealed the facility admitted R101 on 09/08/2025.Review of the admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 09/12/2025, revealed the facility assessed R101 as having a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated intact cognition.Review of R101's Care Plan revealed the facility noted a problem area dated 09/09/2025, indicating the resident had a potential for shortness of breath while lying flat related to chronic obstructive pulmonary disease (COPD). Continued review of R101's Care Plan revealed the interventions included directions for staff to administer medications per the physician's order. Further review revealed no documented evidence the Care Plan included interventions for R101 to self-administer medications or to have medications left at the bedside.Review of R101's physician's order dated 09/14/2025, revealed an order for Trelegy Ellipta (an oral inhaler used to reduce symptoms and exacerbations of COPD) 100-62.5-25 micrograms (mcg) with instructions to inhale one puff daily related to COPD. Further review of the order revealed it included special instructions noting R101's inhaler might be kept at the bedside.Observation on 09/15/2025 at 10:04 AM, revealed R101 lying on the bed with an Ellipta inhaler (medication used to treat COPD) visible on the resident's nightstand. In interview at the time of observation, R101 stated she used the inhaler once a day on her own. R101 further stated the staff usually left the inhaler in her room for ease of use. However, continued review of R101's electronic medical record (EMR) revealed no documented evidence the facility performed an assessment of the resident to see if she was able to self-administer their medication.During interview on 09/16/2025 at 4:15 PM, the Director of Health Services (DHS) stated the facility did not have an assessment for self-administering medications for R101; however, the resident should have had an assessment. She further stated the nurse who took the order for R101's inhaled to be left at bedside, should have followed the proper process (which included assessing the resident).During interview on 09/20/2025 at 4:38 PM, the Assistant Director of Health Services (ADHS) stated if a resident wanted to self-administer their own medications, there was a requirement for the nurse to complete an assessment for self-administration of medications and notify the physician. She said the facility then provided a lock box for the resident to store the medication in, with two keys, one key for the resident, and the other key secured by the nurse. The ADHS reported she was unsure if a physician's order was required for a resident to self-administer medications or keep the medications at the bedside. She further stated the nurse was required to document the resident's use of the medication on the medication administration record (MAR).During interview on 09/20/2025 at 5:08 PM, the DHS stated the facility's policy for a resident to self-administer medications included the need for the resident to be assessed. She said the assessment was to (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ensure the resident was appropriate to self-administer, and understood how to take the medication correctly. The DHS reported then, the nursing staff was required to notify the physician and obtain an order for the resident to self-administer medications. She stated the medications were to be kept in a locked box or locked drawer. The DHS further stated the nurse must document in the resident's EMR after verification the resident had taken the medication as ordered.During interview on 09/20/2025 at 5:46 PM, the Division [NAME] President (DVP) stated before a resident could self-administer medications, the interdisciplinary team (IDT) must assess whether the resident was knowledgeable and had the physical ability to self-administer their own medications. He reported staff must then obtain a physician's order for the resident to self-administer, and the medication was required to be kept in a safe area.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to provide a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) form 2 of 3 residents reviewed for beneficiary notification out of the total sample of 35, (Resident (R)6 and 108). Specifically, the facility failed to issue a SNF ABN to Resident #6 and Resident #108 when the facility notified the residents that they were discharged from Medicare Part A services, even though their benefit days had not been exhausted.The findings include:Review of the Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) Form CMS-10055 (2024), revealed the SNF ABN Form provided information to residents so they could decide whether or not to get the care that might not be paid for by Medicare and assume financial responsibility for that care. Per review, SNFs must use the SNF ABN Form when applicable for SNF Prospective Payment System (PPS) services (Medicare Part A). Further review revealed it was important to note that the SNF ABN Form CMS-10055, was only issued if the beneficiary intended to continue services and the SNF believed the services might not be covered under Medicare.1. Review of the Resident Face Sheet for R6 revealed the facility admitted the resident on 06/30/2023, and readmitted on [DATE], that included diagnoses of type 2 diabetes, bipolar disorder, generalized anxiety disorder, and depression.Review of the SNF Part A PPS Discharge Assessment Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 08/14/2025, revealed the facility assessed R6 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. Further review revealed the start date of R6's most recent Medicare stay was 06/06/2025, and the end date of the stay was 08/14/2025.Review of R6's Care Plan revealed the facility developed a problem initiated 06/12/2025, that noted the resident/family had expressed and acknowledged the need for long term care and had asked that information regarding community services, resources, and referrals not be addressed further. Review further revealed the care plan goal was for the resident's long-term care needs to be met.Review of R6's Inpatient Financial Coverage Review Form, dated 06/03/2025, revealed as of that date, the resident had 100 of 100 days remaining of traditional Medicare benefits.Review of the SNF Beneficiary Notification Review Form, completed by the facility, revealed R6 had a Medicare Part A skilled service episode start date of 06/06/2025, and the last covered day of Part A Service was 08/14/2025. Per review of the form, the facility initiated the discharge from Medicare Part A services when benefit days were not exhausted (the resident had 30 days remaining); however, a SNF ABN Form was not provided. Further review of the Form revealed the facility had not provided a SNF ABN Form because they were not aware that ABN Part A needed to be issued.2. Review of the Resident Face Sheet for R108 revealed the facility admitted the resident on 04/18/2025, diagnoses that included acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, hypertensive heart disease with heart failure, and type 2 diabetes. Further review of the Resident Face Sheet revealed the facility discharged R108 on 05/25/2025.Review of R108's Care Plan revealed it included a problem statement initiated by the facility on 03/28/2025, that noted the resident planned to return to her previous living environment after successful completion of her rehabilitation program. Continued review revealed the interventions directed staff to encourage the resident and representatives to actively participate in discharge planning (initiated 03/28/2025).Review of R108's Resident Financial Insurance Coverage Review Form, dated 03/25/2025, revealed as of that date, the resident had 82 of 100 days remaining of her traditional Medicare benefits.Review of the SNF Beneficiary Notification Review Form, completed by the facility, revealed R108 had a Medicare Part A skilled service episode with a start date of 03/27/2025, and the last covered day of Part A Service was 05/20/2025. Further review of the Form revealed however, the facility initiated a discharge from Medicare Part A services when R108's benefit days were not exhausted (the resident had 51 days remaining). Review of the Form further revealed the facility had not provided a SNF ABN Form (continued on next page)

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Franciscan Health Care Center	3625 Fern Valley Road Louisville, KY 40219

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because they were not aware Part A ABN needed to be issued at that time.During interview on 09/17/2025 at 11:23 AM, the Director of Social Services (DSS) stated she had not completed a SNF ABN Form for R6 or R108. During a follow-up interview 09/17/2025 at 12:11 PM, the DSS stated she was the person responsible for issuing SNF ABN Forms for residents since February 2024. She further stated however, she had not been aware of the Form's existence until 08/20/2025. During further interview on 09/17/2025 at 3:24 PM, the DSS stated R6 had been admitted with Medicare Part A for skilled services related to wounds and had 30 days of coverage remaining when her services were terminated. She reported R108 had been admitted with Medicare Part A for skilled services related to therapy and had 51 days of coverage remaining when the resident's Medicare Part A was terminated. The DSS further stated R6 and R108 should have received SNF ABN Forms as required.During interview on 09/20/2025 at 5:03 PM, the Director of Health Services (DHS) stated she expected SNF ABN Forms to be issued timely and according to the facility's policy. During interview on 09/20/2025 at 5:16 PM, the Division [NAME] President (DVP) stated he expected the SNF ABN Forms to be issued anytime there was a change in Medicare benefits for a resident, and the resident was continuing services.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to timely report an allegation of abuse for 1 of 1 resident reviewed for abuse, out of the total sample of 35, (R103).The findings include:Review of the facility policy titled, Abuse, Neglect and Exploitation Procedural Guidelines, revised 12/16/2024, revealed under the section titled Procedure the reporting/response noted any staff member, resident, visitor, or resident representative might report known or suspected abuse, exploitation, neglect, or misappropriation to local or state agencies. Per policy review, all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were to be reported immediately; however, not later than two hours after the allegation was made if the events that caused the allegation involved abuse or result in serious bodily injury. Continued review revealed if the allegation did not involve abuse or serious bodily injury, the allegation was to be reported no later than 24 hours. Review revealed the allegations were to be reported to the Administrator of the facility and to other officials (including the State Survey Agency [SSA] and Adult Protective Services [APS] where state laws provided for jurisdiction in long term-care facilities) in accordance with State law through established procedures.Review of the Resident Face Sheet for R103 revealed the facility admitted the resident on 09/11/2025, diagnoses that included acute respiratory failure with hypoxia (low levels of oxygen) chronic obstructive pulmonary disease (COPD) with acute exacerbation and enterocolitis (inflammation of the intestine) due to clostridium difficile (c-diff).Record review revealed the facility had R103's admission Minimum Data Set (MDS) Assessment in progress at the time of the SSA Survey.Review of R103's baseline Care Plan revealed the facility developed a problem area initiated on 09/12/2025, noting the resident demonstrated moderate symptoms of depression as evidenced by a score on the Patient Health Questionnaire (PHQ-9, a questionnaire used to assess the severity of depression symptoms). Continued review revealed the Interventions instructed staff to offer and encourage R103 to voice his feelings as needed; observe the resident's mood, affect, and behaviors with all direct care and contacts; and provide supportive counseling contacts as needed.In interview on 09/15/2025 at 10:44 AM, R103 stated the night of his admission [DATE]), a Certified Resident Care Associate (CRCA) yelled at him because he was not familiar with the facility's routine. R103 reported the staff member told him she had many residents assigned to her to care for. The resident said the CRCA also told him activating his call light was not going to get her there any quicker to provide assistance. R103 further stated he had not reported the incident at the time of the occurrence.On 09/15/2025 at 10:50 AM, the SSA Surveyor reported to the Administrator R103's statement regarding an unidentified CRCA yelling at him on the night he was admitted to the facility. The SSA Surveyor also informed the Administrator R103 reported the incident occurred when the CRCA entered his room to answer his call light which had been activated by the resident.In interview on 09/18/2025 at 3:29 PM, the Director of Health Services (DHS) stated after being made aware of the concern voiced by R103 related to a CRCA (identified as CRCA 11) yelling at him, the facility instructed the social worker (SW) to talk to the resident. She said during the conversation between the SW and R103, the resident had not voiced feeling the way CRCA 11 spoke to him to be abusive, but rather that the staff member had a loud voice, so the SW competed a concern form. The DHS reported she spoke with Registered Nurse (RN) 18 and R103, and they felt it was more of a customer service issue. She said R103 reported being satisfied with the care he was receiving, and there had been no further incidents. The DHS further stated the facility had not report incident as an allegation of abuse because the way R103 relayed the concern, it was not considered abuse.In interview on 09/19/2025 at 12:15 PM, R103 stated the facility staff had discussed with him the concern regarding the girl yelling at him on the night of his admission. R103 reported they came in and told him they (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	talked to the staff member, and she said she had not been yelling at the resident, only talking loudly. The resident further stated he told the facility staff that no, CRCA 11 had been yelling and had not been friendly.In interview on 09/19/2025 at 5:14 PM, CRCA 11 acknowledged she had been assigned to R103 on the night of 09/11/2025. She said she had responded to R103, who had been frequently activating his call light on 09/11/2025. CRCA 11 reported however, she never yelled at R103, she had only spoken louder to ensure the resident could hear her. She stated she had continued providing care for R103 following his admission, and the resident had not voiced any concerns to her about her speaking loudly or regarding the care she was providing.In interview on 09/20/2025 at 8:30 AM, R103 was lying on his bed and appeared agitated. R103 he had been surprised the night before (09/19/2025) when nurse who had been assigned to his care on the night of his admission, was again assigned to care for him. The resident said he felt the things the nurse was doing to him the night before had been in retaliation for his previous allegation towards CRCA 11. On 09/20/2025 at 8:36 AM, following the additional allegations voiced by R103, the SSA Surveyor immediately reported to the DHS, the resident's concerns of feeling like the nurse assigned to him on 09/19/2025 had been retaliating against him. The DHS said R103 was telling the SSA Surveyor a different story than what he was telling her. She reported she asked R103 if he had any concerns with the nurse assigned to his care, and the resident said he had no concerns at that time. The DHS further stated she would ensure that RN 18 did not care for R103 again. In interview on 09/20/2025 at 8:43 AM, the Division [NAME] President (DVP) stated the facility was reporting and conducting a full investigation related to the allegations involving R103, provided by the SSA Surveyor on the morning of 09/20/2025. He said after discussing with the facility staff, the Director of Social Services (DSS) went to talk to R103 to gather more information. The DVP reported because of what R103 described to the DSS, the facility handled the concern as a customer service issue, and completed a concern form on R103's behalf. He further stated the facility would have reported the concern at the time of the initial allegation had they felt it to be a matter of abuse. Review of the Resident Concern Log provided by the facility on 09/20/2025 at 11:50 AM ,revealed an entry made by the DSS that noted R103 had voiced a concern about customer service on 09/15/2025. Per review of the log, the concern had been addressed by the DHS on 09/17/2025, and noted she had spoken with R103. Continued review revealed the DHS reviewed the response with R103 provided by the nurse who cared for the resident on 09/11/2025, and the resident was satisfied with the resolution and voiced he had no concerns with any other staff caring for him. Further review revealed the log also noted a concern made by R103 on 09/20/2025 that had been reported to the facility's governing body. In interview on 09/20/2025 at 2:10 PM, the DSS stated she entered R103's room on 09/15/2025, after she was notified of a concern the resident had made. The DSS said at the time, R103 complained of RN 18's behavior on the second shift. She reported R103 told her the emergency medical technicians (EMTs) placed him on his bed and laid his indwelling urinary catheter bag on top of him. The DSS stated R103 reported approximately 30 minutes later, his bed felt wet, so the resident activated his call light to alert staff for assistance. She reported R103 said RN 18 came in his room and spoke to him loudly, saying she was busy with other residents and she would get to hi, as soon as she could. The DSS further stated following the concern voiced by R103 on 09/15/2025, she interviewed all residents on the rehabilitation halls, and no one voiced any concerns.In interview on 09/20/2025 at 4:38 PM, the Assistant Director of Health Services (ADHS) stated all allegations of abuse needed to be reported immediately to the facility's Executive Director and to the SSA. She further stated if a resident reported a staff member yelling at them, that was considered verbal abuse. In interview on 09/20/2025 at 5:08 PM, the DHS stated if an allegation of abuse was made, the facility collected additional information to determine if the allegation needed to be reported and investigated further. In interview on 09/20/2025 at 5:46 PM, the DVP stated anytime there was an allegation of abuse, the allegation was to be reported.

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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. Based on observation, record review, interview, and facility policy review, the facility failed to obtain an order for the use of oxygen for 1 of 4 residents reviewed for respiratory care out of the total sample of 35 (Resident (R)17).The findings include:Review of the facility policy titled, Administration of Oxygen, reviewed 12/13/2024, revealed a section titled , SOP Details that noted staff were to verify the physician's order for the procedure. Further review revealed in cases of emergency oxygen might be administered as a nursing intervention until a physician order may be obtained.Review of the Resident Face Sheet for R17 revealed the facility admitted the resident on 08/21/2025, diagnoses of chronic obstructive pulmonary disease (COPD) with acute exacerbation, acute and chronic respiratory failure with hypoxia (low levels of oxygen in body tissue), and hypercapnia (elevated levels of carbon dioxide in the blood).Review of the admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 08/28/2025, revealed the facility assessed R17 as having a Brief Interview for Mental Status (BIMS) score of eight out of 15, which indicated the resident had moderate cognitive impairment. Further review of the MDS revealed the facility assessed R17 to have shortness of breath or trouble breathing when lying flat; however, the use of oxygen was not identified in the assessment.Review of R17's Care Plan revealed the facility developed a problem area initiated 08/22/2025, noting the resident had a potential for shortness of breath while lying flat related to COPD, chronic respiratory failure, and pulmonary fibrosis. Further review revealed the interventions included directions for staff to administer oxygen per physician orders and as needed.Review of R17's hospital Discharge Summary dated 08/21/2025 (date of admission to the facility) revealed documentation of R1's baseline use of supplemental oxygen having been delivered at 4 liters per minute (LPM) at the hospital. However, review of the facility's physician's Orders, for R17, including all active orders, revealed no documented evidence of an order for the use of supplemental oxygen.Observation on 09/15/2025 at 10:52 AM, revealed R17 lying flat on the bed bed with supplemental oxygen being administered at 3.5 liters. Observation on 09/17/2025 at 2:39 PM, revealed R17 sitting in the recliner with supplemental oxygen being administered at 3.5 liters.Review of the facility's vital signs documentation for R17 from 08/16/2025 through 09/16/2025, revealed the use of intermittent oxygen use as follows:-08/21/2025 at 9:42 PM oxygen (O2) saturation 96% with oxygen flow at 3 liters.-08/23/2025 at 9:01 AM O2 saturation 96% with oxygen flow at 2 liters.-08/23/2025 at 6:43 PM O2 saturation 95% with oxygen flow at 2 liters.-08/24/2025 at 1:44 PM O2 saturation 96% with oxygen flow at 2 liters.-08/24/2025 at 6:59 PM O2 saturation 98% with oxygen flow at 2 liters.-08/27/2025 at 6:21 PM O2 saturation 97% with oxygen flow at 2 liters.-08/29/2025 at 10:47 AM O2 saturation 97% with oxygen flow at 3 liters.-08/30/2025 at 11:48 AM O2 saturation 98% with oxygen flow at 2 liters.-09/01/2025 at 9:21 AM O2 saturation 97% with oxygen flow at 2 liters.-09/02/2025 at 7:30 AM O2 saturation 98% with oxygen flow at 2 liters-09/03/2025 at 8:55 AM O2 saturation 97% with oxygen flow at 2 liters.-09/05/2025 at 9:16 AM O2 saturation 98% with oxygen flow at 2 liters.-09/07/2025 at 8:46 AM O2 saturation 94% with oxygen flow at 2 liters.-09/08/2025 at 7:45 AM O2 saturation 99% with oxygen flow at 2 liters.-09/15/2025 at 7:29 AM O2 saturation 97% with oxygen flow at 3 liters.Review of the facility's Resident Progress Notes for R17 revealed a physician's note dated 09/08/2025, that noted the resident's lungs were diminished, with limited ventilation on home oxygen at 4 liters. Per review of the Resident Progress Notes, for R17 revealed a note by the Nurse Practitioner (NP) dated 09/11/2025 documenting the resident remained on continuous oxygen at her home use requirements, with O2 saturation at 100% on 4 liters of oxygen via nasal cannula. Continued review of the Resident Progress Notes revealed a note dated 09/14/2025, documenting the resident used oxygen and to refer to the physician's orders for the liter flow and delivery method. Further review of the Resident Progress Notes for R17 revealed a physician's note dated 09/15/2025, noting the resident had been seen for a diagnosis of pneumonia with a productive cough, and remained on continuous oxygen use per her home requirements.During interview on (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	09/17/2025 at 2:44 PM, Licensed Practical Nurse (LPN) 2 reviewed R17's electronic medical record (EMR) and stated the resident's physician's orders did not include the use for supplemental oxygen. She said she needed to review R17's hospital records to verify what the resident's oxygen use to be and then contact the physician to get an order for the oxygen. LPN 2 reported the order for oxygen was to include the liters to administer and the mode of how the resident would receive the oxygen such as via nasal cannula (NC) or face mask. She further stated she needed to obtain ancillary orders also to change the oxygen tubing and the frequency to check R17's O2 saturations.During interview on 09/20/2025 at 3:08 PM, the Infection Control Nurse (ICN) stated physician's orders were required for the use of supplemental oxygen which would include the liters, frequency to change the tubing, and to obtain oxygen saturations. She reviewed R17's EMR and verified verbally she had been responsible for entering R17's physician's orders on admission from her hospital discharge summary. The ICN reported she had not transcribed any orders for oxygen use for R17 upon admission. After reviewing R17's hospital discharge summary which included the resident's use of supplemental oxygen at 4 liters, the ICN further stated she should have obtained orders for the resident's O2 from the physician and transcribed the order into the resident's EMR.During interview on 09/20/2025 at 4:38 PM, the Assistant Director of Health Services (ADHS) stated residents who required the use of supplemental oxygen were to have orders transcribed in their EMR that included the number of liters of oxygen to be administered. The ADHS further stated the orders were also to include the frequency to check the resident's oxygen saturation, assessments for the oxygen use and effectiveness, and frequency to change the tubing.During interview on 09/20/2025 at 5:08 PM, the Director of Health Services (DHS) stated residents who required the use of supplemental oxygen were to have orders for the use to include a range for the liters to be administered. During interview on 09/20/2025 at 5:46 PM, the Division [NAME] President (DVP) stated the facility needed to have a physician's order for the use of supplemental oxygen residents. The DVP further stated the orders were to include the flow rate for liters to be administered and typically included the need to change the oxygen tubing.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident was assessed for bed rail use and consent obtained for the use of the bed rails for 1 of 2 residents reviewed for accidents, out of the total sample of 35 residents (Resident (R)101). The findings include:Review of the facility policy titled, Guidelines for the Use of Bed Rails, dated 10/09/2017, revealed prior to the installation of bed rails, the facility was to attempt to use alternatives. Per review, if the alternatives attempted were not adequate to meet the resident's needs, the resident was assessed for the use of bed rails. Continued policy review revealed the bed rail assessment was to include review of risks including entrapment; and informed consent for the rails to be obtained from the resident or if applicable, the resident's representative. Further review revealed the facility must ensure the bed was appropriate for the resident and the bed rails were properly installed and maintained. In addition, review of the policy also revealed the use of bed rails as an assistive device was to be addressed in the resident's care plan.Review of the Resident Face Sheet for R101 revealed the facility admitted R101 on 09/08/2025, with diagnoses that included arthritis and cerebrovascular accident (CVA).Review of the admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 09/12/2025, revealed the facility assessed R101 to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated the resident had intact cognition. Continued review of the MDS revealed the facility assessed the resident to require partial to moderate assistance with rolling left and right in bed, sitting to lying and lying to sitting in bed, and chair/bed to chair transfers. Further review of the MDS revealed the facility had not assessed the use of bed rails for R101 as a restraint during the assessment look-back period. Review of R101's Care Plan revealed the facility developed a problem area dated 09/09/2025, noting the resident had an impairment in functional status related to weakness. Continued review revealed the interventions included instructions for staff to assist R101 as needed with self-care and mobility functional tasks (initiated 09/09/2025). Further review revealed no documented evidence the facility addressed the use of bed rails for R101.Review of the facility's Active Orders for R101 revealed no documented evidence of an order for the use of bed rails.Observation on 09/15/2025 at 10:04 AM, revealed R101 lying on her bed with the head of the bed in an elevated position and quarter bed rails up on both sides of the upper bed. In interview at the time of observation, R101 stated she used the bed rails to sit up in bed.During interview on 09/16/2025 at 4:15 PM, the Director of Health Services (DHS) stated the facility had no assessment or consent for the use of bed rails for R101. During a follow-up interview on 09/20/2025 at 5:08 PM, the DHS stated if a resident wanted to use bed rails, the facility had to complete an assessment and obtain a physician's order. She further stated bed rails for R101 being utilized should have been included in the resident's care plan.During interview on 09/20/2025 at 7:29 PM, the Therapy Director stated routinely when they assessed a resident and determined the resident would benefit from the use of bed rails, they notified nursing staff. She stated the nursing staff completed a bed rail assessment and any associated paperwork. The Therapy Director further stated therapy did not complete bed rail assessments.During interview on 09/20/2025 at 5:46 PM, the Division [NAME] President (DVP) stated the facility needed to assess a resident prior to the use of bed rails. He said if bed rails were used for bed mobility, the facility staff were to assess the resident's strength and encourage range of motion. The DVP reported if the resident continued to request bed rails, facility staff were to assess the resident and provide bed rails if it was deemed safe. He further stated the facility was to have an order for the use of bed rails, and the use of the rails was to be included in the resident's care plan.

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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 observation, interview, record review, and facility policy review, the facility failed to ensure medication carts were clean, organized, and medications that were opened had an opened date for 5 of 5 medication carts observed (the medication carts involved were: Downtown, Berry, Bell 1, Bell 2, and TCU 1) Further observation revealed 10 total medication carts located within the facility. The findings include:Review of the facility policy titled, Medication Storage in the Facility-Storage of Medications, revised 11/2018, revealed medication storage areas were to be kept clean, well-lit, and free of clutter and extreme temperatures and humidity. Per policy review, certain medications or package types, such as IV solutions, multiple dose injectable vials, ophthalmics, nitroglycerine tablets, blood sugar testing solutions and strips, once opened, required an expiration date shorter than the manufacturer's expiration date to ensure medication purity and potency. Continued review revealed drugs dispensed in the manufacturer's original container were to carry the manufacturer's expiration date. Policy review revealed once opened, the medications were good to use until the manufacture's expiration date was reached unless the medication was: an item for which the manufacturer had specified a usable life after opening; when the original seal of a manufacturer's container or vial was initially broken, the container or vial might be dated. Further review revealed a date opened sticker was to be placed on the medication, and all expired medications removed from the active supply and destroyed in the facility, regardless of amount remaining.Observation during medication administration on 09/17/2025 at 8:27 AM, revealed a bottle of latanoprost (an eye drop for glaucoma) for R15 which did not have an opened date on it. Further observation of the eye drops revealed the pharmacy date on the box was 07/28/2025.Observation during the medication administration on 09/17/2025 at 9:07 AM, revealed a bottle of dorzolamide (an eye drop for glaucoma) eye drops for R2 did not have an opened date on it.Observation of the Downtown medication cart on 09/17/2025 at 3:19 PM, revealed two loose pills with pill powder and debris in the second drawer, two loose pills with pill powder and debris in the third drawer and a spilled liquid medication in the bottom drawer. In interview at the time of observation, RN 3 stated it was the night shift's responsibility to clean and organize the medication carts.Observation of the Berry medication cart on 09/17/2025 at 3:35 PM, revealed a bottle of Humalog insulin on top of the medication cart in the basket with the glucometer and blood sugar supplies. In interview at the time of observation revealed RN 4 stated the insulin should have been put back in the cart after she used it.Observation of the Bell 1 medication cart with Certified Resident Medication Assistant (CRMA) 7 on 09/17/2025 3:42 PM, revealed six loose pills in the second drawer. Observation of the Bell 2 medication cart 7 on 09/17/2025 at 3:46 PM, with CRMA 7 revealed a loose pill in the second drawer, with pill powder and other debris in the back of the drawers.Observation on the TCU 1 medication cart on 09/17/2025 at 4:00 PM revealed broken pieces of pills, debris in the back of the second drawer, and a sticky substance in the bottom drawer. In interview LPN 8 stated it was all the nurses' responsibility to keep the medication carts clean and organized and make sure that all eye drops, inhalers, and insulins were dated when opened. LPN 8 said she could not say how long dorzolamide or latanoprost was good for once opened, but thought it was 45 days.In interview on 09/20/2025 at 4:38 PM, the Assistant Director of Health Services (ADHS) stated night staff was to clean and organize the facility's medication carts, and pharmacy also performed a review of the carts. The ADHS further stated she was unsure about the amount of time the medication was good once it was opened. She further stated she knew the medications needed to be dated when they were opened.In interview on 09/20/2025 at 5:08 PM, the Director of Health Services (DHS) stated any of the nurses could clean the medication carts, and the nurses should make sure the medications on the cart were not expired. The DHS said the facility also had corporate people and pharmacy to observe and review the medication carts. The DHS further (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated if the medication were not dated when they were opened, the nurse should go by the pharmacy delivery date to determine how long the medication was good for. In interview on 09/20/2025 at 5:46 PM, the Division [NAME] President (DVP) stated the pharmacy, the DHS, and the charge nurses were to review the facility's medication carts. The DVP further stated nursing was to date medications when they were opened for tracking to know when to discard it.

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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. Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff cleaned and disinfected glucometers (device used to monitor blood sugar levels) after use for 1 of 2 residents observed for glucometer checks, out of the total sample of 35.The findings include:Review of the facility policy titled, Glucometer Cleaning and Control Test Guidelines, dated 05/11/2016, revealed if glucometers were used from one resident to another, they should be cleaned and disinfected after each use. Further review revealed to see the manufacture [sic] guidelines for cleaning and disinfecting.Review of the manufacturer's guidelines for the facility's, Assure Prism multi Blood Glucose Monitoring System revealed the blood glucose monitor/meter was only to be used for testing multiple patients when standard precautions and the manufacturer's disinfection procedures were followed. Per review of the guidelines, the meter was to be cleaned and disinfected after use on each resident. Continued review revealed Super Sani-Cloth Germicidal Disposable Wipes had been shown to be safe for this meter. Further review revealed the guidelines for cleaning and disinfecting the monitor/meter included to wipe the entire surface of the meter using the germicidal towelette at least three times vertically and three times horizontally to clean blood and other body fluids from the meter. In addition, review revealed to allow the exterior to remain wet for 1 minute, then wipe meter dry using a dry cloth. Resident Face Sheet indicated the facility admitted Resident #21 on 08/29/2025. According to the Resident Face Sheet, the resident had a medical history that included diagnosis of type 2 diabetes mellitus with diabetic chronic kidney disease.Review of the admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 09/02/2025, revealed the facility assessed R21 to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating intact cognition.Review of R21's Care Plan revealed the facility developed a problem statement initiated on 08/29/2025, indicating the resident was at risk for hypo/hyperglycemia related to diabetes mellitus. Further review revealed the interventions included an intervention instructing staff to monitor R21's blood sugar per physician orders (implemented 08/29/2025).Observation of Registered Nurse (RN) 3's medication administration on 09/17/2025 at 11:48 AM, after using a glucometer to check the resident's blood sugar, the RN placed the glucometer in a basket of blood sugar finger stick supplies. Per observation, RN 3 failed to clean the glucometer prior to putting it in the finger stick supply basket, which she was observed to take back to the medication cart. Continued observation at 11:55 AM, revealed RN 3 took the finger stick supply basket with the dirty glucometer still in it, into another resident's room in case he needed to check that resident's blood sugar. Further observation revealed the RN carried the basket with the dirty glucometer in it back to the medication cart and put it on top of the cart.During interview on 09/17/2025 at 12:01 PM, RN 3 stated (in regards to cleaning the glucometer) he cleaned the glucometer with Sani-Cloth wipes three times a day. He reported after completing the resident glucose checks he cleaned the glucometer in the morning, after lunch, and after dinner; however, not after each resident use as required per the manufacturer's guidelines.During interview on 09/17/2025 at 12:34 PM, the Director of Health Services (DHS) stated RN 3 had misunderstood the State Survey Agency (SSA) Surveyor's question and meant to say he (RN 3) had cleaned the glucometer three times that day. She further stated however, the glucometer should have been cleaned after the RN used it on R21 and before placing the glucometer into the basket with other finger stick supplies.During interview on 09/17/2025 at 4:38 PM, the Assistant Director of Health Services (ADHS) stated the glucometer was to be cleaned after each use with the disinfecting wipes. In a follow-up interview on 09/20/2025 at 5:08 PM, the DHS stated the glucometer should have been cleaned and sanitized between each resident with the bleach wipes.During interview on 09/20/2025 at 5:46 PM, the Division [NAME] President (DVP) stated glucometers were to be cleaned after each resident interaction with bleach wipes for the appropriate dwell time indicated on the label.