STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BLOOM AT KOKOMO	2800 S DIXON RD KOKOMO, IN 46902

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00407320. Complaint IN00407320. No deficiencies related to the allegations are cited. Survey dates: June 21 and 22, 2023 Facility number: 011366 Residential Census: 82 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on June 30, 2023.	R 0000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of the plan of correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by state law. Bloom at Kokomo desires this Plan of Correction to be considered the community's Allegation of Compliance. Compliance is effective July 21, 2023.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
James Kesler	Executive Director	07/14/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure an attempt was made to hold fire drills in conjunction with the local fire department at least every six (6) months for the twelve (12) months reviewed for fire drills. Finding includes: During a review of the twelve yearly fire drills, there was no documentation to include the local fire department had been contacted to participate in any of the facility fire drills. During an interview, on 6/21/23 at 12:45 p.m., the Executive Director (ED) indicated the facility did not have documentation the local fire department had been contacted and asked to participate in any of the twelve fire drills. The fire department was at the facility, August 9, 2023, due to a fire alarm not being silenced. The facility did not have a policy on including the local fire department in the drills.	R 0092	Deficiency ID: R 0092 Completion Date: July 21, 2023 Plan of Correction Text: **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** All residents living in the community had the potential to be affected. None were affected. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents living in the community had the potential to be affected. Executive Director to schedule a Fire and Disaster Drill in conjunction with local fire department by July 15th. Executive Director or designee to invite local fire department at a minimum of at least once every six months (July and December). **What measures will be put in place or what systematic changes the facility will make**	07/21/2023

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			to ensure that the deficient practice does not recur: The facility Policy and Procedure for Fire and Disaster Drills were reviewed and by Executive Director, Administer in Training, and Maintenance Director. Fire and Disaster Drill results including invitations to local fire department will be audited monthly by Administrator or designee. **How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place:** Fire and Disaster Drill results will be audited monthly utilizing a Fire and Disaster audit tool by Administrator or designee. Results of audit will be reviewed in monthly QA meeting by Administrator and leadership team. Any issues or concerns will be corrected.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake			

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	staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure staff met the requirements of Cardiopulmonary Resuscitation (CPR) and First Aid staffing for 8 of 42 shifts reviewed for CPR and first aid certificates. Findings include: A record review, on 6/22/23 at 11:00 a.m., indicated multiple shifts from Thursday 6/15/23 through Wednesday 6/21/23 were not staffed with CPR and First Aid certified staff. The dates and shifts included were: a. Thursday, 6/15/23, no CPR coverage for the day and night shift. b. Thursday, 6/15/23, no First Aid coverage for the night shift. c. Friday, 6/16/23, no First Aid coverage for the day and night shift. d. Sunday, 6/18/23, no First Aid coverage for the day shift. e. Monday, 6/19/23, no First Aid coverage for the day shift. f. Wednesday, 6/21/23, no First Aid coverage for	R 0117	Deficiency ID: R 117 Completion Date: July 21, 2023 Plan of Correction Text: **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** All residents living in the community had the potential to be affected. None were affected. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents living in the community had the potential to be affected. Executive Director to ensure that a minimum of 1 awake staff person with current CPR and first aid certificates is on site at all	07/21/2023

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	the night shift. During an interview, on 6/22/23 at 3:00 p.m., the Executive Director indicated he did not know why there was no CPR and First Aid coverage for the missing shifts. The facility did not have a policy on Associates CPR and First Aid requirements.		times. **What measures will be put in place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** A new facility Policy and Procedure for CPR and First Aid was implemented by the Area Director of Operations. Policy and Procedure reviewed and by Executive Director, Administer in Training, and Wellness Director. A monthly audit of CPR and First Aid certifications will be performed before creating staffing schedules. **How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place:** CPR and First Aid certifications will be audited monthly utilizing a CPR/First Aid audit tool by Administrator or designee. Results of audit will be reviewed in monthly QA meeting by Administrator and leadership team. Any issues or concerns will be corrected.	
R 0296 Bldg. 00	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for			

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	ongoing training to ensure competence of medication staff. Based on observation, interview and record review, the facility failed ensure the competence of medication staff when medications were not administered as ordered by the physician for 1 of 5 residents reviewed for medication administration. (Resident 14) Finding includes: The record for Resident 14 was reviewed on 6/22/23 at 10:15 a.m. Diagnoses included, but were not limited to, hypertension, dementia, type 2 diabetes mellitus, and kidney disease. A physician's order, dated 2/7/23, indicated to administer metoprolol (a medication to treat high blood pressure) 25 mg (milligram) at 7:00 a.m., 1:00 p.m. and 7:00 p.m. During a medication administration observation, on 6/21/23 beginning at 4:00 p.m. and ending at 4:40 p.m., LPN 3 attempted to administer Resident 14 the metoprolol which would have been more than two hours early. A medication administration policy had not been received from the facility at the time of exit.	R 0296	Deficiency ID: R 296 Completion Date: July 21, 2023 Plan of Correction Text: **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** None were affected. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents living in the community that receive medication administration had the potential to be affected. All nursing staff will receive medication administration education to include the 5 Rules of Medication Administration by July 20th 2023, and quarterly thereafter. **What measures will be put in place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** Medication Administration Policy and Procedure was reviewed and by Executive Director, Administer in Training, and Wellness Director. All nursing staff will receive medication administration	07/21/2023

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			education to include the 5 Rules of Medication Administration by July 20th 2023, and quarterly thereafter. **How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place:** Medication Administration Audits will be completed daily for 4 weeks and twice weekly there after by Wellness Director or designee. Results of audit will be reviewed in monthly QA meeting by Administrator and leadership team. Any issues or concerns will be corrected.	
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days.			

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	Based on observation, interview and record review, the facility pharmacy failed to ensure the facility had policies and practices in place for medication storage, disposing of medication, and verifying controlled substance counts for 1 of 1 medication room observed and 2 of 3 medication carts observed. Findings include: 1. During a medication storage observation, starting on 6/21/23 at 12:48 p.m., the following was observed in the medication storage room on the second-floor memory care unit: a. The medication refrigerator used to store medications and vaccines did not have temperatures completed on June 9, June 17, and June 18, 2023. b. The medication refrigerator had medications on the top shelf and medication on the shelf inside the door. There was applesauce and chocolate syrup also stored on the shelf inside the door. The lower shelf had cans of soda on it. 2. During a medication storage observation, starting on 6/21/23 at 12:48 p.m., the medication cart on the second-floor memory care unit was observed to have the following: c. One Lantus (long acting) insulin pen for Resident 14 which was opened and not dated. d. One Humalog (fast acting) insulin pen for Resident 14 which was opened and not dated. e. One Lantus insulin pen for Resident 11 which was opened and not dated. d. The narcotic count book had no signatures to indicate two nurses had confirmed the controlled drug counts on June 10, 14, 15, and 17, 2023. e. One card of tramadol (narcotic pain medication) 50 mg (milligram) for Resident 11 had the foil opened for dose 6 and the pill was held on the	R 0298	Deficiency ID: R 298 Completion Date: July 21, 2023 Plan of Correction Text: **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** Resident 14 and 11's injectable medication was disposed of at time of survey and new injectable medication was opened and dated and is being stored and administered per pharmacy policy. Resident's 11 improperly stored tramadol was discarded at time of survey per pharmacy policy and is now being stored, counted and administered per pharmacy policy. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents living in the community who receive medication administered by the facility staff have the potential to be affected. All residents who receive medication administered by the facility will have it stored, administered, and accounted for per the pharmacy policy. **What measures will be put in place or what systematic changes the facility will make**	07/21/2023

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	card with tape. A physician's order, dated 9/27/22, for Resident 14 indicated to inject Lantus insulin 22 units daily at 8:00 a.m. A physician's order, dated 8/5/20, for Resident 14 indicated to inject lispro (generic for Humalog) insulin three times a day per sliding scale. A physician's order, dated 8/3/22, for Resident 11 indicated to inject Lantus insulin 28 units daily at 8:00 a.m. 3. During a medication storage observation, on 6/21/23 at 1:15 p.m., the following was observed: a. The first-floor memory care unit medication cart had missing signatures for the controlled drug count sheets on June 1, 2, 9 and 19, 2023 to confirm two nurses had verified the controlled substance count. During an interview, on 6/21/23 at 12:50 p.m., the Wellness Director indicated the tramadol 50 mg tablet should not have been taped to the medication card and two nurses should have disposed of the medication. The nurses should have signed the controlled drug count sheets with two nurses at each shift change. During an interview, on 6/21/23 at 2:39 p.m., the ED (Executive Director) indicated the facility did not have a policy for the medication refrigerator to indicate if medications and food could be stored together and no policy on keeping track of the medication refrigerator temperatures. There was no policy on labeling insulin pens when opened. During an interview, on 6/22/23 at 2:40 p.m., the ED indicated the controlled substance count		**to ensure that the deficient practice does not recur:** The facility has received and reviewed the pharmacy policy and procedure manual. All staff who administer medication have been educated on medication storage, disposing of medication, and verification of controlled substance counts. The Director of Nursing or designee ill conduct audits 5 times weekly for 1 month, then 2 time weekly thereafter to ensure compliance. **How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place:** The Director of Nursing or her Designee will conduct audits 5 times weekly for 1 month then 2 times weekly thereafter to ensure compliance. Results of audit will be reviewed in monthly QA meeting by Administrator and leadership team. Any issues or concerns will be corrected.	

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	should be completed between the oncoming nurse and outgoing nurse with signatures from each nurse. The temperatures for all refrigerators including the medication refrigerator should be documented daily. A current policy, titled "Refrigerator/Walk-in Cooler Temperature," dated September 2011 and received from the ED on 6/22/23 at 8:56 a.m., indicated "...It is the policy...to record the temperatures on a daily basis for all the walk-in coolers, stand-up coolers, refrigerators and freezers...." The CDC Storage Best Practices for Refrigerated Vaccines, not dated, indicated "...Don't put food or beverages in refrigerator...." The current Nursing Drug Handbook indicated Lantus insulin pens could be stored at room temperature and must be discarded after 28 days, The current Nursing Drug Handbook indicated Humalog insulin pens could be stored at room temperature and must be discarded within 28 days.			
R 0301 Bldg. 00	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription.			

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	If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation, interview and record review, the facility failed to ensure insulin had pharmacy labels which included the name of the physician, the prescription number, date of issuance and name of the pharmacy which filled the prescription in 1 of 3 medication carts reviewed for medication storage. (Third-floor cart) Finding includes: During a medication storage observation, on 6/22/23 at 10:00 a.m., the third-floor medication cart had the following: a. A clear plastic bag for Resident 60 which included an insulin pen, blood glucose meter and lancets. The plastic bag had hand printed instructions which indicated to complete an accucheck in the morning and evening and to administer Levemir (long acting) insulin 40 units daily in the morning. The label was not from the pharmacy and did not include the name of the physician, the prescription number, the date the insulin was filled or the name of the pharmacy. b. A clear plastic bag for Resident 36 which included an insulin pen, blood glucose meter and lancets. The plastic bag had handwritten instructions to inject Fiasp (fast acting insulin) 8 units three times a day with meals, to inject Humulin 70/30 (intermediate acting) insulin 40 units once daily in the morning and sliding scale insulin in the evening. The label was not from the pharmacy and did not include the name of the physician, the prescription number, the date the insulin was filled or the name of the pharmacy. A physician's order, dated 4/5/22, for Resident 60	R 0301	Deficiency ID: R 301 Completion Date: July 21, 2023 Plan of Correction Text: **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** None were affected. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents living in the community who receive medication administered by the facility staff have the potential to be affected. All residents who receive medication administered by the facility will have it labeled, stored, administered, and accounted for per the pharmacy policy. **What measures will be put in place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** The facility has received and reviewed the pharmacy policy and procedure manual. All staff who administer medication have been	07/21/2023

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	indicated to administer Levemir insulin 40 units daily at 8:00 a.m. A physician's order, dated 9/7/22, for Resident 36, indicated to inject 8 units of Fiasp insulin three times a day with meals. A physician's order, dated 9/29/22, for Resident 36 indicated to inject 40 units of Novolin (same insulin as Humulin) 70/30 insulin in the morning and Novolin 70/30 per sliding scale in the evening. During an interview, on 6/22/23 at 9:57 a.m., the ED (Executive Director) indicated the facility nurses had hand printed the insulin orders on the plastic bags and the labels did not come from the pharmacy. A current policy, titled "Medication Storage," dated May 2012 and received from the ED on 6/23/23 at 2:27 p.m., indicated "...Medications shall be stored in the container which is supplied by the pharmacy. These medication containers shall retain their original pharmacist label...." A current policy, titled "Medication Labeling," dated May 2012 and received from the ED on 6/22/23 at 8:56 a.m., indicated "...All medications must be labeled in a container that conforms to State regulations and should be consistent with physician's orders...The Nurse, or designee, who receives medication is responsible for verifying that the label is correct. Any item that is not properly labeled shall be returned to the supplier[...pharmacy...family...]...Medication containers having soiled, damaged, incomplete, illegible, or make-shift labels shall be returned to the supplier for re-labeling or disposal...The medication label must not be altered or modified by any associate in any way resulting in damage		educated on medication labeling and storage. The Director of Nursing or designee will conduct audits 5 times weekly for 1 month, then 2 time weekly thereafter to ensure compliance. **How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place:** The Director of Nursing or her Designee will conduct audits 5 times weekly for 1 month then 2 times weekly thereafter to ensure compliance. Results of audit will be reviewed in monthly QA meeting by Administrator and leadership team. Any issues or concerns will be corrected.	

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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
	to the original label...Labels must be firmly affixed to the container...The containers of all medications shall bear a label containing all of the following information...Name and strength of the medication...Quantity in the container...Name of the resident...Directions for use...Name of the physician...Date the drug was dispensed...Name and address of the pharmacy...Prescription number...Expiration date, when applicable...."			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, interview and record review, the facility failed to ensure there was a procedure in place for cleaning blood glucose meters after use, to ensure the staff were aware of what to use for cleaning and disinfecting the glucometers, to ensure glucometers were cleaned after use, and to ensure glucometers were not used for more than one person unless cleaned and disinfected for 3 of 12 residents who received blood glucose monitoring. Finding includes: 1. During a medication storage observation, on 6/21/23 at 12:48 p.m., with the Wellness Director	R 0407	Deficiency ID: R 407 Completion Date: July 21, 2023 Plan of Correction Text: **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** None were affected. **How the facility will identify other residents having the potential to be affected by the same deficient practice and**	07/21/2023

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		A. BUILDING 00 B. WING	06/22/2023

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	and LPN 2, the medication cart on the 2nd floor memory care unit had one glucometer in the top drawer without a resident name. The medication cart had alcohol prep pads and no other cleaning wipes noted in or on top of the medication cart. During an interview, on 6/21/23 at 12:50 p.m., LPN 2 indicated the glucometer was used for any resident who may need to have a blood glucose check completed and did not have their own glucometer. During an interview, on 6/21/23 at 12:51 p.m., the Wellness Director indicated alcohol prep pads were approved to clean the glucometers and there were no other cleaning wipes or solution in the facility for cleaning the glucometers. 2. During a medication administration observation, on 6/21/23 starting at 4:40 p.m., LPN 3 completed a blood glucose meter check for Resident 14 and did not clean the glucose meter before or after the procedure. 3. During a medication storage observation, on 6/22/23 at 9:57 a.m., with the ED (Executive Director) and LPN 2, the medication first-floor cart had one glucometer used for Resident 79 and Resident 69. During an interview, on 6/22.23 at 9:59 a.m., the ED indicated the Sani-cloths (a disinfectant cloth utilized for non-porous hard surfaces and medical devices for high level disinfection) were at the nurses' station and he was not sure why the Wellness Director did not know this information. He was not sure the reason Resident 79 and Resident 69 did not have their own glucometers. During an interview, on 6/22/23 at 10:00 a.m., LPN		**what corrective action will be taken:** All residents living in the community that receive blood sugar monitoring had the potential to be affected. All nursing staff will receive infection control education to include the cleaning of glucometers. All residents that require glucose monitoring will have an individually assigned glucose monitor that will be cleaned after each use. **What measures will be put in place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** Infection Control Policy and Procedure was reviewed and by Executive Director, Administer in Training, and Wellness Director. All nursing staff will receive Infection Control (Glucose Monitor Cleaning) education. PDI Sani-Cloth wipes will be available at each nurse station for proper cleaning of Glucose Monitors. **How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place:** Infection Control Audits will be completed daily for 4 weeks and twice weekly there after by Wellness Director or designee. Results of audit will be reviewed in monthly QA meeting by	

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	2 indicated if the facility had the Sani wipes, they would be used to clean the glucometers and if there were no Sani wipes available then alcohol prep pads were used. More often than not, the alcohol pads were used to clean the glucometers. During an interview, on 6/22/23 at 10:40 a.m., the ED indicated the facility did not have a policy on the cleaning of the glucometers and the infection control policy did not include the cleaning of the glucometers. The "Aga Matrix Presto blood glucose monitoring system Owner's Guide," not dated and provided by the ED on 6/22/23 at 10:50 a.m., indicated "...This system should be used: for use at home...by persons with diabetes or in a clinical setting by healthcare progressions as an aid to monitor the effectiveness of diabetes control...When should you clean your meter...Important health related information...Healthcare professionals should use their institutions infection control procedures...." A current policy, titled "Equipment and Supplies for Administering Medications," dated as reviewed on 5/31/23 and received from the ED on 6/22/23 at 12:22 p.m., indicated "...The facility will maintain the necessary equipment and supplies for the preparation and administration of medication[s] with minimal interruptions...Glucometer, glucometer cleaning/disinfecting supplies...." The CDC (Centers for Disease Control and Prevention) guidance for "Infection Prevention during Blood Glucose Monitoring and Insulin Administration," indicated "...The Centers for Disease Control and Prevention [CDC] has become increasingly concerned about the risks for		Administrator and leadership team. Any issues or concerns will be corrected.	

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	transmitting hepatitis B virus [HBV] and other infectious diseases during assisted blood glucose [blood sugar] monitoring and insulin administration...Whenever possible, blood glucose meters should not be shared. If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions. If the manufacturer does not specify how the device should be cleaned and disinfected, then it should not be shared...." A CDC, "Guidelines for Disinfection and Sterilization in Healthcare Facilities," indicated "...Alcohols are not recommended for sterilizing medical and surgical materials...."			