STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275067	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendive Medical Center N H	202 Prospect Dr Glendive, MT 59330

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to implement appropriate measures to prevent skin breakdown, to provide consistent care and monitoring of the pressure ulcers, and failed to ensure pressure ulcers were identified, classified, and the severity determined and documented accurately, for 1 (#6) of 15 sampled residents, resulting in the development of multiple pressure ulcers. Findings include: Review of resident #6's nurse's note dated 6/27/25 at 11:48 a.m., showed the resident complained because her knee popped. An x-ray was ordered of resident #6's right knee. The results of the x-ray were negative. Review of resident #6's nurse's note dated 6/28/25 at 3:06 a.m., showed the resident was found on the floor. Review of resident #6's nurse's note dated 6/28/25 at 4:04 p.m., showed resident #6 was diagnosed with a non-displaced tibial plateau fracture. The resident was to wear a knee immobilizer and be non-weight bearing for two to three months. Review of resident #6's nurse's note dated 6/29/25 at 4:59 a.m., showed the resident's immobilization brace was put on and the resident was tolerating the brace well. The resident was reminded to let staff know if she had any discomfort from the brace. Review of resident #6's nurse's note dated 6/29/25 through 7/18/25, failed to document resident #6's skin had been assessed under the immobilizer brace. Review of a nurse's note dated 7/19/25 at 11:12 a.m., showed the brace on resident #6's right leg had rubbed an open area on the outer Achilles area on the ankle, and this caused some purple bruising, related to pressure. The wound was draining serous fluid. The note showed an area on the resident's lower back leg above the ankle had an abrasion with a scab, and a small abrasion to the inner right ankle. The brace was left off for comfort. Review of resident #6's nurse's note dated 7/20/25 at 6:16 p.m., showed the right lower extremity brace had been placed on the resident during the night shift. The nurse's note showed . Metal bar was once again pushing into an edematous area on resident's outer ankle. Review of resident #6's Significant Change Nutrition Assessment, dated 7/24/25, completed by the dietitian, showed resident #6's skin was intact. The dietitian did not include the pressure ulcers resident #6 had on her right ankle area and did not take into consideration the increased caloric, protein, or fluid needs associated with pressure ulcers. Review of resident #6's nurse's note dated 7/28/25 at 4:05 p.m., showed the first measurement of the lateral malleolus wound bed had tan slough and measured two centimeters. The facility failed to follow the facility procedure directing the staff to identify the type of wound. No other wounds were identified or measured according to this note. Review of a hospital progress note dated 7/30/25 by a physician showed resident #6 had an open wound of her right ankle caused by the immobilization splint. Review of resident #6's, nurse's note dated 8/1/25 at 4:05 p.m., showed the staff alerted the nurse that the resident had a blister on her right medial heel. The blister measured four centimeters by three centimeters and was fluid-filled. The note showed the staff first noted the blister on 7/30/25, but no treatment was started at that time. The nurse's note showed the nurses could not find the cause of the blister. The immobilizer brace had been discontinued on 7/28/25. Bunny boots were applied 8/1/25 after the development of the pressure wounds. Review of resident #6's nurse's note dated 8/1/25 at 4:12 p.m., showed resident #6 had an open area on her right lateral heel. The wound was cleansed and measured 1.7 centimeters by 1.4 centimeters and had a tan slough area of 0.6 centimeters by 0.6 centimeters. The facility failed to identify the type of wound and failed to stage (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275067	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendive Medical Center N H	202 Prospect Dr Glendive, MT 59330

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 0686 Level of Harm - Actual harm Residents Affected - Few	the pressure ulcer on resident #6's right heel. No other wound was mentioned or measured. Review of resident #6's Skin Observation Tool - (Licensed Nurse) dated 8/2/25 was completed. The assessment showed the skin was pink, moist and intact. The assessment failed to identify the blister area on resident #6's heel and the wound on the lateral malleolus. Review of resident #6's NAR (nutrition at risk) meeting note, dated 8/7/25 at 4:43 p.m., showed resident #6 had a significant weight loss. The identified reason for weight loss was addressed. The only skin issues identified in the weight meeting was the blister on resident #6's right ankle. The heel pressure wound was not taken into consideration. The facility failed to identify the resident's need for increased nutrition related to wound healing.Review of resident #6's physical therapy note, dated 9/9/25 at 3:08 p.m., showed, . Wounds were first evaluated by (physical therapist name) on 8/7/25 please see this note for details. It is approximately 2 weeks later the patient still has this blister with discoloration of the blister therefore upon nursing notification. The physical therapist failed to stage resident #6's pressure ulcer. The physical therapist decided to debride the wound to abate any unknown problems contained underneath the blister. 4) Measurements: Lateral wound = 1.0 cm 0.7 cm wide X unknown depth.Posterior superior wound = 2.7cm X 2cm X unknown depth.Posterior wound = 0.1cm by 0.8cm by unknown depth. [sic] Review of resident #6's nurse's note dated 8/7/25 at 4:58 p.m., showed, . PT returned later and popped the blister and debrided the open area. New dressing orders - for area that had the blister. Orders are to cleanse with wound wash, cover with Xeroform and gauze daily. After blister was popped a light red area that is 5 cm x 3m with a depth of less than 1 mm was noted. Open area on lateral ankle wound bed is red after being debrided by PT. The area measures 1.7 cm x 1.2 cm x 1.5 mm. The skin around the open area is slightly red. It measures 4 cm x 4cm. The areas capillary refill is less than 1 second. [sic]. The facility failed to identify and document the stage of the pressure ulcer on resident #6's lateral ankle wound. Review of resident #6's nurse's note dated 8/8/25 at 5:33 p.m., showed resident #6 had a small circular reddish/purple area on the end of her great toe. The size of the wound was the size of a pencil eraser. The area was blanchable. Review of resident #6's nurse's note dated 8/9/25, showed the wound to the tip of resident #6's right great toe was .25 cm round and dark blue/black in color. The area was non-blanchable. The note showed a foot cradle would be added to the bed.Review of resident #6's care plan, dated 8/12/25, showed a foot cradle had been added to the resident's care plan. This showed a delay in treatment of three days for resident #6. Review of resident #6's nutrition at risk meeting note dated 8/14/25 at 4:58 p.m., showed the facility identified two wounds and implemented a fortified diet for resident #6. Review of resident #6's current care plan showed, the Bunny Boots were to be put in place on 8/1/25. The care plan did not include treatment for the heel pressure ulcer. The foot cradle was not added to the care plan until 8/12/25, after resident #6 developed a wound on her right great toe. The care plan failed to identify that Physical Therapy would assist in the treatment and care of the pressure ulcers. The care plan failed to identify the leg immobilizer was being used and when the immobilizer was discontinued.During an observation and interview on 9/11/25 at 9:46 a.m., staff member F notified the surveyor and resident #6 she was going to do the dressing change on the sores the resident got from her leg immobilizer. During the observation, staff member F provided pressure ulcer treatment to two open areas on resident #6's right lower leg. One area was just above the round portion of the heel, and the other area was to the right and below the malleolus. A small red/brown wound was observed on the tip of resident #6's right great toe. No treatment was provided to that wound. Review of the facility's policy titled, Subject: Skin Integrity (impaired) Documentation, undated showed:Policy: All patients and residents having a wound present will have the wound identified according to type.Purpose: To provide guidelines for required documentation regarding all new and existing skin integrity issues .To provide a standardized assessment tool wound healing chart to monitor healing over time. Procedure: Identify the type of wound: The nurse initially observing a new skin integrity issue will identify the type of skin integrity issue present. Initiate a treatment plan. All nursing departments will use the following policies on specific wound types to choose and initiate treatment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275067	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendive Medical Center N H	202 Prospect Dr Glendive, MT 59330

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 0686 Level of Harm - Actual harm Residents Affected - Few	Documentation: The nurse who assesses and existing skin integrity issue will document the following in the nursing notes or on the skin problem treatment sheet. a. onsetb. description of skin integrity issuec. Locationd. Size measured in metric system (head to toe) Width (right to left)e. Depth of the tissue involvementf. Presence of undermining or tunneling.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275067	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendive Medical Center N H	202 Prospect Dr Glendive, MT 59330

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation, interview, and record review, the facility failed to ensure the dietary manager completed a certification program approved by a national certifying body or had higher education in a related field. This had the potential to affect residents and their nutritional status or meal safety for those who consumed food prepared and served by the facility. Findings include:During the initial tour of the kitchen, on 9/8/25 at 11:56 a.m., no documentation of advanced training for the dietary manager was posted.During an interview on 9/9/25 at 3:45 p.m., staff members A, G, and K were present. Staff member G said he did not have the CDM certificate.During an interview on 9/10/25 at 8:50 a.m., staff member E and Q were present. Staff member Q said he coordinates nourishment for the facility. He assesses the residents and recommends diets and textures for the residents. Staff member Q said he does not complete any kitchen sanitation tours and does not go into the kitchen to monitor the dietary requirements. Staff member E said staff member K is the kitchen manager's supervisor. Staff member E said she and the administrator agreed the facility needs to have a certified dietary manager.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275067	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendive Medical Center N H	202 Prospect Dr Glendive, MT 59330

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure clean and sanitary conditions were maintained throughout the kitchen and the dietary storage areas; fand failed to ensure kitchen staff labeled and dated food in the coolers. This deficient practice increased the risk for the development of foodborne illnesses and deficient practices related to sanitary conditions for all residents who received food from the kitchen. Findings include:During the initial tour of the kitchen, on 9/8/25 at 11:56 a.m., the following observations were made:-The coffee machine nozzles were soiled.-The juice machine nozzles and the plates behind the nozzles were heavily soiled with a sticky substance.-Three fans were observed in the kitchen, and all fans were coated with fuzzy brown material. One fan blew air directly on a food prep area, the industrial fan blew air directly into the kitchen, and the third fan blew air into the clean dish area. -Staff member L had her personal food and drink stored in the resident reach in refrigerator.-Chicken and ham soup base paste was open and not dated.-An open and partially used tub of vanilla yogurt was not dated.-A gallon jug of buttermilk, with an expiration date of 8/15/25, was in the cooler. The buttermilk whey was floating on top of the curds.-An opened and partially used carton of liquid eggs was not dated.-Two cans of apples and two cans of mandarin oranges were significantly dented along the bottom seam of the cans.-A case of bottled water was sitting directly on the floor.-The area under the small and the large mixers were splattered with white and tan food debris.-The shelf under the mixer was soiled and sticky from an opened bottle of honey.-Large rolling bins of panko, flour, and sugar were not labeled or dated, and the bin lids were soiled.-A bag of spaghetti and a bag of linguini were opened and not dated when opened.-Two, three-tiered carts were soiled with food particles and stains from dried liquid. -Corn was observed on the floor of the freezer.-Food not labeled or dated in the walk-in refrigerator included bacon, cream cheese, chili sauce, black olives, melon, pineapple, fruited Jello, cake, and mixed lettuce. The food was identified by staff member M.-A bucket of pickles was stored on the floor.-Pizza sauce was dated 9/2/25.-28 small tubs of food and 14 glasses of liquid were unlabeled and undated.-Spices were opened and not dated for red peppers, parsley, taco, pepper, chili powder, bay leaves, and rosemary.-The small reach in freezer contained opened bags of pepperoni, mozzarella sticks, and chicken strips. The bags were not labeled, dated or closed.-The food prep area was soiled with a greasy substance. -The area under the large-sized spices, near the poles holding the spice shelf, was dirty, greasy, and felt sticky to touch. -There was an unlabeled and uncovered cup filled with a white granular substance. This cup was sitting on the top of the oven in the cooking area. Staff member M was unable to identify the contents of the cup. -Chicken was being held in a small container and was placed in a tub with melted ice. The temperature of the chicken breast was 73 degrees. Staff member M said the chicken should be chilled to and held at 40 degrees.-The small freezer was missing the documented temperatures for September 4th, 6th, and 7th, 2025. One red sanitation bucket was observed in the kitchen. The chemical tested at over 500 parts per million. Staff member M said the chemical should be 200-400 parts per million. Staff member M said there should be three buckets out and being used. The areas near the grill, soup tureen, and pizza oven were heavily soiled with a brown/black greasy substance which could be scraped with a thumbnail. The front panel from the grill to the floor was missing. The floor from the grill to the Vulcan steamer was covered with a black oily substance. Under the soup tureen, cloth fabric was observed lying on the floor over the gas lines. The cloth, which had some white areas showing, was covered in a black layer of debris. The tile grout under the steam table was black, and the orange tiles were soiled with a greasy black substance. The bin to catch water near the soup tureen was half full of a substance which had a caked dry appearance. During an interview on 9/8/25 at 11:56 a.m., Staff member M said the food was only good for five days when it is left over in the cooler. Staff member M said the pizza sauce was outdated in the cooler. Staff member M stated, We don't use dented cans. Staff member M (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275067	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendive Medical Center N H	202 Prospect Dr Glendive, MT 59330

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	removed the dented cans and threw them in the garbage. Staff member M said there was a flood, and the towels probably got thrown under the soup tureen area then. Staff member M was unable to identify when the flood occurred. During an observation on 9/9/25 at 10:00 a.m., staff member N was serving food to the residents in the main dining area. Staff member N failed to have a beard net covering his beard.During an observation on 9/9/25 at 10:08 a.m., staff members G, P, and O were all in the food service area. The three staff members all had beards, and none of the staff wore beard nets. During an interview on 9/9/25 at 3:45 p.m., staff members A, G, and K were present. Staff member G said the floors are cleaned every night, and environmental services come in monthly to do a deep clean. Staff member G said there are schedules for cleaning the entire kitchen. Staff member K said he thinks the kitchen was not getting cleaned per the schedule.Refer to F801 related to the lack of oversight by a Certified Dietary Manager of the kitchen and dietary services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275067	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendive Medical Center N H	202 Prospect Dr Glendive, MT 59330

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on interview and record review, the facility failed to complete a Significant Change minimum data assessment within fourteen days after the facility identified a major decline in 1 (#6) of 15 sampled residents. The decline had the potential to impact the resident's physical and health status. Findings include:Review of resident #6's nursing note, dated 6/28/25 at 4:04 p.m., showed resident #6 was diagnosed with a non-displaced tibial plateau fracture. The resident was to wear a knee immobilizer and was non-weight bearing for two to three months. Review of resident #6's MDS, with an assessment reference date of 5/8/25, showed the resident needed partial to moderate assistance with performing oral care, getting herself on and off the toilet, showering, removing her footwear, personal hygiene, toilet transfer, transfer from bed to chair, and moving from a sitting to a standing position. Comparing the minimum data assessment with an assessment reference date of 7/17/25, showed the resident had declined and needed substantial to maximum assistance. During an interview on 9/11/25 at 9:30 a.m., staff member C said she had been completing the minimum data assessments for about one year. Staff member C said she had been trying to educate herself with online training. Staff member C said she had not completed all the training yet. Staff member C said she now knows that you have two weeks to set the assessment reference date for a resident who had a significant change in condition. Staff member C said the Significant Change minimum data set assessment reference date was not set on time, and the minimum data assessment was late.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275067	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendive Medical Center N H	202 Prospect Dr Glendive, MT 59330

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review, the facility failed to update the comprehensive care plan for a resident who developed avoidable pressure ulcers for 1 (#6) of 15 sampled residents. Findings include:During an interview on 9/11/25 at 9:30 a.m., staff member C said she updated the care plans when needed and reviewed care plans quarterly. Staff member C said she was not sure how she failed to identify the wounds on resident #6's ankle which were caused by the immobilizer. Review of resident #6's nurse's note, dated 7/19/25 at 11:12 a.m., showed the brace on resident #6's right leg had rubbed an open area on the outer Achilles area on the ankle with some purple bruising related to pressure. Review of resident #6's care plan, dated 8/1/25, showed an open area to resident #6's right ankle below the ankle was identified. The care was not updated timely as the Bunny Boots were added to the care plan on 8/1/25, a delay of 13 days following the development of pressure ulcers on resident #6's ankle area. The care plan did not include the pressure ulcer to resident #6's right heel. The care plan did not show resident #6's had a right heel pressure ulcer or a wound to the right great toe. The care plan was updated on 8/14/25 when the nutrition at risk team determined a fortified diet would be an appropriate intervention for wound healing. The foot cradle was not added to the care plan until 8/12/25 after resident #6 developed a wound on her right great toe. The care plan failed to identify Physical Therapy would assist in treatment and care of the pressure ulcers. The care plan failed to identify the leg immobilizer was being used and when the immobilizer was discontinued. During an observation and interview on 9/11/25 at 9:46 a.m., staff member F informed the surveyor and resident #6 she was going to do the dressing change on the sores she got from her leg immobilizer. During the observation staff member F provided pressure ulcer treatment to two open areas on resident #6's right lower leg. One area was just above the round portion of the heel, and the other area was to the right and below the ankle bone. A small red/brown wound was observed on the tip of resident #6's right great toe.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275067	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendive Medical Center N H	202 Prospect Dr Glendive, MT 59330

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility staff failed to have the necessary knowledge and skill set related to the proper monitoring and documentation of quality control checks for a blood glucose testing machine, and it was found a system was not in place for the checks. This deficient practice had the potential to affect all residents who require blood glucose monitoring, as inaccurate readings could lead to improper assessment, delayed interventions, or incorrect treatment decisions.During an interview on 9/10/25 at 9:40 a.m., staff member F stated a blood glucose control solution test was completed daily, but not on her shift. Staff member F stated she did not know where to find documentation showing a controlled test was completed on the glucose monitoring system.During an interview on 9/10/25 at 9:45 a.m., staff member B stated the blood glucose monitoring system was new and she was not sure if the controlled test was completed weekly or monthly. Staff member B stated she would need to review the current policy. Staff member B could not find documentation showing when control testing was completed for the glucose monitoring system.During an interview on 9/11/25 at 10:35 a.m., staff member B confirmed the facility did not have a system in place to ensure quality control checks were being completed and documented as required by the facility policy and manufacturer guidelines. Staff member B stated the facility had implemented a blood glucose quality control testing log as of 9/11/25.A request was made to the facility for blood glucose quality control documentation. No documentation was received by the end of the survey.Review of the facility's policy titled, [NAME] Real-Time blood glucose monitoring system Policy, undated, showed: Policy: It is the policy of (facility name) to ensure accurate blood glucose readings are documented within the Electronic Medical Record (EMR).Purpose: To guide licensed staff on the use of the [NAME] Real-Time blood glucose monitoring system. Performing a Control Solution TestDo a control solution test when:You first receive the meterAt least once a week to routinely check the meter and test stripsYou begin using a new vial of test stripsYou suspect the meter or test strips are not working properly,Patients' blood glucose test results are not consistent with how they feel, or if you think the results are not accurate,Practicing the testing process or have dropped or think you may have damaged the meter. [sic]