STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155234	A. BUILDING 00 B. WING	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTRIDGE HEALTH CARE CENTER	125 W MARGARET AVE TERRE HAUTE, IN 47802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00455208. Complaint IN00455208 - No deficiencies related to the allegations are cited. Survey dates: March 16, 17, 18, 19, and 20, 2025 Facility number: 000139 Provider number: 155234 AIM number: 100266410 Census Bed Type: SNF/NF: 41 Total: 41 Census Payor Type: Medicare: 5 Medicaid: 34 Other: 2 Total: 41 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 25, 2025.	F 0000	Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the Statement of Deficiencies. The Plan of Correction is prepared and submitted because of the requirement under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance. Please find enclosed this Plan of Correction for this survey. Due to the low scope and severity of the survey findings, the Facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance feel free to contact me.	
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination Based on interview and record review, the facility failed to ensure residents were provided showers/bed baths as preferred for 2 of 3 reviewed for choices (Residents 41 and 40). Findings include:	F 0561	**F561** ***What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?***	04/10/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lisa Bloesing	Administrator	04/09/2025

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	1. During an interview, on 3/17/25 at 9:29 a.m., Resident 41 indicated he had requested to receive two complete bed baths twice a week, but it was a challenge to receive the bed baths because of the facility not having enough staff. He indicated the bed baths were scheduled to occur on Monday and Thursday evening, but they were not getting done twice a week as requested. Resident 41 would sometimes only receive a washcloth from staff to wash his face and armpits and that was all he would get washed because he was unable to complete the task himself. Resident 41's record was reviewed on 3/18/25 at 10:50 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 12/3/24, indicated the resident was cognitively intact and required 1 to 2 staff assistance with activities of daily living (basic tasks that individuals perform to maintain their health and well-being). Review of daily preference assessment, dated 8/29/24, indicated Resident 41 prefers bed baths two times a week in the evenings. Review of the scheduled showers/bed baths for the 200 hall, indicated Resident 41 was to receive a bed bath on Monday and Thursday from 2-4 p.m. Review of point of care (when healthcare services are provided) documentation, indicated the resident received a bed bath on 3/17/25, 3/10/25, 3/6/25, 2/24/25, 2/18/25. The record lacked documentation of a bed bath being completed on 3/13/25, 3/3/25, 2/27/25, and 2/20/25. In the last 30 days the resident didn't receive 4 of his scheduled bed baths. During an interview, 3/19/25 at 8:36 a.m., Certified		The noted residents, number 41 and 40, were not negatively affected by the alleged deficient practice. Resident 41 and 40 were interviewed for their preferences of showers and/or bed baths. Resident 41 stated that he was happy with 2 bed baths a week and wanted no changes made. Resident 40 shower/bed bath preferences were updated. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** No residents were affected by the alleged deficient practice; however, all residents have been interviewed for shower and/or bed bath preferences. Shower schedules have and will continue to be updated accordingly as needed. Any noted discrepancies were immediately corrected. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*** The facility resident's rights policy has been reviewed and no changes are indicated. All nursing staff will be re-educated on the facility's policy. The in-service will focus on resident's shower preferences and notifying the DON if any changes to the schedule are	

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	Nurse's Aide (CNA) 6 indicated Resident 41 doesn't refuse his bed baths and was something he wanted to make sure he received as scheduled. The CNA indicated there were times she would have to stay past her scheduled shift to help the next shift get their showers/bed baths completed. There were times it was a challenge to get all tasks completed due to staffing. During an interview, on 3/19/25 at 2:07 p.m., the Administrator indicated Resident received his scheduled bed baths but was unable to provide documentation of the bed baths being completed by staff. 2. On 3/16/25 at 2:21 p.m., during initial observation and interview Resident 40 indicated he did not receive regular showers. He indicated he was scheduled for two showers per week in the evenings but did not always receive them. On 3/17/24 at 11:00 a.m., Resident 40 record was reviewed. The most recent quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact and required 1 staff member for assistance with bathing and toileting. Review of the residents care plan dated 11/6/23, indicated the resident daily preferences were very important to him and he preferred to have two showers per week in the evening. A care plan dated 4/10/23, indicated the resident sometimes rejects care. Intervention included but not limited to attempt to determine the immediate cause for rejection. Seek solution if able. The medical record lacked documentation of resident refusals to take offered showers. On 3/18/25 at 1:44 p.m., during interview with Certified Nurse Aide (CNA)10., she indicated the residents are given showers at least two days a		requested or needed for the residents. A monitoring tool has been implemented. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** The DON, or designee, will be responsible for completing the monitoring tool to ensure that all resident's showers are scheduled per resident preferences. Shower sheets and shower/bed bath schedules will be audited for all residents 5 times per week for 4 weeks, then weekly for 4 weeks, then monthly thereafter. Should any concerns be found, immediate corrective action will occur. Results of these audits and any corrective action will be discussed during the facility's QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices until 100% compliance is achieved. ***Date of completion: April 10, 2025***	

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	week and some are three days a week. She indicated the CNA's record of the shower on a document referred to as a shower sheet. Once it is filled out they turn the shower sheet into the Director of Nursing (DON) for review. She indicated blank shower sheet forms are kept in the nurses station, file cabinet. She indicated if the resident refused a shower they would complete a behavior sheet and a shower sheet, staple them together and report to the DON. She indicated Resident 40 was scheduled for two showers a week to be administered in the evenings. The CNA demonstrated the shower schedule was in the CNA record book and indicated the schedule is updated as needed. Review of the shower schedule indicated the resident was scheduled to be administered a shower on Mondays and Thursdays in the evening. On 3/18/25 at 2:26 p.m., during interview, CNA 9 indicated each resident is to receive two showers a week on the day or evening shift. And the shower schedule for each resident is in the CNA book. If a resident refused a shower, she would report it to the nurse and would complete a shower sheet. If the resident refused to take a shower she would record the refusal on a behavior sheet and a shower sheet. If the resident refused to sign the shower sheet she would record that as well. She would turn the behavior sheet and shower sheet into the DON. On 3/18/25 at 1:00 p.m., the DON provided several copies of CNA assignment sheet. The document indicated Resident 40 had refused some of the scheduled showers. The CNA assignment sheet was not part of the resident's medical record. The point of care record, part of the resident's medical			

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	record, lacked documentation indicating the resident had refused showers. On 3/18/25 at 1:30 p.m., the point of care documentation which was recorded by the CNA and was part of the medical record was reviewed. From December 1, 2024 to March 17, 2025 the resident was scheduled to receive a total of 30 showers. The record indicated the resident received 17 showers. From January 12 to 18, 2025 and March 16 to 18, 2025 the record lacked documentation of showers being administered. On 3/18/25 at 3:00 p.m., during interview the DON indicated if a resident refused a shower the staff would ask again and then they would ask the nurse to talk to the resident. She indicated if a resident refused to take a shower they do not have the resident sign a shower sheet. She indicated they have used shower sheets, but they use the CNA assignment sheet now and also document in the medical record. She indicated at times the staff would fill out a behavior sheet if the resident refused a shower, but many of the residents do not take regular showers. She indicated the residents should receive a minimum of 2 showers a week. The DON could not recall the last time the facility used shower sheets. I asked for a copy of any shower sheets they had used for Resident 40. The facility failed to provide requested documentation. On 3/19/25 at 9:34 a.m., during interview, CNA 3 indicated there were times when they did not have staff to administer showers. This had occurred mostly on the evening shift. She indicated she was not aware if Resident 40 had ever refused a shower. On 3/19/25 at 9:38 a.m., during interview Resident			

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	40 indicated he had never refused a shower when it was offered. On 3/19/25 at 2:00 p.m., during an interview, the Administrator indicated Resident 40 had received several showers from the Occupational Therapist. The Administrator provided a document, dated 3/12/25, and indicated it was documentation of occupational therapy providing showers for the resident. The document lacked evidence of administration of a shower. She did not know if the staff could document a refusal in the resident's electronic record. The occupational therapy staff recorded showers they administered in their records. On 3/20/2025 at 11:54 a.m., the Regional Nurse Consultant provided a document, titled, "Resident Rights," dated 9/17, and indicated it was the policy currently being used by the facility. The policy indicated, "...This facility shall treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life ... This facility shall provide equal access to quality of care regardless of diagnosis, severity of condition, or payment source ...." 3.1-3(u)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observations, interviews, and record reviews, the facility failed to ensure expired medications were disposed of for 1 of 2 medication carts and 1 of 2 medication storage rooms reviewed (Residents 36 and 26).	F 0761	**F761** ***What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?***	04/10/2025

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	Findings include: 1. On 3/19/25 at 09:35 a.m., the south hall medication cart contained two expired insulin (medication used to lower blood sugar) vials with an open date of 2/6/25. The insulin vials contained labels that indicated they were for Resident 36. During an interview, on 3/19/25 at 09:37 a.m., Qualified Medication Aide (QMA) 7 indicated insulin was good for 30 days once opened. The insulin vials in the cart should have been discarded. Resident 36's record was reviewed on 3/19/25 at 10:06 a.m. The profile indicated the resident diagnosis included, but were not limited to, type 2 diabetes mellitus with hyperglycemia (occurs when the body either doesn't produce enough insulin or its cells don't respond properly to insulin, leading to a buildup of glucose [simple sugar] in the blood stream). A physician order, dated 2/5/25, indicated to administer Humalog (insulin medication) solution 100 unit/ml (milliliter). Inject 12 units subcutaneously (under the skin) three times daily. A physician order, dated 2/5/25, indicated to administer Lantus (insulin medication) solution 100 unit/ml. Inject 24 units subcutaneously at bedtime. 2. On 3/19/25 at 9:51 a.m., the north hall medication storage room contained an expired insulin pen (contains insulin in a cartridge that is administered into subcutaneous tissue through fine, replaceable needle) with an open date of 1/14/25, it was in the refrigerator, and it contained a label		The noted residents, number 36 and 26, were not negatively affected by the alleged deficient practice Residents 36 and 26 expired insulin were immediately removed from the medication cart and storage room and disposed at the time of observation. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** No residents were affected by the alleged deficient practice; however, all residents that require insulin have the potential to be affected. All insulin vial and pens were audited to ensure that none were expired. Any noted discrepancies were immediately corrected. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*** The facility medication storage and expiration list has been reviewed and no changes are indicated. All nursing staff that administers insulin will be re-educated on the facility's policy. The in-service will focus on monitoring all insulin and insulin pens for expiration dates and destroying if applicable. A monitoring tool has been	

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	that indicated it was for Resident 26. During an interview, on 3/19/25 at 9:52 a.m., Qualified Medication Aide (QMA) 8 indicated insulin was good for 28 days once opened. She indicated she was unsure why the insulin pen was in the refrigerator and why it wasn't discarded. Resident 26's record was reviewed on 3/19/25 at 10:10 a.m. The profile indicated the resident diagnosis included, but were not limited to, type 2 diabetes mellitus without complications (a state where the body doesn't produce enough insulin or doesn't use it properly, leading to high blood sugar). A physician order, dated 12/11/24 with a discontinued date of 1/10/25, indicated to administer Humalog kwikPen 100 unit/ml. Inject 45 units subcutaneously twice a day. On 3/19/25 at 11:27 a.m., the Cooperate Nurse Consultant provided a document, dated 9/2017, titled, "Medication Expiration," and indicated it was the policy currently being used by the facility. The policy indicated, " ...d. Multiple dose injections, such as insulin will expire 28 days after opening unless otherwise noted by manufacturer. 2. Facility staff shall date the label of any multi-use vial the first accessed and access the vial in a dedicated medication preparation area: If a multi-dose vial has been opened or accessed ...the vial should be dated and discarded within 28 days unless the manufacturers specifies a different ...date for the opened vial ...." 3.1-25(o)		implemented. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** The DON, or designee, will be responsible for completing the monitoring tool to ensure that all insulin is within the time frame for administration and not expired. Insulin in medication carts and storage rooms will be audited for expiration dates weekly for 4 weeks, then every other week for 4 weeks, then monthly thereafter. Should any concerns be found, immediate corrective action will occur. Results of these audits and any corrective action will be discussed during the facility's QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices until 100% compliance is achieved. ***Date of completion: April 10, 2025***	

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F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation and interview, the facility failed to label and date refrigerated and frozen food items, so it is used by its use-by date, frozen, or discarded, and the facility failed to prevent possible contamination of food in the refrigerator from water dripping onto food items for 2 of 2 kitchen observations. Findings include: On 3/16/25 at 10:05 a.m., during initial kitchen observation of refrigerated foods with Employee 11. The main refrigerator was observed with tomatoes in a clear plastic container date labeled with an opened date of 2/24. Two clear containers with lettuce inside with an opened date of 2/24. The tops of both containers were covered in water which was dripping down onto covered container of chicken noodle soup on the second shelf. The bottom of the refrigerator also had water on it and boxed food items were wet. On 3/16/25 at 10:10 a.m., an observation of freezer found an undated bag of frozen tater tots, two packages of undated frozen pie shells, two undated cakes, and four undated frozen pies. On 3/16/25 at 10:15 a.m., during interview employee 11 indicated the tots were from last night. She removed the item from the freezer and wrote a date on the bag. On 3/19/25 at 11:10 a.m., during second dietary kitchen observation with Employee 12. The refrigerator noted to have standing water on the top shelf of sealed food items. When moved,	F 0812	**F812** ***What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** None of the residents were negatively affected by the alleged deficient practice. The expired refrigerated and frozen foods were immediately removed at the time of observation. The condensation drainage tubing was noted to be kinked along with a broken seal. Both items were corrected and no water has been noted in refrigerator. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** There were no residents affected by the alleged deficient practice; however, all resident have the potential to be affected. An audit has been implemented will continue to monitor for expired foods and water condensation in the refrigerator. Any noted discrepancies were immediately corrected. ***What measures will be put into place and what systemic changes will be made to ensure***	04/10/2025

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	water spilled down inside of refrigerator and onto the floor. Boxes on the shelves were wet. Food items inside boxes were sealed. On 3/19/25 at 11:05 a.m., during interview the Dietary Manager indicated he did not know where the water in the refrigerator was from. On 3/18/2025 at 11:48 a.m., the Administrator provided a document titled, "Magnolia Health Systems storage guidelines for Refrigerator/freezer/dry storeroom," dated 3/2017, and indicated it was the policy currently being used by the facility. The policy indicated, "...Angel food cake 6-12 months, Pie Shells 12 months freezer, Shredded lettuce (opened) 3 days: reseal tightly, Tomatoes 3 days ...." 3.1-21(i)(1) 3.1-21(i)(3)		***that the deficient practice does not recur?*** The facility food storage and expiration guidelines have been reviewed and no changes are indicated. All dietary staff will be re-educated on the facility's policy. The in-service will focus on monitoring the refrigerator for condensation and to monitor all foods for expiration dates and destroying if applicable. A monitoring tool has been implemented. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** The Dietary Manager, or designee, will be responsible for completing the monitoring tool to ensure there is no excessive condensation in the refrigerator and that all food stored is dated and not expired. Refrigerator, freezer and dry storage rooms will be audited weekly for 4 weeks, then every other week for 4 weeks, then monthly thereafter. Should any concerns be found, immediate corrective action will occur. Results of these audits and any corrective action will be discussed during the facility's QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices until 100% compliance is achieved.	

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			Date of completion: April 10, 2025	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on record review and interview, the facility failed to ensure documentation of the facility contact with the hospital prior to a resident transfer was completed timely for 1 of 4 residents reviewed for hospitalization (Resident 31). Findings include: Resident 31's record was reviewed on 3/17/25 at 2:31 p.m. The profile indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD- a group of lung diseases that cause ongoing inflammation and damage to the airways and air sacs in the lungs), cerebral infarction (a condition where brain tissue dies due to a lack of blood flow caused by a blockage in a blood vessel), and late-onset Alzheimer's disease (a common form of dementia that starts after the age of 65. It can cause memory and cognition issues, impaired judgment, and other symptoms as it progresses). A 5-day Minimum Data Set (MDS) assessment, dated 2/4/25, indicated the resident had moderate cognitive deficit, was totally dependent with all activities of daily living (ADLs-fundamental tasks essential for independent living, including basic self-care and mobility, like bathing, dressing, eating, and toileting), and required continuous oxygen (O2). The census indicated that the resident had been hospitalized from 3/9/25 to 3/13/25.	F 0842	**F842** ***What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** The noted resident, number 31, was not negatively affected by the alleged deficient practice. The missing transfer documentation was corrected to the resident's chart at the time of observation. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** None of the residents were negatively affected by the alleged deficient practice; however, all residents being transferred to the hospital have the potential to be affected. An audit for all residents transferred to the hospital has been implemented to ensure all needed documentation is completed and in the resident's chart. Any noted discrepancies were immediately corrected. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?***	04/10/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The initial review of the record lacked documentation of facility contact with the hospital emergency room (ER) to provide a report of the transfer. During a follow-up review of the resident's record, on 3/18/25 at 2:10 p.m., a late entry progress note, dated 3/18/25 at 1:48 p.m. for 3/9/25, indicated the family and ER had been notified. At the same time the Corporate Nurse Consultant indicated it was dated a late entry on 3/18/25, because the note had just been placed in the record. The note had been added as a plan of correction after it was discovered that there had not been a note written at the time of the transfer. On 3/18/25 at 3:40 p.m., the Administrator provided a document, dated 10/2014, titled, "Charting and Documentation," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: Nurse's notes shall be written on each resident...and shall address the resident's conditions...entries shall be dependent on individual residents' needs and any pertinent change in condition...Document significant information...." 3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(h)(5)(F) 3.1-50(i) 3.1-50 (a)(1)(h)(3)		The facility charting and documentation policy has been reviewed and no changes are indicated. All nurses will be re-educated on the facility's policy. The in-service will focus on required information to include in progress notes for resident's requiring transfers to the hospital. Discharge packets and checklist have been placed at all nurse stations. A monitoring tool has been implemented. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** The DON, or designee, will be responsible for completing the monitoring tool to ensure that all documentation for residents transferred to the hospital is complete. Documentation for all transfers to the hospital will be audited daily for 4 weeks, then weekly for 4 weeks, and will continue monthly for all transfers. Should any concerns be found, immediate corrective action will occur. Results of these audits and any corrective action will be discussed during the facility's QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices until 100% compliance is achieved. ***Date of completion: April 10, 2025***	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155234	A. BUILDING 00 B. WING	03/20/2025

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F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review, and interview, the facility failed to ensure proper handling of the glucometer (small portable machine that's used to measure how much glucose [type of sugar] is in the blood) meter during 2 of 2 blood glucose monitoring opportunities (Residents 42 and 35). Findings include: 1. During a blood glucose monitoring observation, on 3/19/25 at 11:11 a.m., the Qualified Medication Aide (QMA) 7 entered Resident 42's room and placed the glucometer onto her side table, no barrier placed under the meter. The QMA returned the glucometer to a resident specific black case and placed it back in the medication cart. Resident 42's record was reviewed on 3/19/25 at 1:10 p.m. The profile indicated the resident diagnosis included, but were not limited to, type 2 diabetes mellitus with hyperglycemia (occurs when the body either doesn't produce enough insulin or its cells don't respond properly to insulin, leading to a buildup of glucose [simple sugar] in the blood stream). 2. During a blood glucose monitoring observation, on 3/19/25 at 11:17 a.m., QMA 7 entered Resident 35's room and placed the glucometer onto her side table, no barrier placed under the meter. The QMA returned the glucometer to a resident specific black case and placed it back in the medication cart. During an interview, on 3/19/25 at 11:17 a.m., QMA 7 indicated the night shift nurses clean the	F 0880	**F880** ***What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** The noted residents, number 42 and 35, were not negatively affected by the alleged deficient practice. Nursing staff have been re-educated on proper handling of the glucometer when using to obtain resident's glucose, this includes placing a barrier under the meter. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** None of the residents were negatively affected by the alleged deficient practice; however, all residents that require the monitoring of glucose with a glucometer have the potential to be affected. An audit monitoring nursing staff during the collection of glucose with a glucometer was completed and ongoing. Any noted discrepancies were immediately corrected. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?***	04/10/2025

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	glucometers, but she also cleans the machines at the end of her shift daily. Resident 26's record was reviewed on 3/19/25 at 1:20 p.m. The profile indicated the resident diagnosis included, but were not limited to, type 2 diabetes mellitus without complications (a state where the body doesn't produce enough insulin or doesn't use it properly, leading to high blood sugar). During an interview, on 3/20/25 at 9:11 a.m., QMA 10 indicated a paper towel should be placed under the glucometer as a barrier when placing the glucometer on a surface. She indicated this was to prevent any cross contamination. On 3/19/25 at 1:30 p.m., the Cooperate Nurse Consultant provided a document, dated 10/2014, titled, "Blood Glucose Measurement, Evencare G2," and indicated it was the policy currently being used by the facility. The policy indicated, " ...1. Select the resident specific meter/case to be utilized. Place a clean paper towl on the bedside table or stand. Place the close case on the paper towel ...." 3.1-18(a)		The facility blood glucose measurement policy has been reviewed and no changes are indicated. All nursing staff that can collect glucose levels will be re-educated on the facility's policy. The in-service will focus on the steps of the procedure, including placing the barrier on a surface. A monitoring tool has been implemented. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** The DON, or designee, will be responsible for completing the monitoring tool to ensure that all nursing staff collecting glucose with a glucometer are following the facility's policy and procedure. DON, or designee, will monitor 5 random residents 5 times per week for residents requiring glucose monitoring for 4 weeks, then 3 times every other week for 4 weeks, then monthly thereafter. Should any concerns be found, immediate corrective action will occur. Results of these audits and any corrective action will be discussed during the facility's QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices until 100% compliance is achieved. ***Date of completion: April 10, 2025***	

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