STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395361	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Ridge Manor East/West	8300 West Ridge Road Girard, PA 16417

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48496 Based on review of facility policy and clinical records, and staff interviews, it was determined that the facility failed to provide the resident and/or resident representative with a written notice of the facility bed-hold policy (explanation of how long a bed can be held during a leave of absence and the cost per day) upon transfer for one of nine residents reviewed for bed-holds (Resident R65). Findings include: Review of facility policy entitled Bed Hold and Return Policy dated 1/26/24, indicated It is the policy . upon Admissions, Transfers and Therapeutic Leaves, residents and/or resident representatives will be informed in writing of the Bed Hold and Return Policy. Review of Resident R65's clinical record revealed an initial admitted [DATE], with diagnoses that included dependence of renal dialysis (a treatment that helps remove extra fluid and waste products from the blood when the kidneys are not able to), diabetes (a health condition that caused by the body's inability to produce enough insulin), and obstructive and reflux uropathy (a condition that will not let the urine drain naturally). Review of Resident R65's clinical record revealed progress notes dated 10/3/23, at 4:13 a.m. and 2/2/24, at 10:40 p.m. indicating transfers to the hospital. The clinical record lacked evidence that Resident R65 and/or their representative were provided with a copy of the facility bed-hold policy upon transfers. During an interview on 7/30/24, at 2:41 p.m. the Director of Nursing confirmed that he/she had no evidence that Resident R65 and/or his/her representative was provided with a copy of the facility bed-hold policy that included the cost per day. He/she also confirmed that a copy of the facility bed-hold policy should have been provided to the resident and/or his/her representative upon transfer. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(c.3)(2) Resident rights

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 0655 Level of Harm - Potential for minimal harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177 Based on review of clinical records and staff interview, it was determined that the facility failed to provide a written summary of the baseline care plan and order summary to the resident and/or representative for seven of nine residents reviewed for baseline care plans (Residents R39, R59, R68, R183. R188, R22 and R65). Findings include: Resident R39's clinical record revealed an admitted [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD - lung disease that results in difficulty breathing, cough, and mucus production) diabetes, and Hodgkin lymphoma (cancer of the lymph nodes). R39's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R39 and/or his/her representative. Resident R59's clinical record revealed an admitted [DATE], with diagnoses that included dementia a condition that affects your ability to reason, think or remember things), COPD, and atrial fibrillation (irregular and often times a very fast heartbeat). R59's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R59 and/or his/her representative. Resident R68's clinical record revealed an admitted [DATE], with diagnoses that included dysphagia (difficulty swallowing), diabetes, and end stage renal disease (condition when your kidneys are no longer functioning properly). R68's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R68 and/or his/her representative. Resident R183's clinical record revealed an admitted [DATE], with diagnoses that included heart failure, chronic kidney disease, and anxiety. R183's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R183 and/or his/her representative. Resident R188's clinical record revealed an admitted [DATE], with diagnoses that included hearing loss, chronic kidney disease, and age-related physical debility. R188's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R188 and/or his/her representative. Resident R22's clinical record revealed an admitted [DATE], with diagnoses that included dementia (a disease that affects short term memory and the ability to think logically), hypertension (high blood pressure), and diabetes. (continued on next page)

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F 0655 Level of Harm - Potential for minimal harm Residents Affected - Some	R22's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R22 and/or his/her representative. Resident R65's clinical record revealed an initial admitted [DATE], with diagnoses that included diabetes, and obstructive and reflux uropathy (a condition that will not let the urine drain naturally). R65's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R65 and/or his/her representative. During an interview on 7/30/24, at 2:04 p.m. the Director of Nursing confirmed that the clinical records of the residents listed above lacked evidence that a written summary of the baseline care plan and order summary was provided to the resident and/or his/her representative. 28 Pa. Code 211.12(d)(1) Nursing services

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177 Based on review of facility policy and clinical records, observations, and staff interviews, it was determined that the facility failed to ensure that resident with limited range of motion received physician ordered treatment and services to prevent further decrease in range of motion for two of 35 residents reviewed (Residents R79 and R43). Findings include: Review of facility policy dated 1/26/24, entitled Restorative Nursing: Splints and Orthotics: Care of Resident With indicated that The Resident will receive care to assess for, prevent, and treat contracture and that Specific program is written onto the CNA (certified nurse aide) flow sheet and A copy of the splint / orthotic wearing schedule is placed in the resident's closet. Resident R79's admission record revealed an admitted [DATE], with diagnoses that included dementia (a condition that affects your ability to reason, think, or remember things), diabetes, and chronic obstructive pulmonary disease. Resident R79's clinical record revealed a physician's order dated, 8/9/21, that identified Palm splint to left hand. Non-standard wear schedule. The clinical record lacked a wear schedule for the palm splint and the resident's closet lacked evidence of a wear schedule being posted per facility policy. Observation on 7/28/24, at 1:25 p.m. revealed Resident R79 in bed with left hand splint laying on the night stand. Observation on 7/29/24, at 9:54 a.m. revealed Resident R79 in wheelchair with left hand splint laying on the night stand. Observation on 7/31/24, at 8:51 a.m. revealed Resident R79 in bed with left hand splint laying on the night stand. During an interview on 7/31/24, at 8:55 a.m. with Licensed Practical Nurse (LPN) Employee E11, surveyor inquired when Resident R79 was to be wearing his/her left palm splint. LPN Employee E11 reviewed physician orders and stated he/she did not see a wearing schedule for the splint, but believed it was to be put on at night as he/she knows it is not put on during the day shift. During an interview on 7/31/24, at 9:08 a.m. Nurse Aide (NA) Employee E16 was questioned on what shifts he/she worked, who responded that he/she works all three shifts. Surveyor asked NA Employee E16 how he/she knew when Resident R79 was to wear his/her splint. NA Employee E16 stated they just put the splint on when they can and when Resident R79 will let them. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/31/24, at 11:18 a.m. the Director of Nursing (DON) provided a copy of Resident R79's splint schedule that was implemented on 8/9/21. The splint schedule indicated the left palm splint was to be placed on after breakfast and removed for lunch, placed on after lunch and removed for supper, placed on after supper and removed at bedtime, placed on at midnight and removed at 2:00 a.m. DON confirmed the schedule was not posted in Resident R79's closet as policy indicated, that the splint should have been on Resident R79 at the times the surveyor observed the splint to be laying on the night stand and if the resident was refusing to allow staff to apply the splint, the refusal should have been documented in the clinical record. Resident R43's clinical record revealed an admitted [DATE], with diagnoses that included chronic respiratory failure (a condition were your lungs don't exchange air properly), intracranial injury (an injury to the brain caused by external force), and peripheral vascular disease (a condition where your arteries become narrow causing reduce or blocked blood flow). Review of Resident R43's clinical record revealed a physician's order dated 5/17/21, that identified an order for a left resting hand splint to be worn per standard wear schedule. Further review of clinical record revealed a care plan for Activities of Daily Living (ADL) for a left hand contracture. The ADL care plan also revealed interventions of splinting left hand program with standard wearing schedule. Review of therapy splint schedule and Restorative Nursing: Splints and Orthotics policy revealed resting hand splint should be on at 4:00 a.m. and taken off at 8:00 a.m., then on at 1:00 p.m. and taken off at 5:00 p. m., then on at 9:00 p.m. and taken off at 2:00 a.m. Observation on 7/28/24, at 1:00 p.m. revealed Resident R43 was sitting in his/her wheelchair in his/her room with no hand splint on his/her left hand. Observation on 7/28/24, at 3:47 p.m. revealed Resident R43 sitting in his/her wheelchair in the hall with no hand splint on his/her left hand. Observation on 7/29/24, at 2:17 p.m. revealed Resident R43 sitting in his/her wheelchair in his/her room with no hand splint on his/her left hand. Observation on 7/30/24, at 2:10 p.m. revealed Resident R43 sitting in his/her wheelchair in the hall with no hand splint on his/her left hand. Observation and interview with Licensed Practical Nurse (LPN) Employee E18 on 7/31/24, revealed that Resident R43's splint schedule was posted in Resident R43's closet. LPN Employee E18 opened Resident R43's closet door and revealed a paper taped to the inside of the door and indicated the standard wearing schedule for resting hand splint to left hand. Further interview with LPN Employee E18, revealed that he/she stated that Resident R43 did not wear the splint to his/her left hand during any part of LPN Employee E18's shifts on 7/28/24, and 7/29/24. During an interview with LPN Employee E18 on 7/31/24, at 8:57 a.m. he/she confirmed that Resident R43 did not wear his/her splint on his/her left hand as ordered and that the splint should have been on at the times of the observations. LPN Employee E18 also confirmed that the left resting hand splint should be placed to Resident R43's left hand as ordered. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 211.10 (d) Resident care policies 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31185 Based on review of facility policy, clinical records, and facility documentation and staff interviews, it was determined that the facility failed to provide a safe transfer in a manner that protected a resident from injury during a transfer, and resulted in actual harm when the resident received an acute fracture of the femur (the thigh bone) for one of 35 residents reviewed (Resident R304). This deficiency is cited as past non-compliance. Findings include: The facility policy entitled, Lifting Machine, Using a Mechanical, dated January 26, 2024, indicated that at least two nursing assistants are needed to safely move a resident with a Full/Maxi mechanical lift and to follow transfer orders from Physical Therapy (PT) for sit to stand/Sara lift transfer orders. Review of Resident R304's clinical record revealed an admitted [DATE], with diagnoses that included Alzheimer's disease (progressive mental deterioration that destroys memory and other important mental functions), dementia (condition of impaired ability to remember, think, or make decisions that interferes with everyday activities), history of falling and protein calorie malnutrition. Review of Resident R304's quarterly Minimum Data Set assessment (MDS-periodic assessment of resident care needs), dated 10/31/23, revealed that Resident R304's transfer status was total dependance, two-person physical assist, it also revealed that Resident R304 was severely cognitively impaired. Review of a physician's order dated 3/26/21, revealed that Resident R304 was ordered an assist x (times) 2 and with Maxi lift [full body mechanical lift] as needed with assist x 2 with transfers. A review of Resident R304's clinical record revealed a nurse's note dated 1/26/24, at 9:57 p.m. which indicated that Resident R304 had swelling to the right knee and bruising to the upper thigh and knee. A nurse's note dated 1/26/24, at 11:59 p.m. revealed that Resident R304 had large bruises noted to area behind the right knee and distal femur. Nursing Assistant (NA) Employee E13 stated that he/she used the Sara lift (sit to stand lift) to put resident to bed. The nurse's note also indicated that Resident R304's physician's order was a two-person assist or maxi lift. Orders received for x-rays in a.m. of the right hip, femur and knee. A nurse's note dated 1/27/24, at 11:36 a.m. revealed the physician was notified regarding the x-ray results of a displaced fracture of the right distal femur and indicated that Resident R304 was sent to the hospital for evaluation. Review of the facility's investigation revealed that NA Employee E12 confirmed verbally to Registered Nurse (RN) Employee E13 on a written statement dated 1/27/24, that he/she transferred Resident R304 with a Sara lift (sit to stand lift) to bed with assistance of one. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of documentation submitted by the facility dated 1/27/24, revealed that the facility initiated an investigation, regarding Resident R304's injury of unknown origin on 1/26/24. The investigation revealed that the resident was transferred that day with an assist of one on 1/26/24. Following the transfer, the resident's leg had increased swelling and bruising. NA Employee E12 did not follow the resident's physician's orders for safe transfers resulting in harm and employment was terminated. An interview with the Director of Nursing (DON) on 7/29/24, at 10:40 a.m. confirmed that NA Employee E12 transferred Resident R304 with a Sara lift alone even though resident was ordered a Maxi lift as needed with an assist of two. The facility failed to ensure that Resident R304 was free from injury during a transfer resulting in actual harm of an acute fracture of the right femur. This deficiency is cited as past non-compliance. On 1/28/2024, the facility-initiated education for all nursing staff including Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and NAs to ensure that proper transfer status must be followed. This plan included the following: Immediate suspension of NA Employee E12 followed by termination of employment. Immediate education regarding following the resident's transfer orders and proper transfer technique was provided to all facility nursing staff that included RNs, LPNs, and NAs, which occurred from 1/27/2024, to 2/5/2024. Interviews with RN Employee E13 and LPN Employees E2, E3, E4, E6, E8 and E9 and NA Employees E1, E5, E7, E10, E14 and E15 confirmed the facility initiated education starting 1/27/2024, which included education on resident transfer status, following the resident's care plan, and with knowledge of where to find the resident's care plans, and all lifts require two staff. Audits were conducted by the DON regarding transfers to include the correct number of staff, and performed correctly, these audits of 25% of residents on each unit requiring a lift on every shift have been ongoing in the facility since February 2024. Per interview with the Nursing Home Administrator (NHA) and the DON, audits will continue to be completed by the RN Supervisors on each shift as well as the DON quarterly. These audits will be reviewed by the Quality Assurance Performance Improvement (QAPI) Committee. The audits will continue until determined otherwise by the QAPI committee. During an interview with the NHA and DON on 7/30/24, at 11:40 a.m. and review of the facility's immediate actions, education, audits, and review of the QAPI monitoring process to sustain solutions, it was verified that the facility had implemented a plan of correction to ensure residents are free from harm regarding proper transfers and had achieved substantial compliance as of 3/29/24. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47356 Based on review of facility policy and clinical records, observations, and staff interview, it was determined that the facility failed to provide appropriate urinary catheter (tubing inserted into the bladder to drain urine into a bag) care for one of three residents reviewed for catheters (Resident R128). Findings include: A facility policy entitled Foley, Care Of dated 1/26/24, indicated Be sure the catheter tubing and drainage bag are kept off the floor and catheter bags should be covered with a catheter bag at all times. Review of Resident R128's clinical record revealed an admitted [DATE], with diagnoses that included hypertension (high blood pressure), chronic kidney disease, and retention of urine (a condition where the bladder doesn't empty completely when urinating). Review of Resident R128's clinical record revealed a physician's order dated 3/3/23, for an indwelling catheter related to urinary retention. Observations on 7/28/24, at 12:00 p.m. revealed that the bottom of Resident R128's urinary drainage bag was on the floor with the catheter cover only partially covering the urinary drainage bag. At 3:00 p.m. observations revealed that Resident R128's urinary drainage bag was laying flat on the floor, the tubing was lying on the floor, and the catheter cover was completely off the urinary drainage bag and wrapped up around the tubing. During an interview on 7/28/24, at approximately 3:05 p.m. Licensed Practical Nurse Employee E9 confirmed that Resident R128's catheter tubing and bag should not be on the floor, and the catheter cover should be completely covering the urinary drainage bag and not wrapped up around the tubing. 28 Pa. Code 211.12(d)(1)(5) Nursing Services

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177 Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to provide a clinical rationale for the continued use of a PRN (as needed) psychotropic (affecting the mind) medication beyond 14 days and failed to provide evidence that non-pharmacological interventions (interventions attempted to calm a resident other than medication) were attempted prior to the administration of a PRN psychotropic medication for two of seven residents reviewed for unnecessary medications (Residents R87 and R17). Findings include: A facility policy entitled Psychotropic Drugs dated 1/26/24, revealed that 1) All psychotropic's are required to have behavioral interventions and GDR's (gradual dose reductions). 2) PRN orders are limited to 14 days. Antianxiety/Hypnotic - If extended past 14 days, must include prescriber documentation of the rationale in the medical record and have a duration. Resident R87's clinical record revealed an admitted [DATE], with diagnoses that included anxiety, hypertension (high blood pressure), and respiratory failure (difficulty breathing). A physician's order dated 11/22/23, identified to administer Alprazolam (anti-anxiety) 0.5 milligrams (mg) by mouth every 1 hour as needed for anxiety, and lacked the required stop date within 14 days or a clinical rationale for continued use beyond 14 days. Review of the July 2024 Medication Administration Record (MAR) for Resident R87 revealed that the PRN Alprazolam was used on 7/1/24, 7/2/24, 7/3/24, 7/4/24, 7/5/24, 7/6/24, 7/7/24, 7/8/24, 7/9/24, 7/10/24, 7/11/24, 7/12/24, 7/13/24, 7/14/24, 7/15/24, 7/16/24, 7/17/24, 7/18/24, 7/19/24, 7/20/24, 7/21/24, 7/22/24, 7/23/24, 7/25/24, 7/26/24, 7/27/24, 7/28/24, and 7/29/24. Review of the July 2024 MAR, and clinical record progress notes revealed that there was no evidence of non-pharmacological interventions attempted prior to the administration of the PRN Alprazolam. During an interview on 7/30/24, at 2:10 p.m. the Director of Nursing confirmed that Resident R87's Alprazolam orders lacked the required stop date within 14 days or a clinical rationale for continued use beyond 14 days and R87's clinical record lacked evidence that non-pharmacological interventions were being attempted prior to administering Alprazolam. Resident R17's clinical record revealed an admitted [DATE], with diagnoses that included dementia (a condition that affects your ability to reason, think, or remember things), arthritis, and transient ischemic attach (TIA - mini-stroke or where you develop stroke like symptoms that resolve within twenty-four hours). A physician's order dated 4/27/24, identified to administer Lorazepam (anti-anxiety) 0.5 mg / 0.25 milliliter (ml) sublingually (under the tongue) every 3 hours as needed for agitation, and lacked the required stop date within 14 days or a clinical rationale for continued use beyond 14 days. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident R17's April 2024 MAR revealed that the PRN Lorazepam was used eight times (4/27/24 twice, 4/28/24 three times, 4/29/24, and 4/20/24 twice). Review of the April 2024 MAR and clinical record progress notes revealed that there was no evidence of non-pharmacological interventions attempted prior to the administration of the PRN Lorazepam eight of eight times it was used. Resident R17's May 2024 MAR revealed that the PRN Lorazepam was used 16 times (5/2/24 three times, 5/4/24, 5/6/24, 5/7/24 twice, 5/8/24, 5/9/24 twice, 5/10/24, 5/11/24, 5/12/24, 5/17/24, 5/23/24, and 5/26/24). Review of the May 2024 MAR and clinical record progress notes revealed that there was no evidence of non-pharmacological interventions attempted prior to the administration of the PRN Lorazepam 12 of the 16 times it was used. Resident R17's June 2024 MAR revealed that the PRN Lorazepam was used five times (6/9/24, 6/17/24, 6/22/24, 6/24/24, and 6/26/24). Review of the June 2024 MAR and clinical record progress notes revealed that there was no evidence of non-pharmacological interventions attempted prior to the administration of the PRN Lorazepam five of the five times it was used. Resident R17's July 2024 MAR revealed that the PRN Lorazepam was used three times (7/1/24, 7/3/24, and 7/13/24). Review of the July 2024 MAR and clinical record progress notes revealed that there was no evidence of non-pharmacological interventions attempted prior to the administration of the PRN Lorazepam one of the three times it was used. During an interview on 7/31/24, at 9:53 a.m. the Director of Nursing confirmed that Resident R17's Lorazepam orders lacked the required stop date within 14 days or a clinical rationale for continued use beyond 14 days and R17's clinical record lacked evidence that non-pharmacological interventions were attempted 26 of the 32 times PRN Lorazepam was administered. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395361	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Ridge Manor East/West	8300 West Ridge Road Girard, PA 16417

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. 40177 Based on review of facility policy and manufacturer's guidelines, observation, and staff interview, it was determined that the facility failed to properly clean and prevent the potential for cross contamination during the use of a blood glucometer meter (BGM - a device to collect and measure the level of glucose [sugar] in the blood) for two of 13 residents observed during the administration of medications (Residents R165 and R51). Findings include: Review of facility policy entitled Obtaining a Fingerstick Glucose Level dated 1/26/24, indicated to Clean and disinfect reusable reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. Review of manufacturer's guidelines for cleaning and disinfecting procedures for the blood glucose monitoring system indicated that a variety of the most commonly used EPA (Environmental Protection Agency) registered wipes have been tested and approved for cleaning and disinfecting the blood glucose meter. The guidelines go on to indicate four different disinfectants that are approved for use - Clorox Germicidal Wipes, Dispatch Disinfectant Towel with Bleach, Super Sani-Cloth Germicidal Disposable Wipes, and CaviWipes. Observation of medication administration on 7/28/24, between 3:50 p.m. and 4:10 p.m. revealed that Licensed Practical Nurse (LPN) Employee E17 removed a blood BGM from the medication cart, wiped the meter with a 70% isopropyl alcohol prep pad, entered Resident R165's room, obtained a blood glucose level, returned to the medication cart, wiped the meter with a 70% isopropyl alcohol prep pad and placed the meter in the medication cart. LPN Employee E17 proceeded to the next resident, wiped the meter with a 70% isopropyl alcohol prep pad, entered Resident R51's room, obtained a blood glucose level, returned to the medication cart, wiped the meter with a 70% isopropyl alcohol prep pad and placed the meter in the medication cart. During an interview on 7/28/24, during medication observation, surveyor asked LPN Employee E17 if the 70% isopropyl alcohol prep pad was an approved cleaner for the BGM to which he/she replied they assumed it was and it is what he/she always uses. During an interview on 7/29/24, at approximately 2:00 p.m. the Director of Nursing confirmed that use of 70% isopropyl alcohol prep pad was not an approved cleaning agent for the BGM and the BGM should be cleaned after each use with a manufacturer's approved cleaning agent. 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services