

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275025	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER Kalispell Rehabilitation and Nursing LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 171 Heritage Way Kalispell, MT 59901	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>41951</p> <p>Based on observation, interview, and record review, the facility failed to provide clean resident rooms for 12 (#s 1, 2, 3, 4, 5, 6, 7, 8, 11, 12, 13, and 14) of 14 sampled residents. This deficient practice had the potential to affect all residents residing in the facility. Findings include:</p> <p>During an observation on 6/4/24 at 8:30 a.m., resident #1's room had dried spaghetti and unidentifiable food chunks next to the bed and scattered around the room. A used, disposable tooth flosser was on the floor between dressers. Under the bed, were multiple items with dust bunnies and dried food particles. Several areas on the floor had dirt covered, sticky substance spots. The bathroom in resident #1's room had dried urine on the toilet seat.</p> <p>During an observation and interview on 6/4/24 at 8:35 a.m., resident #2 stated she was unsure of the timing of how often she saw housekeeping in her room. Resident #3 stated housekeeping was in their room maybe once a week. Resident #2's and #3's toilet had dried feces on the toilet seat and scattered, dried food on the floor of the room.</p> <p>During an interview on 6/4/24 at 8:45 a.m., staff member K stated she was the only housekeeper in the building at the time, which happened often. She stated housekeeping staff called off several times a week and there were no replacements to help. Staff member K stated staff member C was the supervisor of housekeeping but was not yet in the building. Staff member K stated residents' rooms were cleaned one to two times a week, depending on how dirty they were. She stated if residents had room changes or there were new admissions, it took a lot of time to do the terminal cleaning, which delayed cleaning occupied residents' rooms.</p> <p>During an observation and interview on 6/4/24 at 8:55 a.m., resident #4's room had used tissue paper on the floor, around the garbage can, and dried food particles scattered around the room. Resident #4 stated the room was cleaned usually once a week.</p> <p>During an observation and interview on 6/4/24 at 9:10 a.m., resident #5 stated housekeeping cleaned her room once a week. She stated housekeeping did not empty her garbage often and it was often overflowing onto the floor. Resident #5 stated, They are slacking. She stated some days the hallways did not get cleaned also. Underneath resident #5's bed were dried food particles and dust bunnies. Resident #5's bathroom doorknob had a sticky substance on it and the floor was dirty. Resident #5 stated she did not use her bathroom.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 6/4/24 at 9:18 a.m., the hallway outside of resident #5's room had several areas of sticky substance, with dried dirt attached to the areas.</p> <p>During an observation and interview on 6/4/24 at 9:32 a.m., resident #6's and #7's room had dried food particles on the floor and dried food crumbs against the baseboard, next to the window. Resident #6 stated the room was cleaned maybe once a week, if at all. She stated the garbage cans were usually overflowing and there was always garbage on the floor. Resident #6 stated her roommate (resident #7) often collected their garbage, tied the bags, and took the garbage bags to staff because they were overflowing.</p> <p>During an observation on 6/4/24 at 11:40 a.m., staff member L was sweeping the memory care unit's common area.</p> <p>During an observation on 6/4/24 at 11:50 a.m., staff member L was no longer on the memory care unit.</p> <p>During an observation on 6/4/24 at 11:52 a.m., resident #8's and #11's toilet had dried feces on the seat.</p> <p>During an observation on 6/4/24 at 11:55 a.m., resident #12's and #13's toilet had dried feces on the seat.</p> <p>During an observation on 6/4/24 at 12:02 p.m., resident #14's toilet was full of urine and toilet paper with dried feces on the seat. In the bathroom garbage can, were two urine soiled incontinence briefs. There was not a liner in the garbage can.</p> <p>During an interview on 6/4/24 at 2:23 p.m., staff member N stated she handled the residents' grievances. She had been in her position since May of 2024. She stated resident council meeting notes from January of 2024 to current (June of 2024) showed housekeeping concerns were expressed each month. She stated each month the council was talking about housekeeping not being completed.</p> <p>Review of the facility's Grievance Report Form, dated 3/1/24, showed:</p> <ul style="list-style-type: none"> - Housekeeping Concerns, - 2-3 weeks between room cleans, - Paper towels, toilet paper, & garbage bags are not being refilled, and - Garbage not taken out regularly. - The above grievance was filed by Resident Council. <p>Review of the facility's Grievance Report Form, dated 3/5/24, showed:</p> <ul style="list-style-type: none"> - Garbage has not been emptied in 'at least 3 days,' - Floor has not been swept, <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>41951</p> <p>Based on observation, interview, and record review, staff member M failed to provide services which met professional standards of quality by not priming an insulin pen prior to the administration of insulin for 1 (#6) of 14 sampled residents. Findings include:</p> <p>During an observation on 6/4/24 at 9:57 a.m., staff member M entered resident #6's and performed a blood glucose monitoring test. Resident #6's blood glucose reading was 163.</p> <p>During an observation on 6/4/24 at 10:04 a.m., staff member M had retrieved two new insulin pens for resident #6, from a medication room. Staff member M labeled each insulin pen with an opening date. Staff member M dialed the Tresiba FlexTouch insulin pen to 40 units, then set the pen on top of the medication cart. Staff member M then dialed the Novolog insulin pen to 2 units. Staff member M did not prime either the Tresiba or the Novolog insulin pen with 2 units of insulin to clear any air from the pens.</p> <p>During an interview on 6/4/24 at 10:10 a.m., staff member M stated she had never heard of priming an insulin pen and did not know anything about the process to remove air from the insulin pen prior to each use. Staff member M stated this was her first day of work at the facility after being employed at another long term care facility for several months. Staff member M had previously worked at the facility.</p> <p>During an interview on 6/4/24 at 12:52 p.m., staff member B stated an insulin pen should be primed before each use with 2 units of insulin dialed into the pen.</p> <p>Review of the facility's policy, titled, Insulin and Non-Insulin Pen Delivery Systems Policy, dated 2019, showed:</p> <p>- . When using an insulin pen, as a safety test, a 2-unit dose of insulin must be dialed and released as an air shot prior to dialing and administering each prescribed dose.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41951</p> <p>Based on interview and record review, the facility failed to provide necessary care and services for a dependent resident for 1 (#9) of 14 sampled residents. This deficient practice caused the resident to feel unsafe, dirty, and embarrassed. Findings include:</p> <p>During an interview on 6/4/24 at 8:11 a.m., staff member H stated the scheduling of staff on the units was usually consistent for the residents, so staff were familiar with their care needs. She stated not all residents knew to use their call lights, so staff needed to check in with the residents to see if they needed help, such as repositioning or transfers.</p> <p>During an interview on 6/4/24 at 9:24 a.m., staff member E stated the staff repositioned residents who needed assistance with their positioning usually every two hours, or as needed. The staff also helped with transfers when residents used their call lights.</p> <p>During an interview on 6/4/24 at 1:26 p.m., NF1 stated resident #9 was admitted to the facility on [DATE] for rehabilitation to increase his strength. NF1 stated resident #9 had been in and out of hospitals since January of 2024 and was very weak. NF1 stated resident #9 had called several times during his stay, telling her about the lack of assistance, receiving no help from staff to move him in bed, long wait times for his call light to be answered, and not receiving assistance to the bathroom. He was discharged from the facility on 5/11/24 to return to his home town for care. NF1 stated resident #9 was admitted to a critical access hospital swing bed, located near their home, on 5/11/24.</p> <p>During an interview on 6/6/24 at 9:48 a.m., resident #9 stated during his stay, which lasted from 5/9/24 to 5/11/24, the staff did not help him move in bed. Resident #9 stated when he pushed his call light, it would take an hour on average for staff to answer. He stated he did not have a bedside commode and when he asked staff for assistance to the restroom for a bowel movement, he was told to hold it. Resident #9 stated he wore the same underwear/shorts for the entirety of his stay, and no one would change them. Resident #9 stated he felt, dirty and embarrassed.</p> <p>During an interview on 6/6/24 at 10:08 a.m., NF1 stated on the second night of resident #9's stay (5/10/24), he told her, I don't feel safe here. NF1 stated when resident #9 arrived from the facility on 5/11/24, he smelled of feces and the nurses at the hospital helped clean him. NF1 stated resident #9 had open, bleeding sores on both cheeks of his buttocks.</p> <p>During a interview on 6/6/24 at 10:10 a.m., resident #9 stated the staff at the facility did not empty his urinal. Resident #9 stated, I have never been mistreated like that in my life .I had sores on my bottom from lying there.</p> <p>Review of resident #9's Admission Record, dated 5/9/24, showed admitting diagnoses, not limited to the following:</p> <ul style="list-style-type: none"> - Other specified diseases of pancreas, - Muscle weakness (generalized), and <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Need for assistance with personal care.</p> <p>Review of resident #9's Admission MDS, with an ARD of 5/11/24, showed:</p> <ul style="list-style-type: none"> - Section C, Cognitive Patterns, a BIMS score of 14, intact cognition, and - Section GG, Functional Abilities and Goals, Toileting hygiene, had a score of 1, dependent. <p>Review of resident #9's Baseline Care Plan, completed on 5/10/24, showed:</p> <ul style="list-style-type: none"> - . Focus: Potential for altered skin integrity related to: Limited mobility, Chronic pain, sternal precautions, current wound to coccyx. - . Intervention: Staff will assist resident to turn/reposition regularly to offload pressure points. - . Intervention: Staff will provide prompt peri-care after incontinent episodes. <p>Review of resident #9's Admission Progress Note, with an admitted and time of 5/9/24 at 5:00 p.m., showed:</p> <ul style="list-style-type: none"> - . Mobility status/mobility devices: Limited mobility to right hand, left knee. Pt is unable to bear weight to RLE. Extensive assist needed with bed mobility, transfers. Sit to stand lift used with transfer to bed from w/c. Pt was unable to stand bearing weight to LLE. <p>Review of pictures of resident #9's buttocks, dated 5/12/24, obtained from the critical access hospital he was admitted to on 5/11/24, showed excoriation to both left and right buttocks with red, open areas and peeling skin.</p> <p>Review of resident #9's detail of admission physical assessment, from the critical access hospital, dated 5/11/24 at 6:27 p.m., showed:</p> <ul style="list-style-type: none"> - . Wound type - abrasions on buttocks, <p>- Wound description - right buttocks 2.5 inch by 1/4 inch, left buttocks, 1.5 inch by 1/8 inch reddened scrape on buttocks.</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>41951</p> <p>Based on observation and interview, the facility failed to provide a structured activities program, to meet each residents' individual preferences and needs in the secured, memory care unit. This deficient practice had the potential to affect all residents residing in the secured care unit. Findings include:</p> <p>During an interview on 6/4/24 at 9:17 a.m., resident #5 (who resided on the general care unit) stated residents from the memory care unit did not participate in activities outside of their unit. She stated she participated often in activities, and had not witnessed anyone from the memory care unit in activities.</p> <p>During an interview on 6/4/24 at 11:22 a.m., staff member B stated the CNA's in the memory care unit did activities with the residents. She stated the CNA's did coloring, puzzles, adult bowling, balloon toss, and television programming with the residents.</p> <p>During an interview on 6/4/24 at 11:47 a.m., staff member H stated staff member F did not do activities with residents in the memory care unit. Staff member H stated staff member F occasionally brought coloring pages for the resident to do. Staff member H stated in the past, there was an activities aide but not anymore. Staff member H stated the residents mostly did coloring.</p> <p>During an observation and interview on 6/4/24 at 3:40 p.m., most residents residing in the memory care unit were in the common area. Residents were sitting in recliners and at tables. The television was turned on. No activities were observed. Staff member O stated there were no structured activities which took place in the memory care unit. She stated resident activities would be helpful in the afternoon and evening to keep them occupied. Staff member O stated she did not do activities with the residents. Staff member O stated staff member F did not spend time on the unit. Staff member O stated there was an activity aide in the past, but she moved to a different department.</p> <p>During an interview on 6/4/24 at 4:15 p.m., staff member F stated the facility did not currently have an activities aide, which helped in the memory care unit. Staff member F stated the last time they had an activities aide was in November of 2023. Staff member F stated there were not structured activities in the memory care unit at this time.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41951</p> <p>Based on observation, interview, and record review, staff member M failed to perform proper hand hygiene when entering/exiting a resident's room, during blood glucose monitoring, during insulin administration, and during administration of eye drops for 1 (#6) of 14 sampled residents; failed to utilize a protective barrier during blood glucose monitoring; and failed to clean a glucose monitoring device (glucometer) after use. This deficient practice had the potential to increase the risk of bloodborne pathogens spread to other residents using the same glucometer. Findings include:</p> <p>During an observation on 6/4/24 at 9:54 a.m., staff member M entered resident #6's room to administer medications and perform blood glucose monitoring. Staff member M did not sanitize her hands upon entering resident #6's room. Staff member M placed the glucometer and supplies onto resident #6's over the bed table, which also had the breakfast food tray on the table. Staff member M did not place a protective barrier underneath the glucometer and supplies. Staff member M administered resident #6's medications. Staff member M had turned the glucometer ON and placed the testing strip in the machine. Staff member M did not don gloves, wiped resident #6's finger with an alcohol swab, used a lancet to [NAME] the finger, and squeezed the finger, bringing blood to the surface of the finger. When staff member M picked up the glucometer, it had turned off. Staff member M returned to the medication cart to retrieve another testing strip. Staff member M did not sanitize her hands before leaving resident #6's room.</p> <p>During an observation on 6/4/24 at 9:57 a.m., staff member M entered resident #6's room, did not sanitize her hands, and donned gloves. Staff member M took resident #6's blood glucose reading, doffed her gloves, and did not sanitize her hands. Staff member M proceeded to administer eye drops to resident #6 without donning gloves or hand sanitization.</p> <p>During an observation on 6/4/24 at 10:00 a.m., staff member M returned to her medication cart with the recently used glucometer and placed it into the top drawer of the medication cart. The glucometer did not have any resident's name attached to the device and was not disinfected prior to being placed in the drawer.</p> <p>During an observation on 6/4/24 at 10:07 a.m., staff member M entered resident #6's room to administer the insulin. Staff member M did not perform hand sanitization before entering the room and did not don gloves prior to administering the insulin to resident #6. Staff member M did not perform hand sanitization prior to exiting resident #6's room.</p> <p>During an interview on 6/4/24 at 10:10 a.m., staff member M stated she should have sanitized her hands before entering and before exiting resident #6's room. She stated she did not wear gloves while using a lancet for glucose monitoring or during administration of resident #6's insulin because she was in a rush. When asked about the cleaning of the glucometer, staff member M stated she would clean it with an alcohol swab. Staff member M stated she was unaware of any other method or use of the glucometer manufacturer's suggested sanitization wipes for the equipment cleaning. Staff member M stated this was her first day of work at the facility after being employed at another long term care facility for several months. Staff member M had previously worked at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/4/24 at 12:52 p.m., staff member B stated a glucometer, which was used for more than one resident, should be cleaned with MicroKill wipes. Staff member B stated hand hygiene is expected prior to entering a resident room, before exiting a resident room, and before donning and after doffing gloves. She stated gloves should be worn when performing blood glucose monitoring and with insulin administration.</p> <p>Staff member M failed to perform hand hygiene before entering and before exiting a resident's room. She failed to perform hand sanitization before donning gloves and after doffing gloves. Staff member M failed to don gloves prior to blood glucose monitoring, prior to the administration of insulin, and prior to administering eye drops. Staff member M failed to utilize a barrier prior to placing blood glucose monitoring equipment on a surface in a resident's room. Staff member M failed to properly clean a glucometer after use.</p> <p>Review of the facility's policy, titled, Blood Glucose Monitor Disinfection - MicroKill One Policy, last revised December 2022, showed:</p> <ul style="list-style-type: none"> - PURPOSE - To implement a safe and effective process for disinfecting blood glucose monitors. - . POLICY - The blood glucose monitor will be cleaned and disinfected with wipes following use on each resident when monitors are shared by multiple residents. - .Process - 1. Gather equipment - 2. Place equipment on bedside table/overbed table. Use towel/paper towels as barrier between table and equipment prior to placing equipment on table. - 3. Wash hands and put on pair of gloves. - 4. After performing the glucose test, throw used lancet and strip in sharps container. - 5. Clean all external parts of the monitor with a Micro-Kill One wipe. Discard wipe. - 6. Disinfect monitor by continually wiping or wrapping monitor with a second wipe to ensure contact time of 1(one) minute. - 7. The disinfected monitor will be placed on a towel/paper towel. - 8. Gloves will be removed, and hand washing performed. - 9. The monitor will be placed in the medication cart or other clean storage area until needed.