STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185124	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbanks	851 Kimsey Lane Henderson, KY 42420

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** AMENDED Based on observation, interview, record review, and facility policy review, the facility failed to ensure drugs and/or biologicals used in the facility were current for use and/or stored and labeled in accordance with currently accepted professional principles, including the expiration date when applicable. Medications and nutritional supplements were opened but not labeled with a date as to calculate the discard date. Medications were found loose, without identification as to whom they belonged and/or what they were. This failure affected three of three medication rooms observed (out of a total of five rooms) and two of five medication carts observed (out of a total of nine carts.) The findings include: Review of the facility's policy, titled Storage of Medications, revised 04/2007, revealed the facility shall store all drugs and biologicals in a safe, secure, and orderly manner and the nursing staff shall be responsible for maintaining medication storage. Additionally, drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received. Review of the facility's policy, titled Administering Medications, revised 12/2012, revealed the expiration/beyond use date on the medication label must be checked prior to administering and that when opening a multi-dose container, the date opened shall be recorded on the container. 1. Items not dated upon opening: a. An observation of the [NAME] Unit Medication Cart 1 on 06/12/2025 at 8:55 AM revealed one 8.3-ounce bottle of PEG 335 Polyethylene Glycol for R141, as well as one 4.1-ounce bottle of PEG Clear Lax for R140, which were opened but not dated. b. Observation of the [NAME] Unit medication room on 06/12/2025 at 8:45 AM revealed one 32-fluid ounce container of Med Plus NSA 1.7, High Calorie, High Protein Nutritional Drink, Vanilla Flavor, one 32-fluid ounce container of Med Plus 2.0, High Calorie, High Protein Nutritional Drink, Butter Pecan Flavor, and one 46- fluid ounce container of ReadyCare Thickened Orange Juice in the refrigerator that were opened. None of these containers had a date indicating when the containers were opened, resulting in no way of determining the use by date. In an interview with Licensed Practical Nurse (LPN) 4 during observation of the [NAME] Unit medication room on 06/12/2012 at 8:50 AM, she stated that she writes the date on anything she opens and that is what should be done by everyone. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. An observation of the South medication room on 06/11/2025 at 3:39 PM revealed a 32- ounce container of Med Pass that was opened but not dated. Interview with Certified Medication Aide (CMA) 8 revealed that containers should be dated by whoever opened them. CMA 8 stated the container should be thrown away since staff would not be sure of how long it had been opened and opened containers should be discarded 30 days after opening them. During an interview with Registered Nurse (RN) 1 on 06/11/2025 at 3:55 PM, she stated all medicine should be dated when opened and should not be given to the residents as it could be expired. During an interview with the South Hall Unit Manager (UM) on 06/12/2025 at 4:10 PM, she stated the CMAs and Nursing staff were responsible to check the medication rooms weekly as part of their assigned duties. She stated the facility uses a lot of Med Pass, but she expected staff to date the container as they open it. During an interview with the Director of Nursing (DON) on 06/12/2025 at 3:40 PM, she stated she expected staff to date and initial any item when they open it. Additionally, she stated that central supply staff are to check supply expiration dates on their daily rounds, and if an item was not dated, it should be disposed of. The DON stated the unit manager was responsible for checking the medication rooms for expired medications as part of their weekly rounds. Interview with the Executive Director on 06/12/25 at 4:15 PM, revealed that containers of nutritional drinks/supplements should be dated when opened and that dietary staff and nurses putting new items in a refrigerator should check dates. 2. Expired Supplies: a. An observation of the [NAME] Unit Medication room on 06/12/2025 at 08:45 AM revealed one bag of 0.45% potassium chloride in normal saline 1000 milliliters, dated 05/25. In an interview with LPN4 during this observation, she stated that expiration dates should be checked prior to using any IV fluids and, The IV bag should have been thrown out. b. Observation of the [NAME] Unit medication room on 06/12/2025 at 8:45 AM revealed an Intel Swab Covid 19 Rapid Test on the supply shelf with an expiration date of 11/30/2024. Observation of the Harbor Unit medication room on 06/12/2025 at 9:25 AM also revealed an OHC Covid-19 Antigen Self-Test on the supply shelf with an expiration date of 01/27/2024. Interview with LPN5 during the observation of the Harbor Unit medication room on 06/12/2025 revealed that covid tests should be thrown away when expired. In an interview with the DON on 06/12/2025 at 3:40 PM, she stated that central supply staff are to check supply expiration dates on their daily rounds. She stated if containers are expired, there is a chance to have a negative outcome for the resident. In an interview on 06/12/25 at 4:15 PM, the Executive Director stated that expired medications should be thrown out. She added that the responsibility to check expiration dates falls on the nurse using the product, and they should check the expiration date before using a product. 4. Unlabeled/Unidentified Medications: a. Observation of [NAME] Medication Cart 1 at 8:56 AM on 06/12/2025 revealed loose medications in (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the drawers without identifying information such as the name of the resident for whom it was prescribed, and the name/dose of the medication. In the left side Drawer 2, there was a capsule which was gray on one end and brown on the other end and Lifestar 404 printed on the capsule. (Per a pill identifier, this capsule was nitrofurantoin 100 milligrams (mg) (an antibiotic).) In the left side Drawer 3, there was a green, oval tablet with E imprinted on one side and 47 imprinted on the other. (Per a pill identifier, this tablet was losartan potassium 100mg (used to treat high blood pressure).) In the left side Drawer 4, there was a white, round tablet with ZC41 imprinted on one side. (Per a pill identifier, this tablet was carvedilol 12.5mg (used to treat conditions related to the heart and blood vessels).) In an interview with LPN 4 during observation of the [NAME] Unit medication room on 06/12/2012 at 8:50 AM, she stated that it is easy for pills to pop out of their cards when being replaced in the cart but they should have been removed from the draw and wasted. b. An observation of the South Medication Room on 06/11/2025 at 3:39 PM revealed a paper medicine cup in a drawer that contained a half tablet inside of the cup. The bottom of the medication cup had a handwritten note identifying the tablet as Keppra 250mg. During an interview with CMA8, she stated she did not know who the Keppra tablet belonged to or how long it had been in the drawer, adding that it should be discarded. During an interview with RN1 on 06/11/2025 at 3:55 PM, she stated she was not aware of the Keppra being in the drawer and did not know how long it had been there, adding that it should be discarded. She stated the nurses were responsible for checking the medication rooms but did not know how often it should be done. During an interview with the South Hall Unit UM on 06/12/2025 at 4:10 PM, she stated she did not have an explanation as to why the Keppra was found in a drawer. She stated it was in a drawer on the side of the medication room that was not often even used and had no idea why it was in there. Further interview revealed her statement that the CMAs and Nursing staff were responsible to check the medication rooms weekly as part of their assigned duties. In an interview with the DON on 06/12/2025 at 3:40 PM, she stated that she would not expect to find loose pills in medication carts, but it can happen, and her expectation was that staff would check for things like that. Additionally, she stated her expectation was that that the unit managers would check the medication rooms weekly and that medication carts would be cleaned weekly.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of facility policy, it was determined that the facility failed to store food in accordance with professional standards for food service safety and quality. Opened foods were not dated. Expired foods and/or foods which were past their use by date were available for use and service to residents. This failure had the potential to affect 129 of 131 residents who consume food from the facility's kitchen and/or unit refrigerators. The findings include: Review of the facility policy titled Food: Preparation, with a revision date of 02/2023, revealed Item 17 stated that all refrigerated, ready-to-eat Time/Temperature Control for Safety (TCS) prepared foods that are to be held for more than 24 hours at a temperature of 41 degrees F or less, will be labeled and dated with a prepared date (Day 1) and a use by date (Day 7). Observation of the walk-in refrigerator, on 06/10/2025 at 6:25 AM, revealed one partial box of cabbage containing two bags of cabbage with showed a use by date of 06/08/2025. One opened bag of lettuce had a use by date of 06/08/2025 and showed browning of the lettuce. Observation of the reach-in refrigerator, on 06/10/2025 at 6:35 AM, revealed one partial container of ham salad with a use by date of 05/03/2025, one partial container of potato salad with a use by date of 05/25/25, and one open container of parmesan cheese with an open date of 04/08/2025. Ongoing observation of the Reach-in Refrigerator for Cooks revealed two chicken salad sandwiches dated with a use by date of 06/09/2025. In addition, this refrigerator contained an open gallon jug of mayonnaise that was undated (no open date), and an open jug of teriyaki sauce with a received date of 05/28/2025 which did not list an open date. Observation on 06/12/2025 at 1:15 PM of the Central nursing station resident food refrigerator revealed 15 single-serve grape juice containers with best by dates of 01/17/2025 and 06/08/2025. Observation on 06/12/2025 at 1:30 PM of the South Port nursing station resident food storage revealed seven single-serve grape juice containers with a best by date of 01/17/2025. Interview with the Dietary Manager (DM) on 06/10/2025 at 6:30 AM, revealed that dietary staff should have removed the items which were beyond their use by date from the refrigerator. Additional interview with the DM, on 06/12/2025 at 2:03 PM, revealed that once food leaves the kitchen, it is a team effort of the floor staff and kitchen staff to ensure items are not stored beyond the best by date for food safety to prevent food related illness. In an interview with the Dietary Supervisor (DS) on 06/12/2025 at 2:10 PM, the DS stated that it was his expectation that staff provide nutritious and filling meals without bacterial growth. He stated once food was past the beyond use date, there was the potential to allow bacteria to grow and potentially cause foodborne illness. He added that in the cooler, longer storage times would allow increased moisture to form that alters the environment and may allow for contamination or cross contamination. In an interview with the Director of Nursing (DON) on 06/12/25 at 3:42 PM, the DON stated that it was the responsibility of the kitchen to remove the beyond use juices from the unit refrigerators. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	She stated the dietary department has a stock list and pantry list that is brought to each unit every day that includes juices, as well as other items, and the juices should be switched out every day by the dietary staff when they bring out the new tray of juices. Interview with the Executive Director on 06/12/25 at 4:15 PM revealed she expected food items to be labeled and dated to prevent potential food-borne illnesses.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases for four (Resident (R)109, R93, R37, and R41) of five sampled residents reviewed for infection control. Facility staff failed to indicate, via signage, the need for precautions, as well as provide and/or ensure the use of Personal Protective Equipment (PPE) and hand hygiene by staff and visitors for R109, who was on contact isolation precautions. Action to protect others from the risk of infection was not taken when R109 was out of her room for non-essential purposes. In addition, staff failed to follow manufacturer's instructions after cleaning/disinfecting a used glucometer used on R41. During medication pass for R93 and R37, staff handled medications with bare hands, did not perform hand hygiene as required and/or administered medication that had fallen on top of the medication cart. Findings include: 1. Review of R109's Face Sheet revealed that the facility admitted the resident on 01/11/2025 with diagnoses including non-traumatic brain dysfunction and unspecified dementia. R109 was placed on the facility's secured memory care unit. Review of R109's Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 04/19/2025, revealed a Brief Interview for Mental Status (BIMS) score of 12/15, which indicated the resident had moderate cognitive impairment. Per this MDS, the resident required substantial/maximal assistance from staff with transfers and was occasionally incontinent of both bowel and bladder. Review of R109's current physician's orders revealed a new order, dated 06/07/2025 at 6:56 PM, for Macrobid (antibiotic) 100 milligrams (mg) oral capsule twice daily for a diagnosis of extended-spectrum beta-lactamase (ESBL - a type of Multidrug Resistant Organism (MDRO). Further review of physician's orders revealed an order dated 06/08/25 at 11:06 AM for Contact Isolation Precautions. Review of this order revealed it did not note whether the resident's infection was contained or not and did not indicate that the resident could leave their room. a. Review of the facility policy titled, Infection Control: Standard Precautions and Isolation, revised 10/2018, revealed its purpose is to guide care for residents known or suspected to have serious illnesses that are easily transmitted through direct contact or contact with contaminated items in the resident's environment. Further review of the policy revealed staff are to wear gloves (clean, nonsterile gloves are adequate) when entering the room if any contact is to be made with the resident or items in the room; change gloves after having contact with infective material that may contain high concentrations of microorganisms (fecal material and wound drainage); and remove gloves before leaving the resident's environment and wash hands immediately with an antimicrobial agent or a waterless antiseptic agent. The policy also stated to wear a gown (a clean, nonsterile gown is adequate) when entering the room if substantial contact is anticipated with the resident, environmental surfaces, or items in the room, or if the resident is incontinent or has diarrhea, an ileostomy, a colostomy, or wound drainage not contained by a dressing; and to remove the gown before leaving the resident's environment. The policy failed to address whether signage was required to be posted to indicate when precautions are in place. Observation of R109's room on 06/10/2025 at 6:30 AM revealed R109 was asleep in her bed. The (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's room contained two large red bins with lids marked with biohazard signage. Continued observation revealed no signage was posted either outside or inside the room to indicate that R109 was on any type of precautions. There was no Personal Protective Equipment (PPE) such as gloves and gown required for Contact Precautions present at the door prior to entering the room or visible inside the room. Observation of R109's room on 06/10/2025 at 6:42 AM revealed State Registered Nurse Aide (SRNA) 3 entered the room without donning PPE (including gloves or gown) and, using his bare hands, placed a large yellow plastic bag into one of the two red biohazard bins in the rooms. He then exited the room without performing hand hygiene. In a brief interview conducted at 6:43 AM, SRNA3 stated the red bins were needed because R109 was on precautions, and One bin is used for soiled linens, and the other for dirty diapers. In an interview with Licensed Practical Nurse (LPN) 4 on 06/11/2025 at 3:40 PM, she stated that Contact Precautions are required when there is a risk of exposure to infectious organisms, such as ESBL, which may be present on surfaces or linens. She reported that whenever a resident is placed on Contact Precautions, a sign should be posted immediately on the door of the resident's room, adding: People must be made aware. b. Further review of the facility policy titled, Infection Control: Standard Precautions and Isolation, revised 10/2018, revealed that the movement of a resident on Contact Precautions should be restricted, stating: Limit the movement and transport of the resident from the room to essential purposes only. Additionally, the policy directed that If the patient is transported out of the room, ensure that precautions are maintained to minimize the risk of transmission of microorganisms to other residents and contamination of environmental surfaces or equipment. However, the policy failed to explain how precautions were to be maintained when a resident was outside of their room, nor did it specify what actions should be taken to minimize the risk of transmission in these circumstances. Observation of the facility's memory care unit dining room on 06/10/2025 at 12:56 PM revealed R109 was in the dining room for lunch, seated at a square, four-person table, with one resident seated to her left and another to her right. Two staff members were also seated at the table, positioned between the residents, and were providing assistance throughout the meal. This assistance included offering verbal encouragement and prompting to eat, as well as handing the residents their drinks and utensils. Neither the staff members nor R109 were wearing any PPE. SRNA11 was observed asking the resident if she was feeling uncomfortable while gently patting her back. She then requested assistance from another aide, and they helped reposition R109 in her wheelchair with their bare hands. After repositioning R109, neither of the two staff was observed to perform hand hygiene. c. Observation of R109's room on 06/11/2025 at 1:07 PM revealed that, after surveyor intervention, a yellow organizer was now hanging on the door with PPE stored in its pockets. A sign was now also posted, indicating that the resident was on Contact Precautions. The sign instructed visitors to speak with nursing staff before entering and outlined the required PPE, including donning gloves and a gown prior to room entry. Observation at this time revealed R109 was in her room with two visitors, Family Member (FM) 109A and FM109B. Neither of the visitors were wearing any PPE. At 1:11 PM, LPN4, the unit charge nurse, approached the doorway and informed the visitors that they should be wearing PPE. FM109-A responded, 'We didn't think we needed to wear anything since she was in the dining room when we got here. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	common area. However, she acknowledged that because R109 does not don PPE, such as a gown, when exiting her room, her clothing could pose a risk for spreading ESBL and admitted that could be an issue. LPN4 stated that on the dementia unit where R109 resided, With these people back here, a lot of them are cognitively impaired, so it is up to staff to monitor it and make sure it isn't getting spread. [R109] does not do her own incontinent care, but if she sits on something it would have to be sanitized, but her room is infected and so her hands may not be clean. When asked whether they utilize any specific clinical criteria to determine whether a resident on Contact Precautions can participate in communal dining, she stated: I feel that if the staff is supervising the area and the resident has been toileted, it is okay for them to attend the meal. No risk assessment is completed. When asked how visitors would be informed and educated about the need to follow Contact Precautions/use PPE, she replied: We need to ensure everyone that goes in that room is wearing PPE .Visitors could take the organism home to their family. Staff are risking every one of these residents getting it. On 06/11/2025 at 3:55 PM, an interview was conducted with the Infection Control and Prevention Nurse (IP), along with Advanced Practice Registered Nurse (APRN) 1 and Advanced Practice Registered Nurse (APRN) 2. APRN1 stated that a resident would be placed on Contact Precautions for ESBL because it is highly contagious; it's so I can keep them away from the other residents. APRN1 then added that the decision to place a resident with ESBL on Contact Precautions is made on a case-by-case basis. However, no evidence was provided as to how this case-by-case decision was made relative to R109. APRN2 stated that R109 is permitted to leave her room, including to eat lunch in the communal dining hall at a table with other residents, because We can't confine them to their rooms; that wouldn't be good for them. However, she later stated that staff do make efforts to keep them in their room. The IP stated, We try to encourage them, but we can't make them stay in their room, and acknowledged that staff should be attempting to put a gown on her. She stated that there were no additional written policies outlining these protocols. Because staff made comments about different isolation requirements between contained and non-contained infections, a request was made on 06/12/25 at 9:06 a.m. with the IP for any policies differentiating Contact Precautions for contained versus non-contained infections. On 06/12/2025 at 9:35 a.m., the IP reported that there were no additional policies delineating the need for isolation in non-contained versus contained infections. The IP stated that it was up to the provider who initiates the orders to determine which should be followed. She stated that the order should contain that specification. Review of the physician's order confirmed that it did not distinguish between a contained or non-contained infection and called for Contact Isolation Precautions. In an interview with the Executive Director on 06/12/2025 at 4:33 PM, she stated that Contact Precautions require signage, PPE (gloves and gowns), red bins, and documentation in the resident's care plan. She reported that visitors are encouraged-but not required-to wear PPE, and staff are expected to read signage and don appropriate PPE upon entry. She explained that residents on Contact Precautions may leave their rooms based on psychosocial needs, though no formal assessment is used to determine this. She acknowledged the risk of exposure in shared spaces like the dining room and suggested that affected residents should avoid close contact with others, stating, Hopefully they won't touch anyone else. Hopefully they are not touching the area. Further interview with the Executive Director revealed that the failure to observe Contact Precautions included the potential for Spread of infection to residents, staff, family. 2. Review of the facility's policy and procedure titled, Administering Medication, revised 12/2012, revealed staff shall follow established facility infection control procedure (e.g. hand washing, antiseptic technique, gloves, isolation, precautions, etc.) for the administrations of medication, as (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185124	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbanks	851 Kimsey Lane Henderson, KY 42420

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(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 - Some	applicable. a. Record review revealed R93's current medications orders included an order for Linzess oral capsule 72 micrograms (mcg) by mouth once a day for constipation. Observation during a medication pass on 06/10/2025 at 7:08 AM revealed Certified Medication Aide (CMA) 1 dropped a Linzess 72 mcg capsule into her bare hand, then proceeded to put it in the medication cup and administer it to R93.Observation revealed CMA1 failed to perform hand hygiene prior to touching the resident's medication with her bare hand. Interview with CMA1, on 06/10/25 at 07:15 AM, revealed it was not best practice to give a pill that had been placed in her bare hand, and it should have been put in a medication cup to administer. b. Record review revealed R37's medication orders included a 12/02/2024 order for Aspirin 325 mg one time a day by mouth for cerebrovascular accident (CVA- stroke). Observation during a medication pass on 06/10/2025 at 7:20 AM revealed CMA1 dropped R37's Aspirin 325mg, on top of the medication cart. CMA1 then proceeded to pick up the medication with her bare hand and administer it to R37.Further observation revealed that CMA1 failed to perform hand hygiene prior to picking up the pill with her bare hand. Interview with CMA1, on 06/10/25 at 07:29 AM, revealed that a medication should not be given after it had been dropped on top of the medication cart, but discarded and staff should administer another one. A joint interview was conducted with the Director of Nursing (DON) and Executive Director on 06/12/2025 at 4:33 PM. During the interview, the DON stated that nursing staff or CMAs were to discard a contaminated pill in the sharps container and get another one to administer. The DON added that the expectation of the staff is to use proper hand hygiene and standard precautions when giving medications. Further interview with the Executive Director revealed the expectation that if a medication was dropped or touched, it should be disposed of and not administered to residents. 3. Review of the facility's undated policy and procedure titled, Obtaining A Fingerstick Glucose Level revealed Step 18 stated staff were to Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. Review of the manufacturer's instructions on the purple-topped container of Super Sani Wipes (used for disinfecting/sanitizing glucometers) revealed that staff were to Wipe Surface thoroughly. Allow surface to remain visibly wet for two minutes. Let airdry. Observation during a medication pass on 06/12/2025 at 11:55 AM, revealed that, per physician's orders dated 05/25/2025, CMA4 obtained a blood glucose reading on R41. After completing the test, CMA4 placed the soiled glucometer on top of the medication cart with no barrier. CMA4 then wiped the soiled glucometer three times for less than a total of ten seconds with a Super Sani Wipe from a purple-topped container. After using the wipe, CMA4 then immediately placed the glucometer on top of clean medical supplies on the medication cart. The product was not allowed to dwell (remain visibly wet) for two minutes, and then airdry before it was placed on supplies which were to be used for other residents. (continued on next page)

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	185124	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbanks	851 Kimsey Lane Henderson, KY 42420

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with CMA4, on 06/10/25 at 11:30 AM, revealed that a soiled glucometer should not be placed directly on the medication cart without a barrier. Instead, it should be placed on a barrier and then cleaned. CMA4 stated education was received on how to clean the glucometer; however, she was unsure how long to allow the solution to dwell. A joint interview was conducted with the DON and Executive Director on 06/12/2025 at 4:33 PM. The DON stated that it was an expectation that the CMAs would place the dirty glucometer on a barrier and clean it for thirty seconds and allow it to dry, according to manufacturer's recommendations, and to dispose of/not use any clean supplies that dirty equipment may have contaminated. The Executive Director confirmed it was the expectation was that nursing staff or CMAs would clean the glucometers with the designated bleach wipes and use proper contact and dry times per policy. Per the Executive Director, if a dirty glucometer was placed on clean supplies, staff should dispose of the supplies and clean the glucometer.