STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105780	A. BUILDING _____ B. WING _____	**03/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKS AT AVON	**1010 US 27 N AVON PARK, FL 33825**

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 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to honor a resident's right for dignity for 2 residents (#21, #31) of 42 sampled residents, related to not ensuring a resident's privacy of their body (#21), and by not covering a urinary catheter bag (#31). Findings included: 1. On 3/05/20 at 3:09 p.m. while standing at the nurses' station on the 100 hall, a resident was heard screaming and shouting. Two nurses and an aide were noted at the nurses' station, but no one responded to the resident's screaming and shouting. On 3/05/20 at 3:10 p.m. Resident #21's door was observed to be open and the resident was still screaming and shouting profanities. From the hall, across from the open door, the resident was noted to be lying in her bed with her dress noted to be up at her chest, and her adult brief was off, and her knees were up in the air with her naked body from the chest down exposed. On 3/05/20 at 3:11 p.m. Resident #21 was noted to continue to shout out profanities. Staff B, Licensed Practical Nurse (LPN) was noted to leave a room from down the hall and walk past Resident 21's room, while the resident was still shouting profanities and her lower body was still exposed. The nurse took a half glance towards the room and continued walking to the nurses' station. Continued observation of Resident #21's room on 3/05/20 at 3:15 p.m. revealed that Staff U, Certified Nursing Assistant (CNA) walked down the hall, saw the open door, noted that the resident was exposed and said, Excuse me, an entered the room and closed the door. An interview on 3/05/20 at 3:16 p.m. with Staff B, LPN confirmed that she walked past the resident's room and reported that she heard the resident screaming and shouting, but, did not think anything of it; as the resident has behavior problems. She reported that she did not realize Resident 21's body was exposed. When asked what the process was to deal with this resident's behaviors, the nurse did not respond to the question. A review of Resident 21's Admission Record revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. A review of the care plan initiated on 9/12/18 revealed a focus of, (Resident #21) has a behavior problem r/t (related to) OBS, Bi-Polar Disorder. Mental [MEDICAL CONDITION]. Resident verbally abusive toward staff during care. Difficult to redirect. Refuses medication at times. ** Repetitive verbalization, Inappropriate Language, Yells out at times. The interventions included, Approach in a calm manner ., Caregivers to provide opportunity for positive interaction, attention. Stop and talk with her as passing by. An interview on 3/05/20 at 3:20 p.m. with the Director of Nursing (DON) revealed that staff should have responded to the resident's screaming and shouting, and that all staff need to ensure privacy and dignity of all residents. Review of the Resident Bill of Rights, provided by the facility revealed, Quality of Life: Dignity/Self Determination and Participation. You have the right to receive care from the facility in a manner and in an environment that promotes, maintains, or enhances your dignity and respect in full recognition of your individuality. 2. During the initial tour of facility on 03/02/20 at 8:10 p.m., an interview with Resident #31 was conducted. Resident #31 stated she had just come back from the hospital. Further observation revealed a catheter bag on right side of bed that was not covered. (Photographic Evidence Obtained) A review of Resident #31's Admission Record documented an admission date of [DATE]. The [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS) Quarterly Assessment, completed on 1/10/20, revealed in Section C for Cognitive Patterns a Brief Interview for Mental Status score of 13 out of 15 (cognitively intact). Further review of the MDS in Section H Bladder/Bowel revealed Resident #31 was coded for an indwelling catheter. An observation was made on 03/03/20 at 10:56 a.m. There was no privacy bag covering the catheter bag for Resident #31 as she was escorted to the physical therapy gym by the therapist. On 03/04/20 at 9:30 a.m., Resident #31was observed in bed asleep with an oxygen mask on and the catheter bag was on the floor, uncovered, and visible at the doorway. (Photographic Evidence Obtained) A review of the physician orders, dated 2/29/20, revealed, (indwelling) catheter to drainage bag for [MEDICAL CONDITION] 16fr/5ml (milliliters) (+/-). Observe Q (every) shift- every shift for observation. Irrigate (indwelling) catheter with 30 ml normal saline as needed for blockage/leaking or sluggishness as needed. Change (indwelling) catheter as needed for leakage/blockage or dislodgement- as needed document in residents record. Change catheter bag as needed, label with date- as needed. A review of the initial care plan did not include a focus for the indwelling catheter. A review of the care plan, initiated on 03/04/2020, included a focus for indwelling catheter care, (Resident #31) uses a Urinary catheter with risk for infection. The interventions included, Use catheter bag that promotes privacy/dignity. On 03/04/20 at 9:35 a.m., an interview was conducted with Staff M, LPN. She verified and stated she sees the (indwelling) catheter bag on the floor, and it should not be. She stated she will pick it off the floor. She reiterated the bag should not be on the floor. The LPN also stated that Resident #31 needs to have a privacy bag placed over the catheter bag. She stated the nurses are supposed to make sure the catheter bags are off the floor. She stated the CNAs empty the bags on every shift. An interview was conducted on 03/04/20 at 9:48 a.m. with Staff G, LPN/Unit Manager. She verified the catheter bag was on the floor with no privacy bag. She said, There is a chain of who is responsible to make sure it is done right. The CNAs and the nurses should see that the bag is on the floor, and you can see it from the doorway. She stated the staff has had in-services on privacy and dignity. On 03/04/20 at 9:55 a.m., Staff N, CNA, assigned to the resident verified and stated, The catheter bag was hung wrong, on the floor and no privacy bag. She stated it should be hung with the circle on the bed. Staff N readjusted the catheter bag with the clip underneath the resident's blanket. She stated she has had training once every two months on how to care for a resident with a catheter bag. An interview was conducted on 03/04/20 at 10:56 a.m. with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON). The DON stated her expectation is that the nurse would have identified it (no privacy bag in place) and gotten a (name brand) catheter bag (when resident returned from hospital). Staff will initiate catheter training for CNAs and nurses. An interview was conducted on 03/04/20 at 11:10 a.m. with the Administrator. He stated his expectation is for staff to follow the facility policy for dignity and respect. The Administrator stated, The staff do have in-services on respect and dignity annually, and as needed. He said, The DON and ADON will begin retraining the nursing staff immediately.
F 0584 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility did not ensure that a clean and sanitary environment was maintained in 7 resident rooms (room [ROOM NUMBER], #108, #109, #310, #403, #503 and #509) of 8 sampled rooms of the 56-room facility for environmental cleanliness related to privacy curtains. Findings included: Random observations made between 3/3/20 and 3/6/20 of privacy curtains between the door (A) and window (B) beds throughout the facility revealed: - room [ROOM NUMBER]

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 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) on 3/2/20 at 8:16 p.m. and 3/3/20 at 2:00 p.m.: Soiled with a large number of brown spots that look like something liquid was dropped on floor and splashed on the curtain. Multiple brown spots were seen on other parts of the curtain. All discolored areas were able to be seen from either side of the curtain. (Photographic Evidence Obtained) - room [ROOM NUMBER] on 3/3/20 at 2:03 p.m.: Soiled with multiple dark spots visible from both sides of the curtain. (Photographic Evidence Obtained) - room [ROOM NUMBER] on 3/3/20 at 2:05 p.m.: Soiled on the door side of the curtain with a smear of a red substance, and the side facing the window with a smear of a brown substance. (Photographic Evidence Obtained) - room [ROOM NUMBER] 3/2/20 at 8:41 p.m. and 3/3/20 at 8:41 a.m.: Soiled with a smear of a red substance, brown spots, and two large yellow areas visible from the window side of the curtain. (Photographic Evidence Obtained) - Room#403 on 3/6/20 at 9:55 a.m.: Privacy curtain between the beds is soiled with multiple smears and spots of a reddish-brown substance that appears to be blood visible from both sides of the curtain. (Photographic Evidence Obtained) - room [ROOM NUMBER] on 3/5/20 in afternoon: Soiled with several spots of a red substance that appears to be blood. (Photographic Evidence Obtained) - room [ROOM NUMBER] on 5/6/20 at 9:05 a.m.: Privacy curtain between the beds is soiled with several vertical brown lines that appear to be feces. (Photographic Evidence Obtained) On 3/4/20 at 12:36 p.m. in an interview with Staff C, Certified Nursing Assistant (CNA) and Staff T, Licensed Practical Nurse (LPN) they both said that they would report any issues with the curtains to the housekeeping supervisor. On 3/5/20 at 12:40 p.m. in an interview with Staff E, Registered Nurse (RN) she said that if anyone came to her and let her know that the curtains were dirty, she would let the housekeeping supervisor know directly. On 3/6/20 at 9:15 a.m. in an interview with Staff G, RN she said that the housekeeping supervisor is the one that is charge of cleaning the privacy curtains, and that if she ever found any that were soiled, she would let the housekeeping supervisor know. On 3/6/20 at 12:34 p.m. in an interview with the Assistant Director of Nursing (ADON) she said that the housekeeping supervisor was the one who was in charge of cleaning the privacy curtains, and that they get cleaned when rooms are deep cleaned. The facility has a concierge program where department heads are assigned rooms, and one of the things they are supposed to look at is cleanliness of the room, including the privacy curtains. She was surprised when she was shown pictures of the curtains found with stains and said that she would get a full house audit completed to check other privacy curtains in the facility. On 3/6/20 at 12:00 p.m. the Social Service Director brought a facility document about the concierge program. On the paper was a list of what they were to look at in the rooms in the morning. Curtain was on the list of things to look at. Approximately 1:45 p.m., the Administrator said that it was an internal document and that it could not leave the building. On 3/6/20 at 1:00 p.m. in an interview with the Housekeeping Supervisor, she said that rooms are deep cleaned on a schedule. She said that the facility is short on extra curtains, and they can only clean five curtains at a time. She does plan on ordering more curtains so she can clean more than five at a time. She said that anyone can let her know personally about a curtain that needs attention and she will take care of it.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility did not ensure a medication error rate of less than 5 percent in regards to 3 errors in 32 opportunities for three residents Resident #78, Resident #237, and Resident #24 out of 7 residents sampled, resulting in a 9.38% medication error rate. Findings included: 1. On 3/3/2020 at 8:55 a.m., medication administration was observed with Staff A, Licensed Practical Nurse (LPN) for Resident #78. Staff A pulled a bottle of multivitamins from the drawer of the medication cart, removed a tablet, placed the tablet in a medication cup, replaced the lid and sat the bottle on top of the medication cart. When asked if it was a multivitamin, or multivitamin with minerals, she pulled a different bottle out of the top drawer of the medication cart that read, multivitamin with iron on the label and she said, I think just multivitamin, and put the other bottle back in the cart without taking out a tablet. A review of Resident #78's medical record revealed an admission date of [DATE] for a [DIAGNOSES REDACTED]. A review of the (NAME)2020 physician orders [REDACTED]. She took the [MEDICATION NAME] and the rest of Resident #237's medications into the resident's room and gave the resident her medications. A review of Resident #237's medical record revealed an admission date of [DATE] for a [DIAGNOSES REDACTED]. Other [DIAGNOSES REDACTED]. A review of the (NAME)2020 physician orders [REDACTED]. Hold for diarrhea or loose stool dated 2/29/2020. In a facility policy titled, Medication Administration General Guidelines, dated 09/18 on page 3 under the subheading Medication Administration under #1, the first sentence stated, Medications are administered in accordance with written orders of the prescriber. On page 4, #9 stated, Verify medication is correct three (3) times before administering the medication. In an interview with the Assistant Director of Nursing (ADON) at 12:34 p.m. on 3/6/2020, she said that it was her expectation that medication orders be checked and followed by staff before administration. 2. During observation of medication administration on 3/3/2020 at 9:33 a.m. with Staff L, Registered Nurse (RN), for Resident #24, the nurse pulled out a bottle of aspirin 81 mg (milligrams) chewables and dispensed one tablet into the medicine cup. Staff L, RN stated the resident takes her medicine in pudding. She was going to give her the chewable aspirin, although she confirmed the order was for aspirin 81 mg [MEDICATION NAME] coated. Review of the (NAME)2020 physician order [REDACTED].
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 facility record review, the facility failed to 1. maintain the kitchen and one (North) of two nourishment rooms in a clean and sanitary manner related to thick charred residue on baking sheets and reach in oven, charred aluminum foil in the reach in oven, staff item found in prep area and storage of a personal ice pack, and 2. date a food item, and 3. ensure evening dairy snacks were kept cold after delivery for two (North and South) of two nursing units. Findings included: 1. An initial kitchen tour was conducted on 03/03/20 at 9:15 a.m. with the Certified Dietary Manager (CDM) and the District Dietary Manager. During the initial tour at 9:49 a.m. an observation of the prep area revealed a cell phone charger on the stainless-steel counter. (Photographic Evidence Obtained) The CDM immediately removed the cell phone charger. Further observation of the prep area revealed stacked cooking sheets (10) to have a thick charred residue on the sides of the pans. (Photographic Evidence Obtained) The CDM informed the cook to clean the pans. At 10:02 a.m. on 03/03/20, a tour of the cook's area revealed a thick charred food residue on the inside door of the reach-in oven. (Photographic Evidence Obtained) Staff O, Cook, stated the oven was cleaned last week. The CDM verified the uncleanliness of the oven and stated she will have the oven cleaned tonight. A tour of the dry storage room at 10:18 a.m. revealed a 50 pound bag of flour opened/no date observed. The CDM stated that needs to be dated. (Photographic Evidence Obtained) A follow up tour of the main kitchen area was conducted on 3/5/20 at 11:40 a.m. An observation of the reach in-oven in the cook's area revealed the inside of the reach in oven had pieces of charred aluminum foil on the floor of the oven. (Photographic Evidence Obtained) Staff Member O, Cook, stated the door was cleaned and but she did not clean the bottom of the oven. At 12:02 p.m., a second observation of the cooking sheets revealed a thick charred residue on the sheets. The CDM stated she has ordered more cooking sheets and will discard the old ones. She verified the staff did not re-clean the old cooking sheets. An interview was conducted on 3/5/20 at 12:04 p.m., with Staff P, Cook. She stated they are not allowed to bring personal items into the work/prep areas. An interview was conducted on 3/5/20 at 12: 09 p.m., with the CDM and District Dietary Manager. The CDM verified the night cook delivers snacks to the North and South nursing stations at 7:00 p.m. and places the snacks on the nursing station counter. The labeled snacks included: egg salad sandwiches, chicken salad sandwiches, turkey sandwiches, puddings, potato chips, fruit cup, cereal with milk, apple sauce, Mighty Shakes, Magic Cups, and Ice Cream. On Monday (3/2/20), the CDM stated she told a certified nursing assistant on the South Unit to pass out the snacks as the tray was out on the nursing station counter. The CDM stated, Once the snack tray is delivered to the units, the nursing staff is responsible for passing the snacks out. The CDM stated the milk is supposed to be placed in the black ice container located in the freezers. The dietary staff is responsible for making sure the milk is placed on ice. The CDM verified that it is dietary's responsibility to place the milk or ice cream on ice. She stated her expectation is for staff to follow policy and be educated/in-serviced on the proper set-up for milk and ice cream. A tour of the North Nourishment Room was conducted on 3/5/20 at 12:30 p.m. with the CDM. An observation revealed an unlabeled black (hook and loop fastener) covered ice pack in the freezer compartment. (Photographic Evidence Obtained). Also revealed was a yellow plastic basin of water on the second shelf of the beverage cart. The CDM verified and stated the ice pack and

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) a yellow basin filled with water should not be stored in the nourishment room and should be discarded. An interview was conducted on 3/5/20 at 12:37 p.m. with the Assistant Director of Nursing (ADON). The ADON verified the (hook and loop fastener) covered ice pack in the freezer in the North Nourishment Room. She stated, A family member probably placed it in there. The ADON stated, The expectation is the ice pack could be stored in the freezer but not the Velcro sleeve since it touches the resident's skin/body and the item should be labeled. She stated the facility does not use ice or hot packs. The ADON stated, her expectation for passing snacks would be that, The nursing staff immediately pass out the snacks and if they are not delivering the snacks when brought to the unit, staff should place the snacks in the refrigerator. An interview was conducted with the Administrator and Director of Nursing (DON) at 12:46 p.m. on 3/5/20. The Administrator stated his expectation was, The residents should receive cold items under 41 degrees. The DON verified it is the responsibility of the nursing staff to pass out the snacks. On 3/6/20 at 8:40 a.m., an interview was conducted with Staff Q, Dietary Aide. She stated, No personal items are allowed in the kitchen. On 3/6/20 at 8:42 a.m., a brief interview was conducted with Staff R, Cook. She stated the CDM talked about labeling everything with the open date, reviewed the correct scoop sizes to serve foods, and no personal items in the kitchen area at all. An interview was conducted on 3/6/20 at 8:49 a.m. with the District Dietary Manager. He stated the staff are orientated with a video that has what the dietary staff should do when working in the kitchen including wearing hair nets, beard guards, and use of personal items. The Dining Services Policy and Procedure Manual of the contracted dietary company on Snacks, revised 9/2017, revealed as policy, Snacks and beverages will be provided as identified in the individual plans of care. Bedtime (a.k.a. HS) snacks will be provided for all residents. The Procedures included #2, The Dining Services department assembles on a daily basis snack items (food and beverages) for delivery to each resident/patient area. #3. Snacks will be assembled, labeled, and dated in accordance with the individual plan of care for each resident and those items will be delivered to patient care areas in a timely manner. #6. Nursing Services is responsible for delivering the individual snacks to the identified residents and for offering evening snacks to all other residents. #7. All snacks will be properly stored for time and temperature control, as appropriate. The Dining Services Policy and Procedure Manual of the contracted dietary company on Receiving, revised 9/2017, revealed as policy, Safe food handling procedures for time and temperature control will be practiced in the transportation, delivery, and subsequent storage of all food items. For procedures, #5. stated, All food items will be appropriately labeled and dated either through manufacturer packaging or staff notification. The Dining Services Policy and Procedure Manual of the contracted dietary company on Food Storage: Dry Goods, revised 9/2017, revealed as policy, All dry goods will be appropriately stored will be appropriately stored in accordance with the FDA Food Code. The Procedures included #5. stated, All packaged and canned food items will be kept clean, dry, and properly sealed. #6. stated, Storage areas will be neat, arranged for easy identification, and date marked as appropriate. The Dining Services Policy and Procedure Manual of the contracted dietary company on Equipment, revised 9/2017, revealed as policy, All foodservice equipment will be clean, sanitary, and in proper working order. The Procedures included #3, All food contact equipment will be cleaned and sanitized after every use. #4. stated, All non-food contact equipment will be clean and free of debris. 2. On 3/2/20 at 7:30 p.m. evening snacks were observed on a tray at the South Unit nurses' station sitting on the counter. At 8:12 p.m. the evening snacks were observed on top of the residents' charts behind the nurses' desk. The evening snacks included approximately 12 sandwiches, 6 milks, one banana and 8 ice cream cups. At 9:20 p.m. the evening snacks were missing from the shelf. An interview conducted with Staff E, Registered Nurse (RN) at 9:20 p.m. revealed the snacks from the nurses' station were delivered to the residents. 3. Interview on 3/4/20 at 2:20 p.m. with a group of alert and oriented residents revealed that for their night time snack the snack items are delivered to the units by the kitchen staff, and that the aides are the ones who usually give out the snacks. The group reported that many times the milk is warm.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of manufacturer's instructions, the facility did not ensure that infection control standards were maintained regarding the cleaning and sanitization of a glucometer after use on one resident (#11) out of two residents observed for blood glucose monitoring. Findings included: On 3/4/20 at 4:00 p.m. Staff B, Licensed Practical Nurse (LPN) was standing at her cart wiping a glucometer with a bleach wipe. She placed the glucometer into a plastic cup that was sitting on top of her cart. She was asked if she had any more (blood glucose monitoring) to complete and she said that she needed to get Resident #11's blood sugar. She gathered her supplies from the top drawer of her medication cart and grabbed the cup with the glucometer in it. She carried a container of testing strips, one alcohol wipe, the glucometer still inside the cup, and a lancet in her left hand to the room. She knocked on the door announcing herself and asked permission to enter the room. Upon entering, she took a pair of gloves from the box on the wall and put them on. After this, she pulled out a testing strip from the container of strips, put it into the glucometer, closed the lid on the container, and then put the container into her right scrub shirt pocket. She then wiped the resident's finger with the alcohol wipe, used the lancet to draw blood for the (blood glucose monitoring), and placed a drop of blood on the testing strip. The nurse said the resident did not need coverage. The nurse thanked the resident, removed and threw away her gloves, the alcohol wipe, and the used testing strip into the trash can. She walked out of the resident's room and back to her cart. She put the plastic cup she had taken into the room on top of her cart and placed the glucometer in it. She opened the bottom drawer of her medication cart and pulled a bleach wipe from a blue topped container and wiped down the glucometer for approximately 45 seconds. She placed the glucometer back into the cup on top of her cart and threw away the bleach wipe. She then opened the top drawer of the medication cart, took out a small plastic resealable bag, placed the glucometer in it, closed it, put it back into the drawer, and closed the drawer. At 4:04 p.m. Staff B, LPN was asked how long the glucometer was supposed to be wiped down for, she said it depended on the wipe. She said that the individual packaged wipes were 3 minutes. When she was asked about the bleach wipes she used on the glucometer she said 3 minutes, and pointed to an area on the container that indicated the wipe kills c-dif ([MEDICAL CONDITION]) in 3 minutes. When asked if she feels she wiped down the glucometer for 3 minutes, or if it was wet for 3 minutes, she said, It feels like it was. The nurse was also asked if she should have gotten a new cup to put the glucometer in after wiping it down, she stated, it's clean. She confirmed that it was the same cup she took into Resident 11's room. Staff B was then asked where the testing strips were, and she opened the top drawer of her medication cart looking for them. When she was asked if they were still in her pocket, she said, Oh, yes they are. The nurse was asked if they should have been taken into the room or be in her pocket and she said, No and placed them in top drawer next to the glucometer and shut the drawer. When she was asked if she thought she should have done something different, she said she would take only a couple of testing strips into the resident's room and would have wiped down the glucometer for longer. On 3/5/20 at 12:03 p.m. in an interview with the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) it was made known that the ADON had just held a competency for all nurses regarding the (blood glucose monitoring) process, and that Staff B, LPN did not attend. The DON said that she expected the nurses to know the (blood glucose monitoring) process properly and expected them to follow that process. She also expected her nurses to wear gloves when handling bleach wipes. The ADON said that she would complete a full competency with Staff B the next time she was scheduled to work the floor, because she wanted to ensure that this was taken care of immediately. Review of the facility policy titled, Glucometer Cleaning and Disinfection Policy, dated October 2019, under the sub-heading of Policy Explanation and Compliance Guidelines #1 read, The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to the manufacturer's instructions for multi-resident use. Review of the manufacturer's instructions in Section B Cleaning and Disinfecting the Meter the first sentence of the second paragraph on page 16 revealed, The meter should be cleaned and disinfected after use on each patient. On page 17 steps for cleaning (steps 1-4) and disinfecting (steps 5-9) are listed: Step 1: Wear appropriate protective gear such as disposable gloves. Step 3: Wipe the entire surface of the meter 3 times horizontally, and 3 times vertically using 1 towelette to clean blood and other body fluids. Step 4: dispose of the used towelette in a trash bin. Step 5: Open the towelette container and pull out 1 towelette and close the lid. Step 6: Wipe the entire surface of the meter 3 times horizontally and 3 times vertically to remove blood-borne pathogens. Step 8: Allow exteriors to remain wet for the appropriate contact time and then wipe the meter using a dry cloth.