STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225533	A. Building B. Wing	09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wachusett Manor	32 Hospital Hill Road Gardner, MA 01440

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review, and interviews, the facility failed to provide notification of transfer and discharge to the State Office of the Long-term Care Ombudsman for five Residents (#51, #43, #53, #92, and #7) out of six applicable residents reviewed, out of total sample of 19 Residents, and one discharged Resident (#89) out of three discharge records reviewed. Specifically, the facility failed to send a copy of the notice of transfer and discharge to a Representative of the Office of the State Long-Term Care Ombudsman when Resident's #51, #43, #53, #92, #7, and #89 were transferred to the hospital. Findings include: Review of the facility policy titled Resident Transfer and Discharge Policy and Procedure dated 2025 indicated:-Ensure resident transfers and discharges are properly documented.-Send a copy of the notice of transfer and discharge to a representative of the Office of the State Long-Term Care Ombudsman.-The facility shall maintain evidence that the notice was sent to the Ombudsman 1. Resident #51 was admitted to the facility in December 2024 with diagnoses including Metabolic Encephalopathy and Gastroesophageal Reflux Disease. Review of Resident #51's Clinical Record indicated:-A Nursing Progress Note dated 4/15/25 indicated the Nurse Practitioner was notified of the Resident having a cough and vomiting. Resident #51 was sent to the hospital for further evaluation.-A Nursing Progress Note dated 4/19/25 indicated Resident #51 was readmitted to the facility from an acute care hospital stay for a Urinary Tract Infection (UTI).-No evidence that the State Office of the Long-Term Care Ombudsman had been notified of Resident #51's transfer to the hospital. 2. Resident #43 was admitted to the facility in June 2025 with diagnoses including End Stage Renal Disease (ESRD) and dependence on Renal Dialysis.Review of Resident #43's Clinical Record indicated:- -A Nursing Progress Note dated 7/4/25 indicated the Resident did not go to their morning dialysis treatment and the Nurse Practitioner ordered Resident #43 be sent to the hospital.--A Medication Administration Note dated 7/6/25 indicated that the Resident was admitted to the hospital.-No evidence that the State Office of the Long-Term Care Ombudsman had been notified of Resident #43's transfer to the hospital. 3. Resident #53 was admitted to the facility in July 2025 with diagnoses including Rheumatoid Arthritis and morbid obesity. Review of Resident #53's Clinical Record indicated:-A Nursing Progress Note dated 8/1/25 indicated Resident #53's labs were reviewed with the Nurse Practitioner and a new order for the Resident to be sent to the emergency room. Resident #53 was sent by ambulance to the hospital.-A Nursing Progress Note dated 8/2/25 indicated the facility received an update from the hospital and Resident #53 was admitted to the hospital.-Further review of Resident #53's Clinical Record failed to indicate any evidence that the State Office of the Long-Term Care Ombudsman had been notified of the transfer to the hospital. 4. Resident #92 was admitted to the facility in December 2024 with diagnoses including acquired absence of the Right Leg Below the Knee and acquired absence of the Left Leg Below the Knee. Review of the Nursing Progress Notes indicated:-A note dated 8/6/25 indicated the Resident was lethargic and had a strong foul smell coming from the Resident's wound.-The Nurse Practitioner was notified of the Resident's status on 8/6/25, and a new order was obtained to send the Resident to the emergency room for further evaluation.-The Resident returned to the facility on 8/14/25 after being hospitalized since 8/6/25.-Further review of Resident #92's Clinical Record failed to indicate any (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	evidence that the State Office of the Long-Term Care Ombudsman had been notified of the transfer to the hospital. 5. Resident #7 was admitted to the facility in July 2025 with diagnoses including Unitary Tract Infection (UTI) and Adult Failure to Thrive (FTT). Review of the Resident #7's Clinical Record indicated:-A Nursing Progress Note dated 8/15/25 indicated the Resident was presenting with increased confusion, altered mental status, difficulty moving or walking, and increased incontinence. The Nurse Practitioner was updated and gave a new order to send the Resident to the emergency room for further evaluation and treatment.-A Nursing Progress Note dated 8/15/25 indicated the hospital had been called for an update and Resident #7 had been admitted to the hospital.-No evidence that the State Office of the Long-Term Care Ombudsman had been notified of Resident #7's transfer to the hospital. 6. Resident #89 was admitted to the facility in June 2021 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD) and peripheral vascular disease (PVD). Review of the Resident #89's Clinical Record indicated:-A Nursing Progress Note dated 8/24/25 indicated the Resident was unresponsive to verbal or physical stimuli. The Nurse Practitioner was notified and an order to send the Resident to the emergency room was obtained and the Resident was transferred to the hospital via ambulance.-A telehealth notification note dated 8/24/25 indicated the Nurse Practitioner agreed with plan for hospitalization for urgent evaluation and the Resident was to be sent to the emergency room for further assessment.-No evidence that the State Office of the Long-Term Care Ombudsman had been notified of Resident #89's transfer to the hospital. During an interview on 9/25/25 at 11:00 A.M., Unit Manager (UM) #1 said when a resident is sent out to the hospital, they have a packet with the bed hold and transfer notices that are filled out by the Nurse on duty. UM #1 said the packet is transferred with the Resident to the hospital and a copy is given to the Social Worker (SW). UM #1 said they do not do the Ombudsman Notification, that Social Services does the Ombudsman Notification. During an interview on 9/25/25 11:07 A.M., the SW said she is responsible for the notification to the Ombudsman when residents are transferred out of the building. The SW said she could not provide any evidence that the Ombudsman was notified of the hospital transfers for Residents #51, #43, #53, #92, #7, and #89. The SW said she should be sending the notifications to the Office of the Ombudsman at least monthly and should have notified the Ombudsman about the Residents being transferred out of the facility, but she did not.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to notify the Physician of pertinent information for one Resident (#5) out of a total sample of 19 residents. Specifically, for Resident #5, the facility failed to notify the Physician as ordered, when the Resident's Finger Stick Blood Sugar (FSBS) level was greater than 350 milligrams per deciliter (mg/dl). Findings include:Review of the facility policy titled Change in a Resident's Condition or Status, dated 2001 revised December 2023, included:-The nurse will notify the resident's Attending Physician or Physician on call when there has been a (an): specific instruction to notify the Physician of changes in the resident's condition.-The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Resident #5 was admitted to the facility in July 2024 with diagnoses including Type 2 Diabetes Mellitus (DM 2) with ketoacidosis without Coma, dependence on Renal Dialysis, and unspecified Dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #5:-was moderately cognitively impaired as evidenced by a Brief Interview of Mental Status (BIMS) score of 8 out of 15 points,-has a diagnosis of Diabetes-was receiving Insulin injections daily. Review of Resident #5's September 2025 Physician's orders included:-Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro). Inject as per sliding scale:-if 0 - 50 [sic FSBS mg/dl]. Give glucose gel/Glucagon IM (intramuscularly) and notify Provider if no improvement. -51 - 100 = Give OJ (orange juice) if less than 70. -101 - 150 = No coverage needed. -151 - 200 = 4, Give 2 units. -201 - 250 = 6. Give 4 units.-251 - 300 = 8. Give 6 units.-301 - 350 = 10. Give 8 units.-351 - 999 = 12. Give 12 units and notify Provider, subcutaneously before meals for DM 2, scheduled three times each day at 7:30 A.M., 11:30 A.M., and 4:30 P.M. (order date 4/13/25, start date 4/14/25). Review of Resident #5's July 2025, August 2025, and September 2025 Medication Administration Records (MARs) indicated that the Resident's FSBS was documented three times each day and the results noted were between 351 - 999 mg/dl on 47 days of 85 days reviewed, requiring Physician notification.Review of the Resident's MAR for July 2025 indicated a FSBS result between 351 - 999 mg/dl on: 7/2, 7/3, 7/4, 7/11, 7/12, 7/14, 7/16, 7/17, 7/18, 7/22, 7/23, 7/24, 7/26, 7/27, 7/30, and 7/31.Review of the Resident's MAR for August 2025 indicated a FSBS result between 351 - 999 mg/dl on: 8/4, 8/5, 8/7, 8/8, 8/9, 8/10, 8/12, 8/14, 8/15, 8/16, 8/19, 8/21, 8/22, 8/23, 8/24, 8/25, 8/26, 8/27, 8/28, 8/29, and 8/30.Review of the Resident's MAR for September 2025 indicated a FSBS result between 351 - 999 mg/dl on: 9/2, 9/4, 9/9, 9/13, 9/14, 9/16, 9/17, 9/19, 9/20, and 9/21. Review of Resident #5's clinical record failed to provide any evidence that the Physician was notified of any FSBS results between 351 - 999 mg/dl on any dates noted during the months of July 2025, August 2025, and September 2025. During an interview on 9/24/25 at 5:01 P.M., the Director of Nursing (DON) said that she reviewed Resident #5's MARs for July 2025, August 2025, and September 2025. The DON said she identified that the Resident's FSBS was noted to be between 351 - 999 mg/dl on multiple occasions during each month but she was unable to find any evidence in the Resident's record that staff had notified the Physician as ordered, that the FSBS was noted to be between 351 - 999 mg/dl. The DON said that it was an expectation that staff would notify the Physician as ordered any time the Resident's FSBS was between 351 - 999 mg/dl and then document that communication in the Resident's record. The DON said that she was unable to provide any evidence that the staff had notified the Physician as ordered, but they should have done so.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to provide an adequate resolution of a filed grievance on behalf of one Resident (#4), out of a total sample of 19 residents. Specifically, for Resident #4, the facility failed to thoroughly review, investigate, adequately resolve a grievance, and provide a written grievance resolution to Resident #4 when the Resident had complaints of noise in their room at night that affected his/her sleep. Findings include: Review of the facility policy titled, Resident and Family Concerns and Grievances Policy and Procedure, 2025, indicated: -The purpose is to provide prompt resolution of medical and non-medical grievances while maintaining confidentiality, in accordance with applicable federal and state statutes and regulations. -The facility will make reasonable efforts to ensure that all grievances are adequately resolved within thirty (30) calendar days from the day the grievance is received. -The facility will advise the resident of the outcome of the grievance investigation. -The facility will provide the resident with a written grievance decision, which shall include: >the date the grievance was received; >a summary statement of the resident's grievance; >a summary of the pertinent findings or conclusions regarding the resident's concern(s); >a statement as to whether the grievance was confirmed or not confirmed; >any corrective action taken or to be taken by the Facility as a result of the grievance; and >the date the written decision was issued. -In the event that the Facility cannot resolve the grievance within thirty (30) calendar days, the Facility will notify the resident, their family members, guardian or representative of the status and estimated completion date of the grievance resolution. -The facility will document all steps of the grievance resolution in the Facility's records, including whether or not the resident/family was satisfied with the resolution. Resident #4 was admitted to the facility in June 2025, with diagnoses that included Infection of Amputation Stump and Acquired Absence of the left leg below knee. Review of Resident #4's Minimum Data Set (MDS), dated [DATE], indicated he/she was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 14 out of possible 15. Review of the Grievance/ Concern form, received 9/4/25, indicated the following: -Resident #4 reported to the Social Worker (SW), that he/she was having trouble sleeping because his/her room was too loud. -The individual designated to take action for the grievance was the Unit Manager and/or Social Worker. -The date Grievance was to be resolved was 9/7/25. -The resolution of the Grievance/Concern was resolved on 9/5/25 after Resident #4 was offered a room change and declined, and then offered a facility change and declined. -A one-to-one discussion was used to notify the Resident of the resolution. During an interview on 9/24/25 at 9:09 A.M., Resident #4 said that he/she does not sleep well at night because the roommate's television is very loud all night and he/she is unable to get restful sleep. Resident #4 was unaware of any grievance filed on his/her behalf and said that he/she was offered a room change which he/she declined. Resident #4 said that he/she does wear disposable ear plugs, but they do not work. Resident #4 said that he/she had told several staff about the roommate's loud television, but nothing had been done and nobody followed up with him/her. During an interview on 9/24/25 at 1:23 P.M., the SW said that Resident #4 had complained about excessive noise from the roommate's television at night and the facility offered him/her a room change and a facility change/transfer, but both were declined. During an interview on 9/24/25 at 3:56 P.M., the SW said that she had considered the Grievance to be resolved on 9/5/25, when Resident #4 declined a room change and facility change. The SW said that she should not have resolved the grievance because the problem persists and she did not follow up with the Resident. During an interview on 9/25/25 at 9:09 A.M., Resident #4 said that he/she did not sleep well the night before because of the noise level in the room and said that he/she was wearing earplugs all night but said they do not work well. Resident #4 said that the facility recently said there is nothing else they can do about the noise complaints. During an interview on 9/25/25 at 10:03 A.M., the SW said since the surveyor brought this to the facility's attention, they (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had decided to offer the roommate headphones for the television and had offered the roommate a room change but both offers were declined. The SW said that the facility would continue to work with Resident #4 to find him/her an alternative room. The SW said that the facility could have explored more options with Resident #4 and the roommate when the Grievance was filed on 9/4/25 and should not have resolved the grievance on 9/5/25. During an interview on 9/26/25 at 4:39 P.M., the Administrator said that a Grievance is considered resolved when the Resident is happy with the outcome and the outcome is discussed with the Resident or responsible party.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement comprehensive care plans for one Resident #8), out of a total sample of 19 residents. Specifically, the facility failed to ensure a comprehensive care plan was developed to address the Resident's history of self-injurious behaviors. Findings include: Review of the facility's policy titled Care Plans, Comprehensive Person-Centered, revised September 2023, included but was not limited to: -A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. -Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change. -The interdisciplinary team reviews and updates the care plan: >when there has been a significant change in the resident's condition; >when the desired outcome is not met; >when the resident has been readmitted to the facility from a hospital stay. Resident #8 was admitted to the facility in May 2024 with diagnoses including Schizophrenia, Restlessness and Agitation, and Major Depressive Disorder. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 9/8/25, indicated Resident #8:-was moderately cognitively impaired with a Brief Interview of Mental status (BIMS) score of 11 out of 15. -had mood indicators of feeling down, depressed or hopeless nearly every day. Review of the Hospital Discharge summary dated [DATE], indicated Resident #8 had grabbed a cord and stated he/she would strangle himself/herself. Review of the Psychosocial Evaluation, dated 8/13/25, indicated Resident #8 was at risk for decompensation and increased monitoring for safety, including risk for falls or self-harm should be considered. Review of a Nursing Progress Note dated 8/18/25, indicated Resident #8 was found with blood on the sheets and long cuts/scratches to both wrists and was sent to the emergency room for suicidal ideations (SI). Review of the Social Work Progress Note dated 8/18/25, indicated Resident #8 had reports of self-injurious behavior and suicidal ideation (SI). Review of the Hospital Discharge summary dated [DATE], indicated Resident #8: -had reportedly cut himself/herself with a knife and began to scratch the cuts with his/her fingernails. -was at risk for self-injurious/suicidal behaviors. -engaged in self-injurious behavior by superficially scratching him/herself with his/her nails. -Discharge diagnosis included status-post self-injurious behavior of gesture by superficially scratching himself/herself. Review of Resident #8's Comprehensive Care Plan failed to indicate a history of self-injurious behaviors or SI. During an interview on 9/25/25 at 12:32P.M., the DON (Director of Nursing) said when the Resident caused self-injury to his/her wrists on 8/18/25, the facility did not complete an investigation or facility incident report about self-injurious behaviors. The DON said staff should have completed an investigation which would have prompted a Care Plan for self- injurious behaviors, but they did not complete an investigation or Care Plan. During an interview on 9/26/25 at 11:10A.M., the DON said if a Resident has a history of self-harm, a Care Plan and Kardex should have been implemented to assist staff in identifying behaviors, triggers and interventions which could prevent future incidences of self-harm. During an interview on 9/26/25 at 3:51P.M., the SW (Social Worker) said that if any Resident has a history of self-injurious behaviors, a Care Plan should be implemented with goals and interventions. The SW said that the facility should have updated Resident #8's Care Plan when the hospital paperwork from 7/10/25 indicated a statement about Resident #8 placing a cord around the neck and then on 9/2/25 when Resident #8 returned from a hospital stay related to self-injurious behavior to his/her wrists. The SW said it would have been important to implement the Care Plan for self-injurious behaviors to help keep Resident #8 safe by having staff aware of symptoms, triggers and interventions.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, and interview, the facility failed to adhere to infection control standards of practice, increasing the risk of contamination and spread of infections on one unit (second floor short hall unit) out of three units, and three resident rooms located on the second-floor short hall unit. Specifically, the facility failed to: -Ensure proper cleaning and disinfecting of shared resident equipment after use for residents who were on Enhanced Barrier Precautions (EBP- measures using protective barrier gowns and gloves as an infection control intervention designed to reduce transmission of multi-drug-resistant organisms [MDRO] during high contact resident care) when Nurse #1 completed vital signs for two residents. -Follow appropriate hand hygiene standards prior to entering and exiting three resident rooms with EBP precaution signage clearly visible, while completing vital signs monitoring. Findings include: Review of the facility policy titled Enhanced Barrier Precautions, revised December 2024, included but not limited to: -Enhanced barrier precautions (EBPs) are utilized to reduce the transmission of multi-drug-resistant organisms (MDROs) to residents. -Enhanced barrier precautions (EBPs) refer to infection prevention and control interventions designed to reduce the transmission of multi-drug-resistant organisms (MDROs) during high contact resident care activities. -Enhanced barrier precautions apply when: <A resident is infected or colonized with a Centers for Disease Control and Prevention (CDC) targeted MDRO, but does not have a wound or indwelling medical device, and does not have secretions or excretions that cannot be covered or contained; <A resident is NOT known to be infected or colonized with any MDRO, has a wound or indwelling medical device, and does not have secretions or excretions that are unable to be covered or contained. -Standard precautions apply to the care of all residents regardless of suspected or confirmed infection or colonization status. -Indwelling medical devices include central lines, urinary catheters, feeding tubes, and tracheotomies. -Examples of secretions or excretions include wound drainage, fecal incontinence or diarrhea, or other discharges from the body that cannot be contained and pose an increased potential for extensive environmental contamination and risk of transmission of a pathogen. Review of the facility policy titled Standard Precautions, revised September 2022, included but not limited to the following practices: <Hand hygiene is performed with alcohol-based hand rub (ABHR) or soap and water; -before and after contact with the resident -after contact with items in the resident's room; and -after removing gloves <Resident Care Equipment -Resident care equipment soiled with blood, body fluids, secretions, and excretions are handled in a manner that prevent skin and mucous membranes exposure, contamination of clothing, and transfer of microorganisms to other residents and environments. -Reusable equipment is not used for the care of more than one resident until it has been appropriately cleaned and reprocessed. Review of the facility policy titled Handwashing/Hand Hygiene, revised October 2023, included but not limited to: -This facility considers hand hygiene the primary means to prevent the spread of healthcare associated infections. -All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare associated infections. -All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. -Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) are readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. Alcohol based hand rub (ABHR) dispensers are placed in areas of high visibility and consistent with workflow throughout the facility. <Indications for Hand Hygiene: -Immediately before touching a resident -After contact with blood, body fluids, or contaminated surfaces -After touching a resident -After touching the resident's environment On 9/25/25 at 9:08 A.M. through to 9:39 A.M., the surveyor observed the following: -Three rooms on the second-floor short hall unit with posted signs for EBP which indicated: -STOP: ENHANCED BARRIER PRECAUTIONS >EVERYONE MUST: -clean their hands including before entering and when leaving the room. -9:08 A.M.: Nurse #1 entered the first resident room carrying blood pressure monitoring (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	equipment and failed to perform hand hygiene prior to entering the resident room. Nurse #1 was observed obtaining a resident's blood pressure utilizing the blood pressure equipment. -Nurse #1 exited the first resident room with the blood pressure equipment and walked to his medication cart without performing hand hygiene or sanitizing of the blood pressure equipment. Nurse #1 was observed to open the computer screen positioned on top of the medication cart and opened the medication cart using keys he removed from his pocket. The surveyor observed Nurse #1 remove an item from the medication cart, locked the cart, and turned to enter another resident room. -9:32 A.M., Nurse #1 entered a second resident room with EBP signage posted outside the room without performing hand hygiene. Nurse #1 was observed to close the door when he entered the second resident room. -9:35 A.M., Nurse #1 exited the second resident room and failed to perform hand hygiene. Nurse #1 walked to his medication cart parked at the end of the hall and picked up the blood pressure equipment. -9:36 A.M., Nurse #1 entered the third resident room with EBP signage posted outside the room without performing hand hygiene. The surveyor observed Nurse #1 utilizing the same blood pressure equipment used in the first resident room that was not sanitized or cleaned after use. -9:39 A.M., Nurse #1 exited the third resident room without performing hand hygiene and walked towards his medication cart and placed the blood pressure equipment next to the medication cart without cleaning or sanitizing the blood pressure equipment. During an interview on 9/25/25 at 9:52 A.M., Nurse #1 said he believed there was a protocol in place that he should clean the blood pressure equipment after each use on a resident as a sanitary precaution. Nurse #1 said he did not clean the blood pressure equipment, and he should have. Nurse #1 said he should have used the wipes provided by the facility to clean the equipment prior to using it again on another resident. Nurse #1 said he typically exits the resident rooms and uses alcohol-based hand hygiene on his medication cart to clean his hands.^Nurse #1 said that he believes there are facility approved wipes to sanitize equipment after each use on a resident and would find and show them to the surveyor. During a follow-up interview on 9/25/25 at 10:08 A.M., Nurse #1 showed the surveyor a cleaning product labeled Sani-cloth germicidal disposable wipe. Nurse #1 said he should have used the wipe to clean the blood pressure equipment when he exited a resident's room and each time the equipment was used on a resident. Nurse #1 also said that he should wait for 20 minutes to allow the product to dry completely before using the blood pressure equipment again. During an interview on 9/25/25 at 11:59 A.M., the Director of Nursing (DON) said that nursing staff should use the Sani-cloth germicidal wipes and clean the blood pressure equipment after each resident use to prevent the spread of infections. The DON said nursing staff should perform hand hygiene prior to entering and exiting the EBP resident rooms using the alcohol-based hand gel provided.^