STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSHIRE NURSING CENTER	**300 MEADOWLAND DRIVE HILLSBOROUGH, NC 27278**

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of this complaint investigation conducted 10/27/2016 Event ID # CEJM11	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 278		11/24/16

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

Electronically Signed | 11/18/2016

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F 278	Continued From page 1 Based on staff interviews and medical record review, the facility failed to accurately code the Minimum Data Set (MDS) assessment to reflect the use of an antidepressant medication for 1 of 5 residents reviewed for unnecessary medications (Resident #92). The findings included: Resident #92 was admitted to the facility on 9/14/16 from a hospital. Her cumulative diagnoses included major depressive disorder. A review of Resident #92 ' s admission medication orders dated 9/15/16 included one-100 milligrams (mg) sertraline tablet and one-25 mg sertraline tablet (an antidepressant medication) to be given every day for depression. No antipsychotic medication was ordered for Resident #92. A review of Resident #92 ' s Medication Administration Record (MAR) revealed the resident received an antidepressant medication on 6 of 7 days from 9/14/16 to 9/20/16. No antipsychotic medication was documented as given to Resident #92 from 9/14/16 to 9/20/16. Resident #92 ' s admission Minimum Data Set (MDS) assessment was dated 9/20/16. Section N of the MDS indicated the resident did not receive an antidepressant medication during the 7-day look back period (9/14/16 to 9/20/16). Section N of the MDS indicated Resident #92 received an antipsychotic medication on 6 out of 7 days during the look back period. An interview was conducted on 10/27/16 at 11:40 AM with MDS Nurse #1. Upon review of Resident	F 278	Resident 92's assessment was modified on 10/27/2016 to correct the error in classification of sertraline to reflect that it is an antidepressant. On 11/17/2016 MDS Nurse 1 and MDS Nurse 2 were inserviced by the DON and the Administrator in regards to the proper coding and importance of accuracy when filling out the MDS assessment. All other residents' MDS assessments that have prescribed psychoactive medications are to be audited and examined for accuracy and proper coding utilizing the "MDS/CP AUDIT TOOL" by 11/24/2016 by MDS Nurse #1. Any errors found will be corrected and will be reported to the DON and the QA committee. In order to prevent future recurrence, the Quality Assurance Committee(Q.A.) has implemented a review policy and procedure, whereby the Director of Nursing Services(DON), the DON's designee, or the facility Nurse Consultant, will review the MDS Nurses' assessments for proper coding/accuracy on all new admits for the next 30 days, and then a ten percent sample each month thereafter. Results will be reported back to the QA committee monthly for 90 days and quarterly thereafter. The QA committee will re-evaluate for ongoing monitoring and performance.	

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F 278	Continued From page 2 #92 ' s MDS and Medication Administration Record (MAR), the MDS nurse confirmed Resident #92 received sertraline on 6 days during 7-day look back period from 9/14/16 to 9/20/16. No antipsychotic medication was identified as having been given during this look back period. Upon further review, MDS Nurse #1 reported another nurse had coded the medications in Section N. An interview was conducted on 10/27/16 at 12:09 PM with MDS Nurse #2. MDS Nurse #2 was identified as the nurse who had completed Section N of Resident #92 ' s MDS assessment. Upon review of the coding of medications in Section N of the MDS, MDS Nurse #2 reported, "I keyed it (the medications) in wrong." She acknowledged the resident received an antidepressant medication and did not receive an antipsychotic medication during the 7-day look back period. An interview was conducted on 10/27/16 at 2:55 PM with the facility ' s Director of Nursing (DON. During the interview, the DON indicated she expected residents ' MDS assessments to be coded accurately.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial	F 279		11/24/16

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F 279	Continued From page 3 needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to develop a written care plan with measureable goals and interventions for Resident #37 who sustained a fractured right tibia and a comminuted fracture of the right fibula. This was evident in 1 of 1 resident in the sample reviewed for accidents. Findings included: Resident #37 had cumulative diagnosis which included osteoporosis (a disease in which the bones become weak and are more likely to break) and was diagnosed with a fractured right tibia (larger bone of the lower leg) and a comminuted fracture of the right fibula (smaller bone in the lower leg) on 8/16/16 requiring a hard cast. By 09/26/2016 the hard cast was replaced with a pillow splint. Review of the October 2016 physician orders included: Vitamin D3 1,000 Units every day by mouth Synthroid 50 micrograms every day by mouth	F 279	On 10/27/2016 Resident 37's care plan was updated to address the goals and interventions associated with the fracture that Resident 37 had sustained. This was done by MDS Nurse #1. MDS Nurse #1 will review all other residents' with fractures care plans for accuracy by 11/24/2016. Any deficits noted will be corrected and revised. The Interdisciplinary Care Plan Team was in-serviced on 11/17/2016 by the Administrator and the Director of Nursing as to the importance of the development of individualized care plans for the resident in order meet the resident's medical, nursing, and mental and psychosocial needs in order to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.	

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F 279	Continued From page 4 Review of the quarterly Minimum Data Set (MDS) assessment dated 06/27/2016 revealed the resident had impaired cognition and required extensive assistant of 2 staff for bed mobility and transfer. Review of the care plans updated on 8/16/16 and 10/4/16 revealed no goals or interventions to address the interventions associated with the care and services for a fractured right tibia and a comminuted fracture of the right fibula. Interview on 10/27/2016 at 1:26 PM with Nurse #2 revealed Resident #37constantly kicked off her pillow splint. Interview on 10/27/2016 at 1:27 PM with Nurse #3 stated Resident #37 kicked off her pillow splint when applied. Interview and record review of the care plans on 10/27/2016 at 4:30PM with the Administrator and MDS Nurse #1 was done. MDS Nurse #1 indicated the MDS Assistant Nurse #3 usually updated the care plans of residents that were long term care placement. MDS Assistant Nurse #3 no longer worked at the facility and attempts to interview MDS Assistant Nurse #3 was unsuccessful. On 10/27/2016 at 4:37 PM an interview with the Administrator and the Director of Nurses revealed they expected a care plan be developed and revised to address the fractures.	F 279	In order to prevent future recurrence, the Quality Assurance Committee(Q.A.) has revised the review policy and procedure, whereby the Director of Nursing Services(DON), the DON's designee, or the facility Nurse Consultant, will review the Care Plans to ensure that they include measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs. Auditor(DON, Designee, or Consultant) will utilize MDS/CP Audit Tool. This will be done for all new admissions for 30 days and 10 percent of the resident population monthly for 90 days. The results will be reported back to the QA committee monthly for 90 days to monitor for compliance and performance and quarterly thereafter. The QA committee will re-evaluate quarterly for ongoing monitoring and performance.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		11/24/16

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F 329	Continued From page 5 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to accurately transcribe and administer a medication in accordance with the physician ' s admission orders, resulting in more frequent dosing of the medication for 1 of 5 residents (Resident #25) reviewed for unnecessary medications. The findings included: Resident #25 was admitted to the facility on	F 329	Nurse #3 was in-serviced on correct order entry, accuracy, clarification, and verification and following physician orders by the DON on 10/28/2016. All Nurses, including nurses identified as administering the bisacodyl on 09/03, 09/04, 09/10, 09/11, will be in-serviced by 11/23/2016 (Dates vary due to work schedules) regarding proper order entry/accuracy/clarification and verification	

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F 329	Continued From page 6 8/31/16 from another nursing home facility. Her cumulative diagnoses included: abdominal aortic aneurysm and constipation. A review of Resident #25 ' s medical record revealed her August 2016 Physician ' s Orders from the previous nursing home facility included an order for a 10-milligram (mg) bisacodyl rectal suppository (a stimulant laxative) to be given every other day; hold if the resident had a bowel movement that day. The August 2016 Physician ' s Orders included a hand-written date of 8/31/16 and was signed by Nurse #3. Further review of Resident #25 ' s current Physician ' s Orders included an order dated 8/31/16 for 10 mg bisacodyl rectal suppository, with instructions to give one suppository rectally once daily at bedtime (scheduled at 9:00 PM daily); hold if the resident had a bowel movement that day. A review of the resident ' s Medication Administration Record (MAR) and BM (bowel movement) and Urine Output Report from 8/31/16 to 9/12/16 revealed the following: On 9/2/16, Resident #25 received a 10 mg bisacodyl rectal suppository (scheduled for 9:00 PM); and, On 9/2/16 at 9:27 PM, the resident was noted as having a large, soft bowel movement. On 9/3/16 at 1:57 PM, Resident #25 was noted as having an extra-large, loose/watery bowel movement; On 9/3/16, the resident received a 10 mg bisacodyl rectal suppository (scheduled for 9:00 PM); and, On 9/3/16 at 9:29 PM, the resident was noted as	F 329	techniques and following physician orders. This was done by the DON. All Other Residents' current, active orders will be reviewed and verified for accuracy by the DON, The DON's designee, Nursing and/or Pharmacy consultant. Any inaccuracies found will be corrected and notified to the DON. This will be done by 11/23/2016 This will continue on a ongoing basis. All written orders will be sent to the pharmacy by the nurse taking the order by fax. The order will then be input into the Electronic Health Record(EHR) by the nurse receiving the order. Then a second nurse will compare the orders entered into the Electronic Health Record(EHR) and verify for accuracy on the same day as the order is received. The second nurse will report any error to the DON and will make any corrections as needed. When the pharmacy delivers the medication to the facility, the nurse receiving the medication will review and confirm the order and medication. The receiving nurse will confirm this in the Electronic Health Record(EHR). Any discrepencies or errors will be reported to the facility/pharmacy for resolution. The DON, or the DON's designee will monitor and verify for compliance a 10 percent sample of the new orders each month and report results utilizing the "Nurse Order Entry Verification Monitor" to the QA committee monthly for three months at which time the QA committee	

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F 329	Continued From page 7 having a small, soft bowel movement. On 9/4/16 at 11:05 AM, Resident #25 was noted as having an extra-large, loose/watery bowel movement; On 9/4/16, the resident received a 10 mg bisacodyl rectal suppository (scheduled for 9:00 PM); and, On 9/4/16 at 9:17 PM, the resident was noted as having a medium, soft bowel movement. On 9/10/16 at 8:38 PM, Resident #25 was noted as having a small, normal bowel movement; and, On 9/10/16, the resident received a 10 mg bisacodyl rectal suppository (scheduled at 9:00 PM). On 9/11/16 at 2:09 PM, Resident #25 was noted as having a medium, normal bowel movement; On 9/11/16, the resident received a 10 mg bisacodyl rectal suppository (scheduled at 9:00 PM); and, On 9/11/16 at 9:33 PM, the resident was noted as having an extra-large, soft bowel movement. Resident #25 ' s admission Minimum Data Set (MDS) assessment dated 9/12/16 indicated the resident had moderately impaired cognitive skills for daily decision making. Resident #25 required extensive assistance for all of her Activities of Daily Living (ADLs), with the exception of requiring supervision only for eating. A review of the resident ' s medical record revealed a Physician ' s Telephone Order was received on 9/13/16 by Nurse #3. The order read, in part: " Change bisacodyl supp (suppository) from every other day to daily until further notice. "	F 329	will re-evaluate quarterly for ongoing monitoring and performance.	

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F 329	Continued From page 8	F 329		

An interview was conducted on 10/27/16 at 9:50 AM with Nurse #3. Upon review of Resident #25's medical record, Nurse #3 stated she was the hall nurse who input the resident's admission orders into her medical record on 8/31/16. Nurse #3 reviewed the August 2016 Physician's Orders and confirmed it was her signature on the order form. The nurse reported her signature indicated these orders were used as the basis for Resident #25 ' s admission orders on 8/31/16. The nurse stated the admission orders for the bisacodyl rectal suppository were written in error and should have been written as every other day (not once daily).

A follow-up interview was conducted on 10/27/16 at 11:45 AM with Nurse #3. During the interview, the nurse recalled she had identified the dosing error of the bisacodyl suppository for Resident #25 on 9/13/16. When she brought the error to the attention to the Nurse Practitioner (NP), he changed the order. The nurse again acknowledged the resident ' s admission order for the bisacodyl suppository was erroneously written and should have included instructions for the suppository to be given every other day instead of every day.

An interview was conducted on 10/27/16 at 1:34 PM with the facility ' s NP. During the interview, the transcription and administration errors made on the dosing frequency for Resident #25 ' s bisacodyl suppository were discussed. When asked, the NP stated the errors were, "absolutely" a concern.

An interview was conducted on 10/27/16 at 2:35 PM with Resident #25. Upon inquiry, the resident specifically recalled having a problem with loose

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F 329	Continued From page 9 stools on one occasion when she had family members visiting her. No other concerns were expressed by the resident at that time. An interview was conducted on 10/27/16 at 2:55 PM with the facility ' s Director of Nursing (DON). During the interview, the DON stated she had not been made aware of the medication dosing error made for Resident #25 ' s bisacodyl suppository prior to the date of the interview. The DON stated her expectation for a resident ' s admission orders would be, "That they are right."	F 329		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to be free of a medication error rate greater than 5% as evidenced by 3 medication errors out of 25 opportunities, resulting in a medication error rate of 12%, for 3 of 7 residents (Resident #104, Resident #16, and Resident #24) observed during medication pass. The findings included: 1) Resident #104 was admitted to the facility on 9/16/15. His cumulative diagnoses included diabetes. A review of Resident #104 ' s physician orders	F 332	On 11/15/2016 Nurses 1, 2, and 4 were given required in-service education by the Director of Nursing(DON) on the facility policy of following Physician's orders as written including but not limited to route, dosing, quantity, frequency. Nurses 1, 2, and 4 will also have medication pass audits conducted by the DON, or Nurse Manger, to verify adherence to facility policy.(11/16/2016) Other Nurses employed will be required to receive in-service training on administration of medications in accordance with physician orders. The will	11/24/16

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F 332	Continued From page 10 included the following medication: 14 units of Humalog insulin to be injected subcutaneously (under the skin) three times daily " WITH MEALS. " Humalog insulin is a rapid-acting insulin. The manufacturer instructions indicate Humalog insulin should be administered within 15 minutes before or immediately after a meal. On 10/25/16 at 4:25 PM, a continuous medication pass observation was made as Nurse #1 completed a blood glucose (BG) check for Resident #104. At 4:30 PM, the nurse drew up 14 units of Humalog insulin into a syringe and administered the insulin to Resident #104. On 10/25/16 at 4:58 PM, an interview was conducted with Nurse #1. During the interview, the nurse was asked when Resident #104 ' s meal tray would be delivered to him. The nurse reported the evening meal tray was usually brought down to the residence hall around 5:00 - 5:15 PM each day. An observation was made on 10/25/16 at 5:10 PM as the meal trays were delivered to Resident #104 ' s hall. At 5:12 PM, Resident #104 was observed to be lying in bed with a family member assisting him with drinking milk from the meal tray. Upon inquiry, the resident and family member reported no concerns with low blood sugars at that time. An interview was conducted on 10/26/16 at 2:00 PM with the facility ' s Director of Nursing (DON). During the interview, the timing of the 10/25/16 Humalog insulin administration 40 minutes prior to a meal for Resident #104 was discussed. Upon inquiry, the DON stated she would have expected when an insulin dose was ordered to be	F 332	be completed by the DON. (TBCB 11/23/2016) The QA committee has established a schedule for each nurse to have a med pass audit, utilizing the "Medication Pass Worksheet/Technique worksheets", conducted by the DON, the pharmacy consultant, or the nurse consultant at least annually and 15% of the nurses will be done on a monthly basis. Any medication administration errors will be reported to the DON and the QA committee for review and further action as necessary.	

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F 332	Continued From page 11	F 332		

given with meals, that it would have been, "given with meals." The DON acknowledged a delay between the administration of a rapid acting insulin and the meal had potential for an adverse effect.

An interview was conducted on 10/27/2016 at 1:34 PM with the facility ' s Nurse Practitioner (NP). During the interview, Resident #104 ' s order for Humalog insulin to be given with the meal was reviewed. Additionally, the NP was informed of the observation of this insulin having been administered 40 minutes prior to the meal. The NP responded, "Oh no." He reported the delay between the insulin administration and meal provision was "absolutely" a concern. The NP emphasized he would not want the Humalog insulin to be given more than 15 minutes before a meal.

2) Resident #16 was admitted to the facility on 10/7/16. Her cumulative diagnoses included gastro-esophageal reflux disease.

A review of Resident #16 ' s physician orders included the following medication: calcium antacid 500 milligram (mg) chewable tablet (calcium carbonate) to be given as 2 tablets via gastrostomy tube one time per day.

On 10/26/16 at 8:55 AM, a medication pass observation was made as Nurse #2 administered 4 medications to Resident #16 via gastrostomy tube. The medications included one-500 mg calcium carbonate chewable tablet.

An interview was conducted on 10/26/16 at 11:07 AM with Nurse #2 related to the medication administration observation. Upon request, Nurse

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#2 reviewed Resident #16 ' s Medication Administration Record (MAR). Nurse #2 acknowledged the MAR indicated two-500 mg calcium carbonate tablets should have been administered to the resident versus only the one tablet given.

An interview was conducted on 10/26/16 at 2:00 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported she had been made aware that one resident observed during med pass had received only one tablet versus two tablets of calcium carbonate ordered. The DON indicated she expected medications to be administered as ordered.

3. Resident #24 was admitted to the facility on 10/07/09 with cumulative diagnoses which included diabetes mellitus.

Review of the October 2016 monthly physician orders included Novolog 100 units/milliliters 3 units (U) subcutaneous (SQ) before meals. Novolog is a rapid-acting insulin. Novolog 3 U SQ was to be held for finger sticks for blood sugars (FSBS) results that were less than 80 milligrams/deciliters (mg/dl). The reference range for FSBS was 80 -130 mg/dl.

Reviewed of the FSBS results on 10/24/16 revealed:
6:30 AM 280 mg/dl
11:30 AM 300 mg/dl
4:30 PM 251 mg/dl
9:00 PM 250 mg/dl

Reviewed of the FSBS results on 10/25/16

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F 332	Continued From page 13 revealed 6:30 AM 100 mg/dl 11:30 AM 321 mg/dl 4:30 PM 234 mg/dl 9:00 PM 211 mg/dl Observation during the medication pass on 10/25/2016 at 4:30 PM revealed Nurse #4 drew up Novolog 5 U into a syringe to administer to Resident #24. Nurse #4 was ready to administer the 5 U of insulin when an inquiry was made regarding the drawn dose. Interview with Nurse #4 stated on 10/25/2016 at 4:37 PM the amount of insulin in the syringe was 3 U. Nurse #4 rechecked the amount of insulin in the syringe then pushed the plunger of the syringe to 3 U. When the plunger was pushed insulin was observed spilling out of the needle. Interview on 10/27/2016 at 4:00 PM with the Director of Nurses revealed she expected medication to be administered as ordered.	F 332		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		11/24/16

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F 441	Continued From page 14 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to practice proper hand-washing or hand sanitizing between residents (Resident #104 and #68) during 1 of 5 continuous observations of a medication pass. The findings included: A review of the facility's policy (not dated) on Basic Care Hand-washing included the following, in part: "Clean your hands: · Before and after having direct contact with a	F 441	On 10/26/2016 Nurse #1 was in-serviced on proper hand-washing and hand-sanitizer use by the DON. On 11/15/2016 Nurse #1 was in-serviced again on proper hand-washing and hand-sanitizer use along with other areas of concern. All Nursing staff will be in-serviced on the facility hand-washing and hygiene policy by the DON by 11/23/2016. The DON and the nursing charge nurses	

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F 441	Continued From page 15 patient ' s intact skin (taking a pulse or blood pressure, performing physical examinations, lifting the patient in bed); · After contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings; · After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient; · After glove removal. " On 10/25/16 at 4:25 PM, a continuous medication pass observation was made as Nurse #1 donned gloves, gathered supplies, and completed a blood glucose (BG) check for Resident #104. At 4:30 PM, the nurse removed her gloves, drew up 14 Units of Humalog insulin into a syringe, and then donned another pair of gloves prior to administering the insulin to Resident #104. Nurse #1 returned to medication cart and removed her gloves. Nurse #1 did not wash her hands nor use hand sanitizer after removing her gloves. On 10/25/16 at 4:35 PM, Nurse #1 was observed as she gathered the necessary supplies to check Resident #68's BG level. The nurse was observed as she donned gloves, checked his BG level, and then returned to the medication cart. Once at the medication cart, the nurse removed her gloves and immediately put on a pair of clean gloves. At 4:40 PM, Nurse #1 drew up 12 Units of Humalog insulin and administered it to Resident #68. The nurse returned to the medication cart, removed and discarded her gloves, and then put away the supplies. Nurse #1 used the computer terminal placed on the medication cart. The nurse did not wash her hands or use the hand sanitizer stored on top of the medication cart.	F 441	will observe and monitor for proper hand washing/sanitizing during medication pass audits and in the course of making daily routine rounds through the facility. 15 percent of the nurses will be monitored monthly using the "medication pass worksheet/technique worksheet" and the results reported monthly to the DON and the QA committee for monitoring, review and further action if needed.	

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F 441	Continued From page 16 On 10/25/16 at 4:45 PM, Nurse #1 was observed as she prepared 4 oral medications for administration to Resident #104. Between pulling the 1st and 2nd medications, the nurse was observed as she coughed into her hand. She did not wash her hands or use hand sanitizer. Nurse #1 was observed as she administered the 4 oral medications to Resident #104. At 4:50 PM, Nurse #1 returned to the medication cart and used the computer terminal placed on the cart. The nurse did not wash her hands or use the hand sanitizer stored on top of the medication cart. On 10/25/16 at 4:53 PM, Nurse #1 was observed as she prepared 3 oral medications for administration to Resident #68. The nurse placed the medications into a med cup, poured water into a cup and placed a straw in the cup. At 4:55 PM, Nurse #1 went into Resident #68's room, adjusted the resident ' s bed using the bedside control panel, assisted the resident by holding the cup and straw, then readjusted the bed position prior to leaving his room. Nurse #1 returned to the medication cart. She did not wash her hands or use hand sanitizer upon return to the cart. On 10/25/16 at 4:58 PM, an interview was conducted with Nurse #1. During the interview, the nurse was asked why she did not wash her hands or use hand sanitizer at any point during the continuous observation of the medication pass. Upon inquiry, the nurse indicated she had forgotten to perform hand hygiene. When asked what her usual practices included, the nurse stated, "Oh yes, I would use sanitizer before and between medications for residents."	F 441		

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F 441	Continued From page 17 An interview was conducted on 10/26/16 at 11:25 AM with the facility ' s Director of Nursing (DON). During the interview, continuous observations of the 10/25/16 medication pass and failure to perform hand hygiene were discussed. In response, the DON stated, "They know better." The DON reported she would always expect nurses to wash hands or use hand sanitizer between residents during med pass administration.	F 441		