STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145671	A. BUILDING _____ B. WING _____	09/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLA AT SOUTH HOLLAND, THE	16300 WAUSAU STREET SOUTH HOLLAND, IL 60473

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, this facility failed to follow professional standards of practice to recognize, identify, evaluate, and manage pain for two residents (R3 and R4) in a sample of three residents reviewed for effective pain management. Findings include: On 3/11/2020 at 4:15 PM, this surveyor observed R4's family at R4's bedside requesting pain medication. V5, LPN (Licensed Practical Nurse), informed R4 and R4's family that the prescribed pain medication, [MEDICATION NAME] (pain medication), has not been delivered yet from pharmacy. V5 stated that hospital did not send a prescription for this medication; R4 would have to wait for physician to come to facility and write prescription before pharmacy will dispense medication. On 9/22/20 at 11:40 AM, this surveyor observed V15, DON (Director of Nursing), removing the controlled substance box from the locked cabinet on the first floor nursing unit. Attached to this box is a list of medications contained inside, including [MEDICATION NAME]-[MEDICATION NAME] (narcotic pain medication) and [MEDICATION NAME] (pain medication). On 3/11/20 at 4:15 PM, V5, LPN (Licensed Practical Nurse), stated the transferring facility must send a printed prescription for pain medication in order for the outside pharmacy to deliver these medications upon admission. V5 stated that without the printed prescription, we have to wait for the resident's physician to physically come to this facility and write the prescription. On 9/22/20 at 11:40 AM, V15, DON ,stated if a medication has not been delivered yet by the outside pharmacy, staff are able to obtain the needed medication from the (automate medication dispensing system) or the controlled substance box. On 9/23/20 at 12:15 PM, V10, LPN, stated V10 reviews transferring facility's medication list with the physician. V10 then places all orders received into the resident's electronic medical record. V10 stated these orders are automatically sent to the outside pharmacy. V10 stated medications are delivered around 11:00 PM. V10 stated medications not yet received are documented with reason in the resident's progress notes. If a medication is not readily available in the (automated medication dispensing system), then the physician should be notified so alternative medication can be ordered if needed. On 9/23/20 at 12:20 PM, V11, LPN, stated with newly admitted residents, the outside pharmacy delivers their medications within 2-3 hours of when orders entered into the electronic medical record. V11 stated V11 is able to remove any needed medications out of the (automated medication dispensing system) located on the second floor nursing unit or the controlled substance box located on the first floor nursing unit. 1. R3: Review of the medical records notes R3 was admitted to this facility on 2/22/20 with [DIAGNOSES REDACTED]. Review of R3's POS (Physician order [REDACTED]. On 2/22 at 2:40 PM, [MEDICATION NAME] 300mg by mouth three times a day for [MEDICAL CONDITION]. On 2/22 at 2:40 PM, [MEDICATION NAME] 2mg by mouth three times a day for muscle spasms. Review of R3's MAR (medication administration record) notes the following: [MEDICATION NAME]-[MEDICATION NAME] not given until 2/23 at 00:46 AM for complaints of pain 9 out of 10. [MEDICATION NAME] not given on 2/22 at 5:00 PM, 2/23 at 9:00 AM or 1:00 PM. First dose administered on 2/23 at 5:00 PM. [MEDICATION NAME] not given 2/22 at 5:00 PM, 2/23 at 9:00 AM or 1:00 PM. First dose administered on 2/23 at 5:00 PM. Review of R3's admission pain evaluation, dated 2/22/20 at 2:36 PM, notes R3 rated pain 9 out of 10 and constant. It also notes the last time and date of [MEDICATION NAME]-[MEDICATION NAME] (narcotic pain medication) was 2/22/20 at 00:00, prior to admission. Review of R3's progress notes the following: 2/23 at 00:46 AM notes [MEDICATION NAME]-[MEDICATION NAME] 7.5-325mg, give 2 tablets by mouth every 4 hours as needed for severe pain, R3's pain 9 out of 10. 2/23 at 00:47 AM notes awaiting delivery from pharmacy. 2/23 at 3:04 PM, medication will be delivered on evening shift (3:00 PM-11:00 PM). 2/23 at 3:30 PM, R3 resting in bed. R3 refused to eat due to pain, pharmacy was called, unable to get medication until delivery. 2/23 at 4:56 PM, skin/wound note: R3 consented to having a skin observation completed, upon R3 lifting right leg, R3 stated that R3 was in pain and wanted to end the observation. 2/24 at 1:00 PM, V17 (attending physician) notes R3 is concerned at times R3 does not get medications on time especially pain medication. There is no documentation found in R3's medical record noting reason why medications were not delivered until 2/23 evening shift, why staff did not request the outside pharmacy for an urgent delivery, or why medications available in this facility's (automated medication dispensing sytem) were not administered to R3. There is no documentation noting R3's physician was notified R3 had not received medications from the outside pharmacy. Review of R3's hospital discharge instructions, dated 2/22/20, notes a prescription for [MEDICATION NAME]-[MEDICATION NAME] 7.5-325mg tablets, 1-2 tablets every 4 hours as needed for pain - severe, was sent with R3 to this facility. Review of this facility's (automated medication dispensing system) and controlled substance box note the following medications available for use until resident's medications delivered from the pharmacy and the quantity available: [MEDICATION NAME]-[MEDICATION NAME] 7.5-325mg tablets; 6 tablets available. [MEDICATION NAME] 300mg tablets; 8 tablets available. 2. R4: Review of the medical record notes R4 was admitted to this facility on 3/9/20 with [DIAGNOSES REDACTED]. Review of R4's POS, dated 3/9/20 at 8:05 PM, notes the following: [MEDICATION NAME] (pain medication) 50mg by mouth daily for [MEDICAL CONDITION]. Documentation of this medication notes it was ordered on [DATE]; on order on 3/10/20; and then re-ordered on [DATE]. Review of R4's medical record notes R4 was admitted to this facility on 3/9/20 at 7:00pm. Review of R4's pain evaluation, dated 3/9/20 at 8:10 PM, notes R4 with repeated calling out, loud moaning/groaning, facial grimacing, and rigid body language (fists clenched, knees pulled up). Last time and date R4 received any medication for pain was 3/9/20 at 9:00 AM. R4's pain score was 7 out of 10. Satisfactory pain management/continue current plan of care. R4's baseline care plan notes R4 with the potential for pain related to arthritis. Interventions identified include: administer [MEDICATION NAME] as per orders, monitor/record/report any signs/symptoms of non-verbal pain: changes in breathing, moaning, yelling out, mood/behavior changes, grimacing, and monitor/record/report complaints of pain or requests for pain treatment. Review of the contents of this facility's controlled substance box notes [MEDICATION NAME] is available for resident use. Review of this facility's pain management policy, dated 11/28/2017, notes it is the facility practice to observe residents for pain upon admission. It notes recognition of pain types: somatic (injury to skin, muscle, bone, or other soft tissue structure), visceral (damage to internal organs), or neuropathic (abnormal functioning of the peripheral or central nervous system). The resident pain experience is highly individual and subjective. Pain is what the resident says it is. Acute pain should be assessed every 30-60 minutes after the onset and reassessed as indicated after [MEDICATION NAME] relief is obtained. Pain management is most effective when the root cause or underlying factor is identified. Signs and symptoms of pain: decreased activity level, change in behavior, resisting care, sighs, groans, crying, restlessness, facial grimacing. The resident's response to interventions and comfort level will be monitored. If acceptable comfort range is not met, the physician shall reconsider approaches and make adjustments as indicated.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure the process for receiving medication orders,

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) acquiring, receiving, and reconciling medications to meet the needs of 3 residents (R3, R4, and R5) out of three reviewed for pharmaceutical services. Findings include: On 3/11/2020 at 4:15 PM, this surveyor observed R4 complaining of cough to V5, LPN (Licensed Practical Nurse), and requesting cough medication. V5 informed R4 and R4's family the prescribed cough medication, as well as [MEDICATION NAME] (pain medication), had not been delivered yet from pharmacy. V5 stated that hospital did not send a script for these medications; R4 will have to wait for physician to come to facility and write scripts before pharmacy will dispense medications. On 9/22/20 at 11:40 AM, this surveyor observed V15, DON (Director of Nursing) removing the controlled substance box from the locked cabinet on the first floor nursing unit. Attached to this box is a list of medications contained inside including [MEDICATION NAME]-[MEDICATION NAME] (pain medication) and [MEDICATION NAME] (pain medication). V15 was observed logging into the computer system on the (automated medication dispensing system). V15 stated that a list of all current residents appears on the screen; select the resident medications are needed for. A list of all medications will appear on the screen; select the medication and it will be dispensed. V15 stated that a resident's as needed medications and inactive medications can be reviewed as well. V15 stated that medications that are scored can be cut if needed to ensure resident receives correct dose. On 9/23/20 at 12:15 PM, V10, LPN (Licensed Practical Nurse), stated V10 reviews transferring facility's medication list with the physician. V10 then places all orders received into the resident's electronic medical record. V10 stated these orders are automatically sent to the outside pharmacy. V10 stated medications are delivered around 11:00 PM. V10 stated medications not yet received are documented with reason in the resident's progress notes. If a medication is not readily available in the (automated medication dispensing system), then the physician should be notified. On 9/23/20 at 12:20 PM, V11, LPN, stated with newly admitted residents, the outside pharmacy delivers their medications within 2-3 hours of when orders entered into the electronic medical record. V11 stated that V11 is able to remove any needed medications out of the (automated medication dispensing system), located on the second floor nursing unit, or the controlled substance box located on the first floor nursing unit. 1. R3: Review of R3' medical record notes R3 was admitted to this facility on 2/22/2020 with [DIAGNOSES REDACTED]. Review of R3's POS (Physician order [REDACTED]. On 2/22, [MEDICATION NAME]-[MEDICATION NAME] 7.5-325mg, give 1-2 tablets by mouth every 4 hours as needed for severe pain. On 2/22 at 2:40 PM, insulin detemir solution 100 units/ml (milliliters), give 20 units subcutaneously at bedtime (9:00 PM) for diabetes. This medication was discontinued on 2/23 at 10:35 PM. On 2/22 at 2:40 PM, [MEDICATION NAME] 25mg by mouth two times a day for high blood pressure. On 2/22 at 2:40 PM, [MEDICATION NAME] 300mg by mouth three times a day for [MEDICAL CONDITION]. On 2/22 at 2:40 PM, [MEDICATION NAME] 2mg by mouth three times a day for muscle spasms. On 2/22 at 2:40 PM, [MEDICATION NAME] 50mg by mouth two times a day, anti-convulsant. On 2/22 at 2:40 PM, [MEDICATION NAME] 10mg by mouth one time a day for depression. On 2/22 at 2:40 PM, [MEDICATION NAME] 20mg by mouth at bedtime (9:00 PM) for high cholesterol. On 2/23, basaglar insulin 100 units/ml (milliliters), inject 20 units subcutaneously at bedtime related to diabetes. Review of R3's MAR (Medication Administration Record) notes the following: [MEDICATION NAME] not given on 2/22 at 5:00 PM, 2/23 at 9:00 AM, 1:00 PM, or 5:00 PM. [MEDICATION NAME]-[MEDICATION NAME] not given until 2/23 at 00:46 AM for complaints of pain 9 out of 10. Insulin detemir not given on 2/22 or 2/23. [MEDICATION NAME] not given on 2/22 at 6:00 PM, noted vital signs (blood pressure 119/65, heart rate 72) outside of parameters. This medication also not given on 2/23 at 9:00 AM. [MEDICATION NAME] not given on 2/22 at 5:00 PM, 2/23 at 9:00 AM or 1:00 PM. [MEDICATION NAME] not given 2/22 at 5:00 PM, 2/23 at 9:00 Am, or 1:00 PM. [MEDICATION NAME] not given on 2/22 or 2/23. [MEDICATION NAME] not given on 2/23. [MEDICATION NAME] sodium not given on 2/22. Basaglar insulin not given on 2/23. Review of this facility's (automated medication dispensing system) notes the following medications available for use until resident's medications delivered from the pharmacy and the quantity available: [MEDICATION NAME]-[MEDICATION NAME] 7.5-325mg tablets; 6 tablets available. [MEDICATION NAME] 25mg tablets; 12 tablets available. [MEDICATION NAME] 300mg tablets; 8 tablets available. [MEDICATION NAME] 10mg tablets; 9 tablets available. [MEDICATION NAME] 20mg tablets not available. [MEDICATION NAME] 40mg tablets; 4 tablets available. This medication is scored and can be cut in half without losing the effectiveness of the medication. There is no documentation found noting any medication was removed for R3 during R3's stay at this facility. 2. R4: Review of the medical record notes R4 was admitted to this facility on 3/9/20 with [DIAGNOSES REDACTED]. Review of R4's POS, dated 3/9/20 at 8:05 PM, notes the following: Diabetic [MEDICATION NAME] (cough medication) 100mg/5ml (milliliter), give 5ml by mouth every 6 hours as needed for cough. [MEDICATION NAME] (pain medication) 50mg by mouth daily for [MEDICAL CONDITION]. Documentation of this medication notes it was ordered on [DATE]; on order on 3/10/20; and then re-ordered on [DATE]. Review of R4's medical record notes R4 was admitted to this facility on 3/9/20 at 7:00 PM. Review of R4's pain evaluation, dated 3/9/20 at 8:10 PM, notes R4 with repeated calling out, loud moaning/groaning, facial grimacing, and rigid body language (fists clenched, knees pulled up). Last time and date R4 received any medication for pain was 3/9/20 at 9:00 AM. R4's pain score was 7 out of 10. Satisfactory pain management/continue current plan of care. R4's baseline care plan notes R4 with the potential for pain related to arthritis. Interventions identified include: administer [MEDICATION NAME] as per orders, monitor/record/report any signs/symptoms of non-verbal pain: changes in breathing, moaning, yelling out, mood/behavior changes, grimacing, and monitor/record/report complaints of pain or requests for pain treatment. Medications removed from this facility's (automated medication dispensing system) and/or controlled substance box were reviewed. There is documentation noting an antibiotic was taken one time for R4, but no pain medication were removed during R4's stay at this facility. 3. R5: Review of the medical record notes R5 was admitted to this facility on 3/10/20 at 7:30 PM, with [DIAGNOSES REDACTED]. Review of R5's POS, dated 3/10/20, notes: [MEDICATION NAME] sodium solution (antibiotic) 1gram intravenous every Monday, Wednesday for infection pneumonia given after [MEDICAL TREATMENT] session by [MEDICAL TREATMENT] nurse; and 2grams intravenous every Friday for pneumonia until 4/11/2020 11:59 PM, give after [MEDICAL TREATMENT] administer by [MEDICAL TREATMENT] nurse. Review of R5's MAR (Medication Administration Record): 3/11, [MEDICATION NAME] 1gram not given. Review of R5's progress notes: On 3/11 at 6:19 AM, [MEDICATION NAME] 1 gram to be given in HD. On 3/13 at 11:09 AM, nurse practitioner notes R5 with bacterial endocarditis - continue present management with [MEDICATION NAME] through 4/11/20. Discussed with R5's family member the seriousness of infection including endocarditis, pneumonia, [MEDICAL CONDITION], importance of completing course of antibiotic as recommended and potential consequences of not finishing antibiotic as prescribed as it could be detrimental to R5's health. The outside [MEDICAL TREATMENT] center's communication form notes [MEDICATION NAME] not given on 3/11 after [MEDICAL TREATMENT]. Review of this facility's omnicell inventory list notes [MEDICATION NAME] 1 gram is available for resident use. There is no documentation found noting any medication was removed for R5 during R5's stay at this facility and sent with R5 to [MEDICAL TREATMENT].

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, and record review, the facility failed to follow their Infection Control policy for COVID-19, and failed to follow CDC (Center for Disease Control and Prevention) guidelines for transmission based precaution as evidenced by staff not removing and changing PPE (Personal Protective Equipment) before exiting a contact and droplet precaution room. This deficient practice has the potential to affected 8 of the 21 residents (R15, R16, R19, R20, R21, R27, R31, and R32) reviewed for isolation infection control practices. The facility also failed to follow its policy and procedure for cleaning medical equipment after its use to prevent the transmission of infection. This failure affected 3 of 3 residents (R4, R7, and R8) reviewed for point of care testing. Findings Include: On 9/22/20 at 1130am AM, observed V22 (Nurse) go into R15's room with medication cup in hand. V22 wearing N95 mask, goggles, and gown. Noted on R15's room with signage for Contact and Droplet precaution on the door. There is no isolation cart with supplies by the door. V22 exited the room without changing PPE (Personal Protective Equipment). Verified with V22 if PPE was changed prior to leaving the room and V22 stated, I don't have to change PPE because R15 is not on any type of isolation. Facility provides us with PPE. R15 is not on isolation. I would know if residents and the rooms are isolation because it would have signage by the door, such as contact or droplet. The room would also have an isolation cart in the hallway, by the door. I don't have any isolation on the first floor. On 9/22/20 at approximately 1230 PM, V22 came up to state surveyor and stated, I need to correct myself. I do have one resident on isolation on the first floor, and R16 is on isolation. I am not aware if there is any isolation on the first floor earlier when you asked me, I came from an agency and I forgot to ask the nurse before me, my fault. On 9/22/20 at 1145 AM, observed V23 (Social Service) go into R27's room. V23 noted to be wearing gown, face mask, and face shield. V23 performed hand hygiene and continued to assist in finding R27's TV remote. Observed V23 conversing with R27. V23 performed hand washing prior to leaving R27's room. V23 observed exiting the room without removing PPE. R27's door has contact and droplet precaution signage; no isolation cart by the door. V23 stated, R27 is not on isolation. The staff would know if a resident is on isolation, it would have sign at the door and isolation cart by the door. On 9/22/20

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) at 12:20 PM, observed V23 inside R21's room conversing with the resident. R21's room noted to have signage on the door for contact and droplet precaution. V23 left the room without removing V23's PPE. V23 stated, R21 is not on isolation, she is a new admission, arrived in the facility just last Friday. The signage on the door is probably from the previous resident of this room. I did not remove the PPE prior to leaving R21's room because R21 is not on any type of isolation. On 9/22/20 at 12:40 PM, observed V24 (Certified Nursing Assistant, CNA) walking the hallway wearing goggles, mask, and putting her gown on. Went to R19's room; door has a contact and droplet precaution signage, no isolation cart by the door. Observed V24 exited R19's room, and verified with V24 that she did not remove or change PPE. V24 stated, R19 is not on isolation, so I don't have to change PPE. We know if resident is on isolation if they have an isolation cart with PPE by the door and signage on the door. I did not notice the sign on the door. On 9/22/20 at 12:45 PM, observed V22, Nurse, again with the same PPE from previous observation, go into R20's room and observed to make contact by touching the legs of R20's. V22 exited the room without changing PPE. On 9/23/20 at 11 AM, observed V26 (Certified Nursing Assistant, CNA) provide care to R31, exited the room without removing or changing PPE. R31's room has a signage on the door for droplet and contact precaution, and no isolation cart with PPE by the door. V26 stated, R31 is not on isolation, there is no isolation cart with PPE by the door. We know if it is an isolation room if there is a cart with PPE by the door. When V26 was asked in regards to the signage by the door, V26 responded, The signage is there just for a warning. But I know R31 is not on isolation. On 9/23/20 at 1145 AM, observed V27 (Housekeeping) cleaning R32's room. R32's room has a signage on the door for droplet and contact precaution, and no isolation cart with PPE by the door. V27 left the room without removing or changing her PPE and continued to enter R15's room. V27 stated, We wear same PPE for everybody if they are not on any isolation. If they are on isolation, of course we have to change our PPE. The signage by the door is just a reminder to follow standard precaution. There is only one resident that I know who is on isolation on the first floor. The rest of the resident on this floor is not on isolation. On 9/22/20 at 1 PM, surveyor interviewed V15 (Director Of Nursing, DON) . V15 stated, Every residents on the first floor are under PUIs (Person Under Investigation). We place new admission and readmission residents on isolation for 14 days to be monitored. All residents on the first floor are with contact and droplet precaution. All doors should have signage. There is no need for isolation cart on each door because it is our standard practice to have staff wear gown, face shield and mask at all time. The gloves are located in each residents' room. We follow CDC guidelines for contact and droplet precaution to prevent the spread of infection. On 9/23/20 at 12 PM, surveyor interviewed V1 (Administrator), V1 stated, I am the one who does the ordering for the PPE supplies, our central supply manager is new to her position, so I am the one who orders. We have enough supplies of PPE for the whole building and we never had shortage with PPE in this facility. Reviewed facility's Infection Prevention and Control Interim Guidelines for suspected or confirmed Coronavirus, with a revised date of 8/27/20, read in parts: It is the practice of this facility to minimize exposure to respiratory pathogens and promptly identify residents with clinical features and an epidemiologic risk for COVID-19 and to adhere to Federal and State/local recommendations. Full PPE should be worn per CDC guidelines for the care of any residents with known or suspected COVID-19 per CDC guidance on conservation of PPE. The facility will admit/readmit residents from hospital where a case of COVID-19 was and is present. Resident will be placed in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19. All recommendation COVID-19 PPE should be worn during care of the resident under observation. The following are additional measures that will be taken to identify the correct type of PPE: post signs on the door or on wall outside the resident room to clearly describe the type of precaution needed and required PPE. Make PPE, including facemasks, eye protection, gown and gloves available immediately outside resident room. Facility provided a copy of their Droplet Precaution signage use in the facility and read in parts: Remove face protection before room exit. On 3/11/20 at 4:15 PM, this surveyor observed V5, LPN (Licensed Practical Nurse) perform blood glucose testing for R4. V5 is observed exiting R4's room after performing blood glucose test. V5 placed the glucometer in a basket with other glucose testing supplies in top drawer of medication cart. V5 did not clean the glucometer prior to placing in medication cart. On 3/11/20 at 4:30 PM, this surveyor observed V5 perform blood glucose testing for R7. V5 performed the blood glucose test and showed the result to R7. R7 requested V5 recheck blood glucose level with a different glucometer. V5 retreived a second glucometer from the basket in the top drawer of medication cart. V5 is observed repeating the test. V5 is observed exiting R7's room afterwards. V5 placed both glucometers in the basket with other glucose testing supplies in top drawer of medication cart. V5 did not clean the glucometers prior to placing in medication cart. On 3/11/20 at 4:50 PM, this surveyor observed V5 perform blood glucose testing for R8. V5 is observed exiting R8's room after performing blood glucose test. V5 placed the glucometer in a basket with other glucose testing supplies in top drawer of medication cart. V5 did not clean the glucometer prior to placing in medication cart. On 9/23/20 at 12:15 PM, V10, LPN (Licensed Practical Nurse), stated the glucometer should be cleaned after each use with an antiseptic wipe, alcohol wipe, or bleach wipe. On 9/23/20 at 12:20 PM, V11, LPN, stated the glucometer should be cleaned with an alcohol wipe in between each resident. Review of this facility's blood glucose meter cleaning, revised 10/5/2018, notes whenever possible, blood glucose meters should be assigned to an individual person and not shared. If blood glucose meters must be shared, the device should be cleaned and disinfected after each use to prevent carry-over blood and infectious agents. The disinfectant recommended by this facility is bleach germicidal wipes. Glucometers will be thoroughly wiped and allowed to air dry after every use and between every resident.