STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH CARE CENTER	318 SOUTH EAST MAIN STREET LEBANON, VA 24266

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 03/09/20 through 03/12/20. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 03/09/2020 through 03/12/2020. No complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 56 at the time of the survey. The survey sample consisted of 15 current resident reviews and 3 closed record reviews.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and review of a facility document, it was determined the facility staff failed to ensure ensure that	F 684	LPN #1 was immediately in serviced on the administration of Dioxin and taking the resident's pulse prior to administration.	4/23/20

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

Electronically Signed | 04/15/2020

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 684	Continued From page 1 residents receive treatment and care for one (1) of 18 sampled residents (Resident #23) as evidenced by a failure to follow physician orders concerning the administration of digoxin. The findings included: Resident #23 was a resident in the facility at the time of this survey on 3/9/2020 through 3/12/2020. The resident had the admitting diagnoses of, but not limited to atrial fibrillation, high blood pressure, diabetes, end stage renal disease, dementia and depression. On the most recent MDS (Minimum Data Set) coded the resident as having a BIMS (Brief Interview for Mental Status) score of 10 out of a possible score of 15. Resident #23 was also coded as requiring extensive assistance with (2) or more staff members for dressing and personal hygiene and being totally dependent on (1) or more staff members for bathing. During the medication pass observation on 03/10/20 at 08:40 AM LPN (licensed practical nurse) #1 was preparing medications on the top of the medication cart outside the resident's room. As LPN #1 prepared the medication in which she stated it was Coreg to the surveyor she continued to verbally state to the surveyor, LPN #1 stated to the surveyor, "I have to check her heart rate before I give this medicine." The nurse placed the medication in which she had stated earlier to the surveyor that it was Coreg and continued to place this pill in a medicine cup. The surveyor observed LPN #1 place this cup to the side and the LPN did not place any other medications in this medicine cup. The surveyor continued to observe LPN #1 check the medication cards with the residents MARs	F 684	Physician for resident #23 was notified on3/10/20 regarding the administration of Digoxin before the pulse was obtained. Current residents in the center who have a physician order for Digoxin have the potential to be affected. Licensed Nurses were educated by the Director of Nursing on the 5 R(s) of medication administration including taking the resident's purse prior to administration of Digoxin and following physician orders. The Director of Nursing/Designee will observe via direct observation Medication Administration 3 xs weekly to ensure the 5 R(s) of medication administration are being completed including obtaining for those residents who have a physician order for Digoxin that the pulse is taken prior to administration. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, observations will be conducted on a random basis. The CAO/DON will be responsible for implementation of the plan of correction.	

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F 684	Continued From page 2 (Medication Administration Records). When LPN #1 had placed another pill in the second medication cup that had other medications in it. After this pill was placed in this cup, LPN #1 handed this medication card to the surveyor. The surveyor wrote this medication information from the label of the medication card in which was handed to her after this statement which read in part, " ...Digoxin 125 mcg (micrograms) 1 po (by mouth) daily. Hold if HR (heart rate) BELOW <60 ..." At 8:47 am, LPN #1 took both medicine cups and entered Resident #23's room along with the surveyor accompanying the nurse. The nurse gave the medicine cup that was full with the resident's medications to the resident and the resident proceeded to take all of these medications. This medicine cup was the cup that contained the Digoxin and the surveyor did not observe the nurse checking the resident's pulse before the Digoxin was administrated. After that, LPN #1 checked the pulse of the resident and gave the Coreg from the medication cup that only had this one pill in it. At 9 am, the surveyor asked LPN #1, why she checked the resident's pulse before she gave the resident the medication Coreg. LPN #1 stated, "I checked the pulse before I gave the Digoxin." The surveyor had notified her of the above documented observations. The nurse stated, "I'm so sorry I checked the pulse before I gave the Coreg but I should had checked it before I gave her the Digoxin." The surveyor notified the regional nurse on 3/10/2020 at 9:15 am, of the above documented findings. The surveyor requested and received	F 684		

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F 684	Continued From page 3 the policy titled, "6.0 General Dose Preparation Products and Services from Pharmacy" which read in part, " ...4.1.2 Confirm that the MAR reflects the most recent medication order ..." The surveyor reviewed the physician order for the Digoxin medication. The physician order read "Digoxin Tablet 125 MCG Give 1 tablet by mouth one time a day ...Hold if HR (heart rate) below 60 ..." This medication order had a date of 2/26/2020 as the order and start date of 2/26/2020 as documented on the Order Summery Report for Resident #52. The administrator, chief nursing officer, regional nurse, director of nursing, regional director of maintenance and regional director of human resources were notified of the above documented findings on 3/10/2020 at 4:45 pm in the conference. The surveyor again notified all named parties in the next end of the day conference on 3/11/2020 at approximately 4:30 pm. No further information was provided to the surveyor prior to the exit conference on 3/12/2020.	F 684		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756		4/23/20

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F 756	Continued From page 4 §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interviews and document review, it was determined the facility staff failed to ensure pharmacist medication regimen reviews were acted on by a provider for two (2) of 18 sampled residents (Resident #38 and Resident #48) as evidence by the absence of provider response documentation.	F 756	Resident 38's physician was notified and order received on 3/12/2020 for the PRN Temazepam to be discontinued. Resident 48's physician notified for new orders on 3/12/2020 regarding the Medication Regimen Review with new orders received.	

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F 756	Continued From page 5 The findings include: 1. The facility staff failed to ensure a provider acted on Resident #38's medication regimen review, dated 1/22/2020. Resident #38's diagnoses included, but were not limited to: high blood pressure, kidney disease, coronary artery disease, anxiety, depression, and chronic respiratory failure. Resident #38's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 1/24/2020, had the residents Brief Interview for Mental Status (BIMS) scored as a 14 out of 15 and the Resident Mood Interview scored as 16 out of 27. Resident #38 was assessed as requiring extensive assistance of two (2) or more individuals with bed mobility, transfers, dressing, and toilet use. Resident #38's progress notes included a pharmacy note, dated 1/22/2020, that indicated the pharmacist's completed medication regimen review recommendation(s) would be found in a separate report. No report dated 1/22/2020 regarding pharmacy recommendations was found within Resident #38's clinical record. On 3/12/2020 at 11:05 a.m., the facility's Regional Director of Clinical Services (RDCS) provided the surveyor with the aforementioned pharmacist's medication regimen review report dated 1/22/2020. The following information was found in this pharmacist report: "Comment: (resident's name omitted) has a PRN [as needed] order for a sedative/hypnotic without a stop date. Temazepam 30 mg Q [every] hs [bedtime] PRN [as needed] for insomnia. Recommendation: Please consider discontinuing or adding a stop	F 756	A three month audit was completed for pharmacy recommendations to ensure the recommendations were completed and new orders written when applicable. Nursing Leadership was educated by the Director of Nursing on the timely follow up on pharmacy recommendations. Pharmacy recommendations are emailed to the Director of Nursing and physicians will address on resident rounds in the center. The Director of Nursing/ Designee will review pharmacy recommendations monthly to ensure physician has addressed the medication regimen review. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, review will be conducted on a random basis. CAO/DON is responsible for the implementation of the plan of correction.	

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F 756	Continued From page 6 date to the current order ..." The area within the report for a physician's response was blank; no notation was made of whether the pharmacist's recommendation would be accepted or declined and no provider signature and date were documented. The RDCS confirmed this pharmacy recommendation dated 1/22/2020 had not been acted on by a provider until 3/12/2020 at 10:43 a.m. when the Temazepam order in question was discontinued; this was after the surveyor had asked about the 1/22/2020 pharmacist recommendations. The RDCS reported that providers including physicians, nurse practitioners, and physician assistants were allowed to address pharmacist's medication regimen review recommendations. Resident #38's clinical documentation included evidence of provider visits document on the following dates and times: 1/23/2020 at 12:50 p.m.; 1/27/2020 at 12:37 p.m.; 2/6/2020 at 1:00 p.m.; 2/7/2020 at 12:20 p.m.; 2/17/2020 at 1:05 p.m.; 2/21/2020 at 12:25 p.m.; and 2/24/2020 at 4:53 p.m. At none of the aforementioned visits did the provider address the Resident #38's 1/22/2020 pharmacist recommendation. The following information was found in the facility's Omnicare policy titled, "9.1 Medication Regimen Review" (with the latest effective date of 11/28/16): "7. Facility should encourage Physician/Prescriber or other Responsible Parties receiving the MRR (medication regimen review) and the Director of Nursing to act upon the recommendations contained in the MRR ... 8. Facility should alert the Medication Director when MRRs are not addressed by the attending physician in a timely manner."	F 756		

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F 756	Continued From page 7 During a survey team meeting on 3/12/2020 at 4:51 p.m., the failure of facility staff members to ensure Resident #38's 1/22/2020 pharmacist's recommendation was addressed by a provider was discussed for a final time with the facility's administrative team (Chief Nursing Officer, Administrator, Director of Nursing , Regional Maintenance director, Corporate Human resources Director, and RDCS). No additional information regarding this issue was provided prior to the exit conference. 2. The facility staff failed to ensure a provider acted on the pharmacist's medication regimen review, dated 01/22/2020, related to fluoxetine (given daily for depression) for Resident #48. Resident #48's clinical record was reviewed on 03/11/2020 and 03/12/2020. Within the admission record, the resident's diagnoses included, but were not limited to, Parkinson's disease, chronic obstructive pulmonary disease, type 2 diabetes mellitus, and other specified depressive episodes. Section C (cognitive patterns) of the resident's MDS (minimum data set) assessment, with an assessment reference date of 02/18/2020 included a BIMS (brief interview for mental status) summary score of 14 out of 15. The progress notes included a pharmacy note, dated 01/22/2020, that indicated the pharmacist's completed medication regimen review recommendation(s) would be found in a separate report. No report dated 01/22/2020 regarding pharmacy recommendations was found within Resident #48's clinical record. The facility's regional director of clinical services was asked about this referenced report on the morning of	F 756		

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F 756	Continued From page 8 03/12/2020. At 3:45 p.m. on 03/12/2020, the facility's director of nursing (DON) and administrator provided the surveyor with the pharmacist's consultation report dated 01/22/2020. The administrator acknowledged the report was not found in Resident #48's clinical record; the report had been emailed to the facility. The pharmacist's consultation report, dated 01/22/2020, read that Resident #48 received fluoxetine 40mg daily for depression and the recommendation read, "Please reduce fluoxetine to 20mg daily with the end goal of discontinuation. Rationale for Recommendation: Fluoxetine has a high incidence of anorexia and decreased appetite." The area within the report for a physician's response was blank; no notation whether the pharmacist's recommendation would be accepted or declined and no signature or date. The DON acknowledged the pharmacist's recommendation had not been addressed. Resident #48's clinical record included an order, dated 11/12/19, for "FLUoxetine HCl Capsule 40 MG Give 1 capsule by mouth one time a day related to OTHER SPECIFIED DEPRESSIVE EPISODES" to be started on 11/13/19. The resident's medication administration record (MAR) provided evidence Resident #48 had received "FLUoxetine HCL Capsule 40 MG" every morning at 9:00 a.m. in the month of January and February 2020 and through the 12th day in March 2020. The administrator provided two printed forms from the clinical record progress notes: 1) "C-Health Nursing Facility Progress Note" dated	F 756		

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F 756	Continued From page 9 02/25/2020, signed by a nurse practitioner and 2) a "Psychiatric Evaluation" with a date of service being 02/24/2020 electronically signed by a psychiatric-mental health nurse practitioner (PMHNP). The administrator stated that since both of these providers had seen Resident #48 after the pharmacist's consultation on 01/22/2020, either of them could have reviewed and acted on the pharmacist's recommendations but there was no evidence that either of them reviewed the pharmacist's recommendations. The facility's Omnicare policy titled, "9.1 Medication Regimen Review" with the latest effective date of 11/28/16 read in part, "7. Facility should encourage Physician/Prescriber or other Responsible Parties receiving the MRR (medication regimen review) and the Director of Nursing to act upon the recommendations contained in the MRR." And, "8. Facility should alert the Medication Director when MRRs are not addressed by the attending physician in a timely manner." The administrative team including the facility's chief nursing officer, administrator, DON, regional maintenance director, corporate human resources director, and regional director of clinical services were informed of the above described concern during a meeting on 03/12/2020 at 4:51 p.m. No further information regarding this issue was provided prior to the exit conference.	F 756		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F 761		4/23/20

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F 761	Continued From page 10 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and the review of a facility document, it was determined the facility staff failed to accurately label a medication for one (1) of 18 sampled residents as evidenced by the label not corresponding with the correct duration of the medication to be administrated to the resident (Resident #52). The findings include: Resident #52 was in the facility in the time of this survey, 3/9/2020 thorough 3/12/2020. On the most recent MDS (Minimum Data Set), the	F 761	Pharmacy was notified and received the updated label for Eliquis. An audit of medication labels was conducted to ensure labels were accurate. Licensed Nurses were educated by the Director of Nursing on medication label change policies and procedures. In addition, education included pharmacy notification of medication changes.	

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F 761	Continued From page 11 resident was coded as requiring extensive assistance of 2 staff members for dressing and personal hygiene and being totally dependent on 2 staff members for bathing. Resident #52 was also coded as having a BMS (Brief Interview for Mental Status) had problems with long and short term memory and was moderately impaired in decision making Resident #52's admitting diagnoses included, but not limited to atrial fibrillation, high blood pressure, diabetes, dementia and depression. During the medication observation on 3/10/22020 at 8:12 am with LPN (licensed practical nurse) #1, the surveyor observed LPN #1 prepared medications to be given to Resident #52. The nurse handed me the medication card for the medication Eliquis which read in part, "Eliquis 5 MG (milligram) Tablet EA (each) Give 10 MG by mouth two times a day for 7 days ..." LPN #1 proceed to administrator this medication to the resident. When the nurse returned to the medication cart, the surveyor asked LPN #1 according to the directions on the MAR (Medication Administration Record) when was the date that the Eliquis was to be stopped on the 7th day. The nurse researched the MAR and stated "The label hasn't been changed because the doctor changed that on 3/3/2020 to be given two times a day with no stop date." The surveyor notified the regional nurse of the above documented findings at 8:25 am at which time the surveyor requested a copy of the facility's policy on medication labels or what to do when the dosage or the duration of the medication had been changed. The regional	F 761	The Director of Nursing/Designee will review medication cards for 5 residents weekly to ensure labels are accurate. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audit will be conducted on a random basis. The CAO/DON will be responsible for implementation of the plan of correction.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 12 nurse provided the surveyor with a copy of the policy titled "Labeling of Medications" at 11 am on 3/10/2020, which read in part as follows: " " ...10. Only the issuing pharmacy may place a drug label on a medication container. " 11. The pharmacy must be informed of any changes in directions for the use of drug ... " 13. Only a physician or pharmacist may change a medication label ..." The surveyor notified the administrator, chief nursing officer, regional nurse, director of nursing, regional maintenance officer and regional human resources officer of the above documented findings on 3/10/2020 at approximately 4:30 pm and again on 3/12/2020 at 4:45 pm. No further information was provided to the surveyor prior to the exit conference on 3/12/2020.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		4/23/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING _____ B. WING _____	03/12/2020

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F 880	Continued From page 13 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the	F 880		

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F 880	Continued From page 14 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and review of a facility document, it was determined the facility staff failed to maintain an infection prevention and control program for one (1) of 18 sampled residents as evidenced by bringing a bottle of blood glucose strips into the resident's room and not cleaning the bottle before storing them in the medication cart and by not changing a pair of dirty gloves before opening the resident's blinds (Resident #23) The findings included: Resident #23 resided in the facility while an unannounced Medicare/Medicaid survey was conducted from 3/9/2020 through 3/12/2020. The resident had the admitting diagnoses of, but not limited to atrial fibrillation, heart failure, arthritis, dementia and chronic obstructive pulmonary disease. On the most recent MDS (Minimum Data Set) coded the resident as having a BIMS (Brief Interview for Mental Status) score of 10 out of a possible score of 15. Resident #23 was also coded as requiring extensive assistance with two (2) or more staff members for dressing and personal hygiene and being totally dependent on	F 880	LPN #1 was immediately educated on the infection control practices during medication administration including removing one strip from the bottle of glucose strips and not taking the whole bottom in the room. In addition, education included wearing gloves and handwashing. Bottle of blood glucose strips were discarded and medication cart cleaned. Current residents in the center have the potential to be affected. Licensed Nurses were educated by the Director of Nursing on proper infection control policies during medication administration including wearing gloves and handwashing practices. The Director of Nursing/ Designee will observe medication observation 3x/week to ensure infection control practices are being followed. The results will be reported monthly to the	

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F 880	Continued From page 15 one (1) or more staff members for bathing. During the medication pass observation on 3/10/2020 at 8:45 am, the surveyor observed LPN (licensed practical nurse) #1 administrated the medications the physician had ordered to be given at the 8am medication pass. While LPN #1 was in the room with the resident, the resident requested LPN #1 to open her blinds. LPN #1 proceeded to open the blinds with the gloves that LPN #1 had previously had on while she was sticking the resident's finger to obtain blood for the blood glucose level. LPN #1 removed her gloves and washed her hands. The surveyor had also observed LPN #1 bring in a bottle of blood glucose strips that had several strips in it. After washing her hands, LPN #1 exited the resident's room, placed the bottle of blood glucose strips in the medication cart drawer for storage. The surveyor did not observe LPN #1 clean and wipe down the bottle of blood glucose strips prior to putting them in the medications cart. At 8:47 am, the surveyor asked LPN #1 what should she had done prior to opening the resident's blinds in her room. LPN #1 stated, "I should had taken my dirty gloves off and washed my hands before I opened the blinds." The surveyor then asked what she should had done before bringing the bottle of blood glucose strips and storing them in the medication cart drawer. LPN #1 stated, "I should had wiped the bottle down with a cleaning wipe." At 9 am, the surveyor notified the regional nurse of the above documented findings. The surveyor requested the facility's policy on the cleaning of multi-use resident supplies once they are brought out of the resident's room.	F 880	Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, the observation will be conducted on a random basis. The CAO/DON will be responsible for the implementation of the plan of correction.	

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F 880	Continued From page 16 At 11:25 am, the chief nursing officer provided the surveyor with the policy titled, "6.0 General Dose Preparation and Medication Administration" which read in part, " ...6.4 Clean any reusable equipment or supplies ..." The surveyor notified the administrator, chief nursing officer, regional nurse, director of nursing, regional maintenance officer and regional human resources officer of the above documented findings on 3/10/2020 at approximately 4:30 pm and again on 3/12/2020 at 4:45 pm. No further information was provided to the surveyor prior to the exit conference on 3/12/2020.	F 880		