STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355102	A. BUILDING _____ B. WING _____	11/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAPOLEON CARE CENTER	311 E 4TH ST NAPOLEON, ND 58561

(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 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: Based on observation, medical record review, and staff interviews, it was determined, for two of 11 sample residents (#6 and #2), that the MDS (Minimum Data Set) assessments completed by facility staff did not accurately reflect information on the residents' status at the time the	F 278	Napoleon Care Center (NCC) will complete accurate assessments reflecting the residents status on the Minimum Data Set (MDS). 1. Accurate assessments re: resident no. 2 will be completed with subsequent scheduled assessments. (resident no. 6 has passed away) Resident no. 6 had section H re: indwelling catheter checked and section J for fall history corrected prior to it being closed on November 18, 2016. 2. All residents will have accurate assessments reflecting the resident's status on MDS. 3. Education will be provided on December 14, 2016 staff meeting to the CNA's, CMA's and nurses for proper coding. Also the MDS nurses will communicate ADL changes to the careplan nurse. 4. NCC will monitor resident no. 2 in addition a random sample of NCC residents that their MDS assessments are completed accurately monthly x 3, then quarterly by an MDS nurse. The QA data will be reviewed by the QA committee. 5. Completion Date: December 19, 2016.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Richard Wegner | TITLE: Administrator | (X6) DATE: 12-16-16

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 278	Continued From page 1 assessments were completed. The findings included: 1. Resident #6's medical record review revealed the resident had been admitted to the facility on 11/24/15. The record showed the resident had been sent to the hospital on 11/3/16 at 2400 (Midnight) with elevated blood pressure and having had two falls. The resident returned to the facility on 11/4/16 with orders for "Comfort Care" with diagnoses of compression fracture (L2), pelvic fracture, and intracranial hemorrhage. a. Review of the resident's MDS assessment showed a significant change was initiated with a reference date of 11/8/16. The section H (0100) was not coded for the resident having an indwelling catheter. The resident was observed during cares on 11/15/16 with a Foley catheter. The area under section J for fall history was also found to be blank even though the resident had two falls since the last assessment. b. Interviews on 11/16/16 with staff responsible for the MDS confirmed that the resident #6's MDS was not accurately coded. 2. Review of resident #2's 8/18/16 annual MDS assessment revealed that the resident was assessed to required extensive assistance by two staff for transfer and dressing. The resident was coded to be moderately hearing impaired. On 11/18/16 at 10:45 AM, in an interview with CNA C, she said that the resident required one staff member for assistance with transfer. Review of the resident's care plan revealed a problem of Mobility/Transfers (dated 8/18/15) with	F 278		

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F 278	Continued From page 2 an approach of provide 1 assist with transfer with the standing mechanical lift. For the problem listed as dressing; dependent for dressing (dated 8/18/15) the approach was noted to be provide 1 assist with dressing. On 11/16/16 at 10:05 AM, during an observation of the resident's care with CNAs (I and C), the CNAs confirmed that the resident was very hard of hearing (HOH) and a communication board to write on was the best way to communicate with the resident. The resident's MDS assessment did not reflect the resident's actual status.	F 278		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	NCC will provide accurate careplans developed by the IDT members to direct resident care needs. 1. Accurate careplans re: resident no. 2, 3, and 10 on their bowel and bladder will be updated. Resident no. 4 will have his mobility/transfer section and behavior section updated. Resident no. 9 will have his fall and behavior sections updated. 2. All residents will have accurate careplans. 3. Education will be provided on December 14, 2016 to the CNA's, CMA's and Nurses re: accurate careplanning and notifying careplan staff of resident changes.	

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F 280	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interviews, the facility failed to ensure residents' plans of care were evaluated and revised to meet residents' individual needs. This was identified for 5 of 11 sampled residents (#3, #4, #2, #10, and #9). The findings included: 1. Review of resident #10's 10/30/16 annual MDS assessment revealed that the resident was coded to frequently be incontinent of bladder and continent of bowel. On 11/18/16 at 10:45 AM, in an interview with CNA C, she said that the resident was continent of bladder in the daytime and incontinent of bladder at night and continent of bowel. Review of the resident's care plan for the problem of toileting (dated 10/30/13), the resident was noted to be "incontinent of bowel & bladder". The resident's care plan did not reflect the current assessment and staff verified information of the resident's bowel and bladder status. Additionally, review of the resident's nursing notes from 6/21/16 to 10/13/16 revealed the resident was having some behaviors and hallucinations and delusions. The resident was seen by the mental health nurse practitioner (MHNP) on 8/12/16. Although a problem of "PSYCH MEDS" and the MHNP's visit were listed on the care plan, the care plan did not address behaviors or give processes for staff to use to care for the resident	F 280	4. NCC will monitor resident no. 2,3,4,9, and 10 in addition to a random sample of NCC residents for accurate careplans montly x 3, then quarterly by the QA coordinator. The QA data will be reviewed by the QA committee. 5. Completion Date: December 19, 2016.	

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F 280	Continued From page 4 in relation to the these issues. 2. Review of resident #2's 8/18/16 annual MDS assessment revealed that the resident was coded to be frequently incontinent of bladder and continent of bowel. On 11/18/16 at 10:45 AM, in an interview with CNA C, she said that the resident was incontinent of bladder and continent of bowel. Review of the resident's care plan revealed a problem of incontinent of urine & bowel. The resident's care plan did not reflect the current assessment and staff verified information of the resident's bowel and bladder status 3. Record review on 11/15/16 of resident #4's Diagnosis and Allergy form in the electronic health record (EHR) revealed diagnoses that included dementia with behavioral disturbances (8/23/16), anxiety disorder, essential hypertension, COPD, gout, generalized osteoarthritis, GERD, depression, and history of falling. Review of the resident's 8/25/16 annual Minimum Data Set (MDS) assessment evidenced that the resident was assessed to have a BIMS of 12 which indicated the resident was moderately cognitively impaired. He was assessed to have verbal behaviors with an improvement in behaviors. The resident was assessed to require extensive assistance for bed mobility, transfer, walk in room, locomotion on and off unit, dressing, toilet use, personal hygiene, and bathing. The resident was assessed to be incontinent of bowel and bladder. The resident was noted to have had two falls with no injury	F 280		

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F 280	Continued From page 5 since his last assessment. Review of the resident's care plan evidenced a problem of mobility/transfers (dated 6/26/14). The resident's care plan indicated that the resident was "independent with transfers with FWW (front wheeled walker). Independent with in room ambulation with FWW. W/c for most mobility. Does self propel. May need 1 assist at times d/t weakness & legs giving out." On 11/18/16 at 10:45 AM, in an interview with CNA C, she said that the resident could stand and pivot (to the wheelchair) with the assist of one. Transfers were observed on 11/15/16 at 10:45 AM which confirmed the CNA's statement. Review of the resident's care plan revealed a problem of Behaviors (dated 5/26/15) related to inappropriate sexual behaviors toward female staff and with one specific resident...Family have expressed great concern and embarrassment with res. behavior and report hat he also makes sexually inappropriate comments towards family/friends. Review of the resident's notes showed that more than one resident had experienced inappropriate behaviors from this resident. The care plan had not been updated to provide a current care plan for consistently dealing with these behaviors which involved additional residents and potentially a consensual relationship between this resident and another resident. 4. Review of resident #3's 8/25/16 quarterly MDS assessment revealed that the resident was assessed to require extensive assistance with bed mobility, transfer, locomotion on and off the	F 280		

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F 280	Continued From page 6 unit, dressing, toilet use, and personal hygiene. The resident was also assessed to frequently be incontinent of bladder and be continent of bowel. Review of the resident's care plan for the problem of toileting (2/25/16) the resident was noted to be continent of bowel and bladder. On 11/18/16 at 10:45 AM, in an interview with CNA C, she said that the resident was incontinent of bladder (more so at night) and continent of bowel. The care plan approach listed was that the resident "may use bedpan as needed at night". There were no approaches such as toilet resident as needed or to ensure that after an incontinent episode appropriate peri-care is provided. 5. Review of resident #9's Diagnoses and Allergy form in the EHR revealed diagnoses of dementia with behavioral disturbances, wandering, history of falls, abnormal weight loss, and pain. Review of the resident's notes evidenced that the resident had experienced two falls on 9/22/16 and one on 11/8/16. Review of the resident's 9/16/16 significant change MDS evidenced that the resident was having increased behavioral symptoms (worsening), required extensive assistance with bed mobility, transfer, walking in room, locomotion on and off the unit, dressing, toilet use, personal hygiene, and bathing, and was incontinent of bowel and bladder. Review of the resident's care plan for falls (dated 7/7/16) listed a problem of falls: at risk for falls; history of multiple falls prior to admission .. last	F 280		

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F 280	Continued From page 7 fall: 9/6/16. The resident's last three falls had not been added to the care plan and there was no evidence of any new approaches. The resident's care plan included behavior as a problem (dated 9/1/16) but did not address the resident's physical and verbal aggression of staff or upsetting other residents with his yelling. Review of the resident's notes verified that the resident resisted cares and grabbed staff by the arms and clothing (11/15/16 at 2:00 PM, 10/17/16 11:53 AM and 8:35 AM, and 10/16/16 at 7:08 PM and 5:35 PM).	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, observation, and staff interviews, it was determined that the facility failed to follow professional standards and facility policies when administering medications to one supplemental resident (#13) and failed to ensure that physician orders were followed for one of 11 sample residents (#9). The findings included: References and Facility Policy: A. Fundamentals of Nursing, Eighth Edition, The Art and Science of Person-Centered Nursing Care, Taylor, Lillis, Lynn, 2015, Pages 760 - 764 (Principles of Medication Administration):	F 281	NCC will provide services that meet professional standards of quality. 1. Medications and labs will be provided as ordered for resident no. 9. Medications administered via mickey tube to resident no. 13 will follow NCC updated policy. 2. All residents will have medications and labs provided as ordered and administered according to NCC policy. 3. Education will be provided on December 14, 2016 to CMA's, and Nurses at the	

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F 281	Continued From page 8 "No medication may be given to a patient without a medication order from a licensed practitioner. ... Safe practice dictates that a nurse follows only a written or typed order, or an order entered into a computer order-entry system because these types of orders are less likely to result in error or misunderstanding. Under certain circumstances,..., a verbal order from the physician may be administered... Nurses are legally responsible for the drugs they administer. Therefore, it is important to question any drug order suspected to be in error. ..." B. Berman, Frandsen, and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., (2015) Pearson Education, Inc., New Jersey, page 68, states, ". . . Carrying Out a Physician's Orders . . . If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. . . ." C. Fundamentals of Nursing, Eighth Edition, The Art and Science of Person-Centered Nursing Care, Taylor, Lillis, Lynn, 2015, Pages 773 - 774 (Administering Oral Medications): "Patients with a gastrointestinal tube (nasogastric, nasointestinal, percutaneous endoscopic [PEG], or jejunostomy [J] tube) often receive medication through the tube. ... Certain solid dosage medications can be crushed and combined with liquid. Crush medication to a fine powder and mix it with 15 to 30 mL of water before delivery through the tube. ... Give medications separately and flush with water between each drug. Some medications may interact with each other or become less effective if mixed with other drugs. ..."	F 281	staff meeting re: medication administration and updated mickey tube policy, and double checking lab orders. 4. NCC will monitor resident no. 9 for medications and labs to be provided timely and resident no. 13 for proper mickey tube administration in addition to a random sample of NCC residents for proper medication administration and lab draws monthly x 3 then quarterly by the QA coordinator. The QA data will be reviewed by the QA committee. 5. Completion Date December 19, 2016.	

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F 281	Continued From page 9 D. Facility policy entitled "MIC-Key Feeding Port/Med Admin. Guide" for Medication Administration (undated) was: "Use liquid medication when possible. If solid medication is safe to crush, mix with water for administration. Use a 30-60 cc catheter tip syringe and flush tube with prescribed (room temp.) water before and after medications. If the tube is not being used, flush the feeding tube as per doctor orders." 1. On 11/16/16 at 8:50 AM during an observation of a medication pass by nurse G to resident #13, the resident's seven medications which were in tablet/pill form were crushed together. These medications were added to a liquid supplement and administered through a PEG (percutaneous endoscopic gastrostomy) tube. 2. Medical record review for resident #9 revealed that the resident had a Valporic Acid level drawn on 8/9/16. The result was low at 34 ug/mL (normal 50-100 ug/mL). A repeat Valproic Acid level was drawn on 9/6/16. The level was low at 27 ug/mL and a recheck was ordered to be done in one month. No additional Valporic Acid levels were found in the resident's record. The Director of Nursing (DON) confirmed that no other Valporic Acid levels had been drawn as of 11/18/16. Record of the resident's October Medication Record (MAR) revealed that the resident had not received his ordered Exelon Patch on 10/24/16 or 10/25/16. The physician order for Exelon 9.5	F 281		

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F 281	Continued From page 10 mg/24 hr patch dated on 9/20/16 was charted as not administered. (Note: Exelon is an anti-Alzheimer drug Review of the resident's Departmental Notes evidenced the following: "10/24/2016 9:07 AM Exelon 9.5 mg/24 hr patch apply topically - scheduled for 10/24/2016 10:00:00 AM. Patch is out and on order." "10/25/2016 10:23 AM Exelon 9.5 mg/24 hr patch apply topically ..scheduled for 10/25/2016 10:00:00 AM was held." "10/26/2016 9:27 AM Exelon 9.5 mg/24 hr patch apply topically ..scheduled for 10/26/2016 10:00:00 AM. Patch is on order. " "10/26/2016 6:13 PM Exelon 9.5 mg/24 hr patch .....patches came in and so it was administered." There was no evidence to show why this medication was not provided so that the medication could be given as ordered.	F 281		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced	F 309	NCC will provide care/services for residents to attain or maintain the highest	

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F 309	Continued From page 11 by: Based on record review and staff interview, it was determined that the facility failed to provide care in a manner to ensure timely care for residents having a change of condition. This failure affected 2 of 11 sampled residents (#6 and #11) ability to reach their highest practicable level of physical, mental, and/or psychosocial functioning. Specifically for resident #6 who had hypertension and falls and for resident #11 who was having recurrent episodes of hypoglycemia and increased confusion. Findings included: 1. During the initial tour of the facility on 11/15/16 at 8:30 AM with the ADON (Assistant Director of Nursing) Resident #6 was identified as being on "Comfort Care". It was reported that the resident had fallen and sustained multiple injuries and was sent to the hospital. The resident had refused surgery returned and was placed on "Comfort Care". a. Review of resident #6's medical record revealed that the resident was admitted to the facility on 11/24/15. The resident's diagnoses included: hypertension, osteoarthritis, kyphosis and hypokalemia. b. Review of the quarterly MDS (minimum data set) assessment completed on 9/20/16 showed the resident had a BIMS (Brief Interview for Mental Status) score of 12 (moderate cognitive impairment) and only required supervision or minimal assistance with ADL's (activities of daily living). c. Review of the "Departmental Notes" showed	F 309	practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 1.Neurological checks will be provided per updated NCC policy for residents who fall with head injury or unwitnessed falls and resident is unable to deny head involvement. Hypoglycemic treatment will be provided following our updated policy/parameters. (residents no. 6 and 11 have passed away) 2.All NCC residents will receive care/services for their highest well-being by having neurological checks completed per policy and hypoglycemic treatment per policy. Hypoglycemic Reaction Treatment and standing orders read: Check residents blood sugar as ordered or prn as suspecting a reaction. If blood sugar is low (40-70) or WNL but resident is reporting not feeling well, offer orange juice or a snack if they are alert. If resident is alert but they are unable to eat may administer Gluctose gel 15 gm in their cheek. If blood sugar is below 40, administer Glucagon 1mg SQ or IM. Recheck blood sugar following treatment.	

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F 309	Continued From page 12 the resident had two falls. The note included: 11/4/2016 (late entry for 11/3/2016) "2100 (9:00 PM) CNA came to nurses station to report that resident was on the floor. When nurse arrived resident was sitting on the floor with legs extended in front of her. Staff report that they found resident with back against the door of her wardrobe and that resident did hit the back of her head. Upon assessment nurse noted a hematoma back of head left side. Resident reports that she got dizzy "then I guess I fell." ROM intact with no c/o pain. Resident was lifted up into w/c with GB (gait belt) and three assist. Was able to bear weight without difficulty but was unsteady and needed staff assist. Vitals T 98.1, 02 98% RA, BP 211/101 per machine, 200/100 manually, HR 86. Neuro checks implemented. Pupils were equal and reactive. Able to state where she was, her name, birthday, spouse name. Unable to recall correct year or the president. Asked resident to use her call light for assistance. Ice pack was placed on back of residents head. 2130 (9:30 PM) Vitals T 98.0, 02 96%, HR 76, BP 202/95 machine, 190/90 manual. Resident c/o low back pain and wanted ice for that. Ice pack was given and placed there as well. 2300 (11:00 PM) Staff went to answer residents call light and found resident on the floor again. This time as laying on her right side with right shoulder behind her and right side of face laying on the ground. Resident stated she was going to get some water "I must have got dizzy and fell" Residents main complaint was that her head hurt and had a headache. Resident was able to move arms and legs when asked. When assisted to sitting position on the floor resident was with	F 309	If unable to arouse resident and/or get their blood sugar up, contact provider at once for further orders. Neurological Assessment Policy reads: The charge nurse will initiate a neurological assessment flowsheet at the time of fall that involved a head injury or the resident is unable to report head involvement and it was not witnessed. The neurological assessment will be repeated every 15 minutes x 4, every 30 minutes x 2, every hour x 2, every 4 hours x 5. Any time there is a change in resident's neurological status or unstable vital signs a provider will be notified for additional orders. A chart note will be entered at the time of fall and the initiation of the neurological check flowsheet will be stated. When the neurological assessments are completed as protocol the flowsheet will be filed on the resident's chart. 3.Education on our updated policies will be provided to nurses at our staff meeting on December 14, 2016. Our neurological check policy and hypoglycemic policy and parameters have been updated with consultation from our medical director and our weekly rounding FNP.. 4.NCC will monitor a random sample of residents who fall and those who have hypoglycemic reaction to assure proper	

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F 309	Continued From page 13 discomfort. Gait belt applied and was lifted to w/c (wheelchair) Vitals T 98. 1, O2 92, 02 92% RA, BP 206/100 machine, 196/90 manual. Resident pupils were equal in size but sluggish with reaction L>R. Chair alarm placed in recliner. Again asked resident to use her call light and resident was placed in her recline. 2315 (11:15 PM) CNA reports that resident "has been saying weird things. 2320 (11:20 PM) Called on call provider at (name of hospital). Provider asks we send her over for evaluation and to get BP under control. Resident in agreement with same. 2400 12:00 AM) Resident left per Napoleon Ambulance for (__NAME) Community Hospital. Transfer paperwork & memo of residents belongings,. was sent along as well as recent lab and physician progress notes. Bed hold policy was given to resident." The notes showed the resident returned to the facility on 11/4/16 at 3:30 PM. by ambulance. The resident was alert and talkative. "VS T 96.7 P 64 , R 24, Oxygen sat 96% B/P 167/91. She denies headache and at this time denies back pain, however nursing staff from (__name of hospital). (__name of Hospital) indicate she does c/o (complain of) back pain from comp fx (fracture) and pelvic fx and has refused all pain medications offered even Tylenol. Lungs are clear w/good air exchange - she moves her head up and down and side to side. Speech is unchanged from before, however does have difficulty finding words at time. Abdomen soft and non-tender, BS active x 4 quads. Is pale in color and warm to touch. Did eat on way down - bun and drank a lot	F 309	policy is followed monthly x 3, then quarterly by QA Coordinator. The QA data will be reviewed by the QA committee. 5.Completion Date: December 19, 2016.	

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F 309	Continued From page 14 of water per metro transfer team. Orders received indicate comfort cares and pain control is the main focus. Bed alarm is placed and call light in reach." The resident expired on 11/16/16. d. Review of the "Neurological Record" dated 11/3/16 revealed three resident's assessments which included: At 2100 (9:00 PM) blood pressure 211/101, temperature 98.1, pulse 84, respirations blank, R. (right) pupil size 2.5 react + (positive), L. (left) pupil size 2.5 react + (positive), eye response was open spontaneously, alert, and speech oriented. This was after the first fall. At 2130 (9:30 PM) blood pressure 202/95, temperature 98.0, pulse 92, respirations blank, R. (right) pupil size 2.5 react + (positive), L. (left) pupil size 2.5 react + (positive), eye response was open spontaneously, alert, and speech oriented. At 2300 (11:00 PM one an a half hours after last assessment resident found on floor) blood pressure 206/100, temperature 98.1, pulse 76, respirations blank, R. (right) pupil and L. (left) pupil sluggish, eye response was open spontaneously, alert, and speech inappropriate words. (This was after the second fall.) The next entry on the form was at 2400 which noted, "sent to (_ name of hospital)". [Note: Resident #6 not only had a fall and struck her head she was having a hypertensive episode requiring increased monitoring and care than what was provided.] e. Review of the hospital records dated 11/4/2016	F 309		

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F 309	Continued From page 15 showed the resident was identified as having an intracranial hemorrhage, L2 compression fracture and pubic rami fracture. The resident was then sent on to another hospital who confirmed the above injuries. The report noted, "A CT scan of the showed an acute hemorrhage adjacent to the left lateral ventricle. It was read by the radiologist that this likely came from a hypertensive episode as there was no trauma in the area, however she did hit her head when she fell, therefore unknown if the bleed caused a fall or a fall caused the bleed... The patient was very clear with her desire to not undergo any intervention for brain bleed or the back fracture... " The resident's wishes to return to the nursing home were then honored and the resident was placed on "Comfort Care". f. Review of the facility's "Neurological Assessment Policy" dated 11/22/10 included: "Policy: Neurological Assessment will be complete with resident's who fall and have involved head injury or residents who have an unwitnessed fall and are unable to report head involvement. Procedure: (see Neurological Assessment flowsheet) -1. The charge nurse will initiate a Neurological Assessment flowsheet at the time of the fall that involved head injury or residents who have an unwitnessed fall and are unable to report head involvement. -2. The Neurological Assessment will be repeated in one hour from initial incidents, if there are no changes or concerns the assessments will continue every 4 hours x 24 hours. Any time there is a change in resident's neurological status a provider will be notified for any additional orders. -3. A chart note will be entered at the time of the	F 309		

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F 309	Continued From page 16 fall and the initiation of the neuro check flowsheet will be started. -4.When the Neurological Assessments are completed as protocol the flowsheet will be filed on the residents chart." The facility's policy did not follow current standards of practice for care and monitoring for "Neurological Assessment" which showed more monitoring of the resident's condition than the facility's current policy. g. REFERENCE:(Example for Long Term Care) Neurological checks for head injuries LTC Clinical Pearls: Powered by HCPro's Long-Term Care Nursing Library, January 8, 2013 Assess the resident for changes in level of consciousness, which is a cardinal sign of untoward pathology. Assess the resident immediately after the fall, then frequently throughout the shift. Assessment should continue for a minimum of 72 hours. 1) Observe the resident for obvious injuries to the scalp, including lacerations, bruises, or contusions; confusion; memory loss; difficulty speaking; gait or balance problems; pupils of unequal size or reactions; headache; vomiting; visual disturbances; or periods of coherence alternating with periods of confusion or lethargy. Monitoring must continue for a minimum of 72 hours (or until the resident is asymptomatic for a specified period of time). Perform frequent neurologic assessments every: -15 minutes for two hours, 30 minutes for two hours, -60 minutes for four hours, - Eight hours for 16 hours, - Eight hours until at least 72 hours have elapsed and resident is stable.	F 309		

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F 309	Continued From page 17 2) Neurological assessments include (at a minimum) pulse, respiration, and blood pressure measurements; assessment of pupil size and reactivity; and equality of hand grip strength. Completing the Glasgow Coma Scale immediately, then once each shift following a head injury, helps keep findings objective. 2. Resident #11 was a closed record review. The resident was identified as being admitted to the facility on 1/14/16 with diagnoses which included: Diabetes Mellitus with neuropathy, severe Alzheimer's disease, cerebral infarction, PVD (peripheral vascular disease). The resident was identified as having a change in condition which required hospitalization. The resident was sent to the hospital on 9/29/16 and returned to the facility on 10/17/16 (18 days later). The resident's diagnoses showed the resident had been admitted to the hospital for acute encephalopathy, hypothroidism, sepsis, UTI (urinary tract infection) and pneumonia. a. Review of the "Departmental Notes" showed the resident was having changes in her condition for at least two weeks prior to the transfer to the hospital. The changes included: fall, disorientation, weakness and hypoglycemic episodes. Some of the notes included: "9/16/2016 7:49 AM Falls- 0540 her bed alarm was answered quickly and staff found her sitting on the floor beside her bed on the mat, bed in low position. No complaints of pain. No skin tears nor bruises noted. Denies hitting her head. Alert. Strength equal and strong in all 4 extremities. PERL. BP 142/63 T= 96.2 P=67 02 sat = 97% She was taken to the bathroom by wheel chair. "She was continent, and voided on the toilet.	F 309		

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F 309	Continued From page 18 (FNP notified by fax.) Her blood sugar = 58 this am. A pudding given her and 60 cc orange juice. 9/20/2016 6:00:00 AM. Fasting blood sugar = 48. Pudding given. 9/27/2016 10:09 AM Late entry for 08:05 AM: Res. was found to be unresponsive this AM by CNA staff. Res. cool & clammy. Accucheck at 8:10 was 42 mg/dl. BP 111/52; P 45; 02 SATs 95%. Res. HOB elevated 90 degrees. 1/2 dose of oral Glutose 15 provided under res. tongue. 8:19 Accucheck 46 mg/dl. 8:20 AM Glucagon 1 mg given IM to R Deltoid. 0830 Glucocheck 36 mg/dl. Ambulance paged as res. continues w/ adverse response. 8:37 Glucocheck 51 mg/dl. Res. opened opens & began to move extremities. Declined ambulance transfer as res. now responding to medications. 2nd 1/2 of Gluctose 15 provided orally with res. swallowing dose. 8:45 Accucheck 317 mg/dl. VS checked. 02 SATs 99%. BP 145/63; P 66. (POA ___name) was notified of incident & impending transfer& was in agreement. Will notify of plan. 0855 Accucheck 101 mg/dl. Res. responding & eyes open, staff will provide meal." [Note: The decision not to transfer this resident was made by the resident who had been found unresponsive, was cognitively impaired and who had just had a severe hypoglycemic episode requiring multiple interventions. Additionally staff reported the facility had had only one dose of Glucagon on hand at the time of this episode and had sent a staff member to the local pharmacy for another dose of Glucagon. -Glucagon is an injectable form of Glucagon is vital first aid in cases of severe hypoglycemia	F 309		

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F 309	Continued From page 19 when the victim is unconscious or for other reasons cannot take glucose orally. The dose for an adult is typically 1 milligram, and the Glucagon is given by intramuscular, intravenous or subcutaneous injection, and quickly raises blood glucose levels.] "9/27/2016 1:14 PM FNP here and orders rec to dc Prosource and due to hypoglycemic incident this AM are to change blood sugar checks to BID daily. 9/27/2016 2:00 PM Call placed to (__name), FNP and orders received to decrease her Levemir to 13 units SQ daily. 9/28/2016 3:17 AM -At 2000 her blood sugar = 407. She was given 6 units Novolog insulin sq stat per standing order sliding scale. At 2100 her blood sugar = 388. At midnight her blood sugar 293. At 0300 up to the bathroom to void. Her blood sugar =176. 9/28/16 11:37 PM Res seems a little more disorientated and not really talking with her niece who is here to visit today. 9/28/16 1:37 PM 1330 res sitting in recliner in TV as she conts with disorientation to time and place since yesterday's hypoglycemic episode, res has now again taken her hearing aide out for the 4th time and this time she was trying to eat it, with it whistling CNA heard it and removed from her and put back in her box in the med cart. 9/29/16 12:04 PM Late entry for morning status: Resident in for bath this morning and it took 3 people to transfer resident as she did not participate in transfer due to weakness. Upon	F 309		

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F 309	Continued From page 20 assessment resident is moving legs in tub per self and cannot hear me due to HOH for hand grasps. Face is not drooping on either side however does lean posturely to the left. Tolerated bath and dressing fine. During breakfast shortly before 10 AM thereafter was not able to follow directions and continued to lean to left, pocketed food in mouth and allowed all fluids to drain from left side of mouth. VS B/P 139/79, P 50, T 86 .6 Ox sat 95%. Blood sugar checked and is 44 (her blood sugar at 0500 was 270). No insulin had been provided this morning thus far. At 1000 Glucagon 1 mg SQ administered per SO and ER kit. POA (___name) notified 1003 of status and request for transfer for evaluation to hypoglycemia x 2 in last 3 days, increased confusion, leaning to left side and lack of ability for oral intake this morning. POA (___name) requested transfer to Bismarck (___name hospital). At 1005 BS 54 and aide providing OJ. 1010 Provider again notified of status and family request - order rec to transfer via ambulance and ambulance service notified. At 1018 BS up to 84, however resident continues lethargic - will not open eyes but drinks w/much encouragement. Ambulance here and report given - resident left w/ambulance at 1025. POA (___name) again contacted w/time of departure per her request so that family may meet her there at the ER. Report call to (___name hospital) ER nurse (___name) at 1030." b. Review of the Hosptial discharge summary dated 10/17/16 identified the resident was admitted to the hospital for acute	F 309		

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F 309	Continued From page 21 encephalopathy, hypothroidism, sepsis, UTI (urinary tract infection) and pneumonia. c. Review of the policy and procedures for diabetic management included the following: "Insulin Reaction " dated 2/2010; -1. Glucometer check PRN -2. Orange juke 4 oz if able to drink. -3. Gluctose Gel 15 gm one dose squirt in resident's cheek. -4. If unable to swallow, administer Glucagon 0.5 to 1 unit SQ or IM for insulin reaction: If no improvement and unable to arouse resident, contact provider at once. -5. Follow with glucochecks after treatment." "HYPOGLYCEMIC REACTION TREATMENT: PURPOSE: To treat residents who are having a hypoglycemic reaction. PROTOCOL: 1. Check residents blood sugar as ordered or prn as suspecting a reaction. 2. If blood sugar is low or WNL but resident is reporting not feeling well, offer orange juice or a snack if they are alert. 3. If resident is alert but they are unable to eat may administer Gluctose gel in their cheek. 4. If resident is unable to swallow, administer Glucagon 0.5 to 1 unit SQ or IM. 5. Recheck residents blood sugar following treatment . 6. If unable to arouse resident and/or get their blood sugar up, contact provider at once for further orders." [Note:The procedures did not have parameters identified for low blood suagrs.] d. On 11/18/16 at 9:07 interview with nurse (G)	F 309		

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F 309	Continued From page 22 confirmed that the facility only had one dose of Glucagon in the emergency kit and one dose of Gluctose Gel. The nurse confirmed the incident with resident #11 and having to send staff to the local pharmacy for a second dose of Glucagon on 9/27/2016.	F 309		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure that each resident's drug regimen addressed pertinent drug irregularities by the licensed pharmacist for 4 of 11 sample residents (#5, #7, #9 and #4). The comprehensive drug regimen reviews, failed to identify that the resident's drug regimen was free of any drugs given in excessive dose, duplicate therapies, excessive duration, without adequate indications for its use, without adequate monitoring or the potential for adverse drug reaction. The findings included: 1. Resident #5's medical record review revealed the resident was admitted to the facility on	F 428	NCC will assure the licensed pharmacist is completing monthly reviews and documenting any irregularities or concerns to the attending physician and the DON. 1. Education and a copy of the regulation F 428 was given to our consulting pharmacist and she is in agreement that her monthly reviews will be more detailed for resident no. 4, 5, 7 and 9. 2. All residents at NCC will have detailed pharmacy reviews. 3. Our consulting pharmacist will note any problems or concerns on the residents EChart note and provide the report summary to the DON and provider to review and address. Napoleon Drug pharmacist will be using a prescriber communication form when new medications are ordered and there are interactions or concerns. 4. NCC will monitor resident no. 4,5,7, and 9 and a random sample of residents medication reviews to	

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F 428	Continued From page 23 4/4/2013. The resident's diagnosis included: Alzheimer's disease, schizophrenia, COPD (chronic obstructive pulmonary disease), heart failure, atrial fibrillation, hypothyroidism and anticoagulant therapy. a. Review of the resident's quarterly MDS (minimum data set) identified the resident as having a BIMS of 15 with moderate depression. b. Review of the November 2016 MAR (medication administration record) showed the resident was on the following medications: Three medications for depression: -Lexapro 20 mg daily (started 11/13/13), -Cymbalta 20 mg daily (started 1/26/15), -Remeron 15 mg at bedtime (started 4/24/14). Two medications for Alzheimer's disease: -Aricept 10 mg at bedtime (started 4/7/14) -Namenda XR 28 mg at bedtime (started 4/26/14). Lasix 60 mg daily (started 6/17/16), Miralax powder 17 GM with juice or water for constipation (started 4/22/14), Senna one tablet twice a day for constipation (started 4/11/16) and increased to two tablets twice a day on 11/8/16. Systane two GTTS (drops) four times a day for dry eyes started on 5/10/16, Vesicare 5 mg one tablet for urinary incontinence started on 8/13/13, Flomax one capsule daily for enlarged prostate started on 1/12/16,	F 428	assure irregularities, lab orders, and concerns are noted for the provider to address monthly x 3, then quarterly by QA Coordinator. The QA data will be reviewed by the QA committee. 5. Completion Date: December 19, 2016.	

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F 428	Continued From page 24 Levothhyroxine 100 mcg 1 tablet daily for hypothyroidism started on 1/11/16 , Metolozone 2.5 mg daily for congestive heart failure started on 8/2/16, Coreg 12.5 mg three times per week for congestive heart failure started 9/7/16 and increased after hospitalization on 11/8/16 to 40 mg twice a day. Coumadin 2 mg daily dose started on 11/8/16 after hospitalization and had been on Coumadin prior to hospitalization with long term anticoagulant use. Spiriva 2 puffs daily started 5/3/16 for COPD , Alubuterol 1 ampule inhaled four times a day for COPD started 4/15/16 and Pulmicort 1 ampule inhaled twice a day for COPD acute exacerbation. Oxygen at 1-2 liters per nasal cannula to keep oxygen saturation greater than 90%. c. Review of the "Medication Regimen Review" sheet noted, 11/4/16 "Pharmacy review completed. No problems noted." (The resident had been sent to the hospital on 11/3/16 when this review was done for large abdominal hematoma.) 10/1/16 "Pharmacy review completed. No problems noted." 9/2/16 "Pharmacy review completed. No problems noted." 8/1/16 "Pharmacy review completed. No problems noted. Multiple warfarin adjustments following protimes." 7/1/16 "Pharmacy review completed. No	F 428		

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F 428	Continued From page 25 problems noted." The pharmacist failed to identify or report a medication or medication combination with significant potential for adverse consequences or medication interactions. The examples included: use of three antidepressants without improvement in depression and one which was Lexapro. [Note: FDA "Black Box Warning" Lexapro and other antidepressant medicines may cause serious side effects, including: 1. Suicidal thoughts or actions: · Lexapro and other antidepressant medicines may increase suicidal thoughts or actions in some children, teenagers, or young adults within the first few months of treatment or when the dose is changed ...., 4. Abnormal bleeding: Lexapro and other antidepressant medicines may increase your risk of bleeding or bruising, especially if you take the blood thinner warfarin, a non-steroidal antiinflammatory drug (NSAIDs, like ibuprofen or naproxen), or aspirin.] d. Resident #5's medical record showed the resident was having increased problems with potential side effects from medications with abnormal protimes, dizziness, increased constipation, dry eyes, and cough. The resident was sent to the hospital on 11/3/16 for abdominal pain and diagnosed with a hematoma due to rectus sheath rupture. The pharmacist failed to assure that medication usage was properly evaluated on an ongoing basis, that risks and problems were identified and acted upon, and that medication-related problems were considered when the resident has a change in condition.	F 428		

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2. Resident #7's medical record review revealed the resident was admitted to the facility on 3/23/2012. The resident's diagnosis included: diabetes mellitus, constipation, dementia, heart failure, CVA (cerebral vascular accident), COPD (chronic obstructive pulmonary disease), osteoperosis, and hypertension. On 10/24/16 the resident returned from hospitalization due to pneumonia.

a. Review of the November 2016 MAR (medication administration record) showed the resident's medications included:

The use of two antibiotics;
Amoxicillin 500 mg daily,
Levaquin 500 mg one tablet every other,

Sertaline (Zoloft) 100 mg daily for anxiety started 11/9/13 for anxiety disorder,
[Note:Sertraline (trade names Zoloft and others) is an antidepressant.]

Zyprexa 2.5 mg daily started 9/3/15 for unspecified dementia with behavior disturbance,
[Note: Zyprexa is an atypical antipsychotic.]

b. Review of the "Medication Regimen Review" sheet noted,
11/4/16 "Pharmacy review completed. No problems noted. Levaquin used every other day for five doses for kidney infection".
The review did not note the potential drug irregularity with Levaquin use. The "Black Box WARNING" for Levaquin used in the elderly and potential for serious side effects was not addressed.

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F 428	Continued From page 27 Additionally, none of the reviews from 7/1/16 to 11/4/16 identified the use of an antipsychotic without appropriate diagnosis for it's use. 3. The pharmacy reviews were completed for resident #9 on 10/1/16 and 11/4/16 with the summary notation "No problems noted." On the 10/1/16 review, the pharmacist noted "Exelon patch dose increased along with depakote dose following two separate reviews." Medical record review for resident #9 revealed that the resident had a Valporic Acid level drawn on 8/9/16. The result was low at 34 ug/mL (normal 50-100 ug/mL). A repeat Valproic Acid level was drawn on 9/6/16. The level was low at 27 ug/mL and a recheck was ordered to be done in one month. No additional Valporic Acid levels were found in the resident's record. The Director of Nursing (DON) confirmed that no other Valporic Acid levels had been drawn as of 11/18/16. Record of the resident's October Medication Record (MAR) revealed that the resident had not received his ordered Exelon Patch on 10/24/16 or 10/25/16. The physician order for Exelon 9.5 mg/24 hr patch dated on 9/20/16 was charted as not administered. (Note: Exelon is an anti-Alzheimer drug Review of the resident's Departmental Notes evidenced the following: "10/24/2016 9:07 AM Exelon 9.5 mg/24 hr patch apply topically - scheduled for 10/24/2016 10:00:00 AM. Patch is out and on order."	F 428		

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F 428	Continued From page 28 "10/25/2016 10:23 AM Exelon 9.5 mg/24 hr patch apply topically ..scheduled for 10/25/2016 10:00:00 AM was held." "10/26/2016 9:27 AM Exelon 9.5 mg/24 hr patch apply topically ..scheduled for 10/26/2016 10:00:00 AM. Patch is on order. " "10/26/2016 6:13 PM Exelon 9.5 mg/24 hr patch .....patches came in and so it was administered." There was no evidence to show that the pharmacist reviewed the resident's record to ensure that the abnormal Valproic Acid level from 9/6/16 was rechecked or that the problem with the medication (Exelon) being omitted when it was not made available to the facility was reviewed. 4. The pharmacy reviews were completed for resident #4 on 10/1/16 and 11/4/16 with the summary notation "No problems noted." On the 10/1/16 review, the pharmacist noted "Carbamazepine dc'd this past month." Review of the resident's November, 2016 MAR revealed that the resident was taking Carbamazepine 300 mg three times a day with a start date of 9/2/16. The pharmacist stated that this medication was discontinued, when it was not. There was no evidence of laboratory monitoring for the drug.	F 428		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441	NCC will maintain an infection control program to provide safe, sanitary and comfortable environment and to prevent the development and transmission of disease and infection.	

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F 441	Continued From page 29 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 (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 record review, observation, and staff	F 441	1. Residents will be provided ADL assist from staff that wash their hands and wear gloves per NCC infection prevention protocol. Resident no. 13 will have their medication administered without it being contaminated. Resident no.. 13 will have her gastrostomy tube disinfected if it becomes contaminated. 2. All residents will receive ADL assist from staff who wash their hands and wear gloves per protocol. All residents will be administered medication that is not contaminated by dirty surfaces or dirty equipment. 3. Education provided to CNA's, CMA's, and Nurses on December 14, 2016 re: proper hand washing, and glove use. Education will be provided to CMA's and Nurses on December 14, 2016 re: medication administration that is free from contamination, and disinfecting contaminated equipment. 4. NCC will monitor resident no. 13 that her medication is free from contamination and her peg tube is properly disinfected if contaminated, in addition to a	

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F 441	Continued From page 30 interview, it was determined that the facility failed to establish and/or implement infection control practices in order to provide a safe, sanitary, and comfortable environment which minimized the potential for the spread of infection among the residents. Specifically, staff failed to ensure proper hand hygiene and glove use when providing direct resident care. This was identified during two of six observations of resident care for residents #7 and #4. The findings included: 1. On 11/15/16 at 2:45 PM, CNAs E and F entered resident #7's room to provide care. The CNA had reported the resident was dependent on staff for all care and used a Hoyer lift to be transferred to a wheelchair. The resident was observed to be resting in bed on his back. The staff had washed their hands and donned gloves prior to starting care. The resident's incontinent brief was checked by CNA E who reported to the resident that he had had a bowel movement and needed to be cleaned up and changed. The resident was rolled to his left side and supported by CNA F while CNA E attempted to wipe the resident's rectal area and right buttock area. The resident had a large semi liquid bowel movement and continued to have stool while staff was wiping the area. CNA E was noted to stop and wipe her gloves with disposable wipes to remove stool from her gloves as she continued with care. The CNA then asked the other CNA to take more disposable wipes out of the container after she had already touched the container with soiled (dirty) gloves. The dirty brief was then rolled under the resident and CNA E rolled the resident back toward her onto his right side, touching the resident's shoulder, leg and pants with dirty gloves.	F 441	random sample of residents monthly x 3, then quarterly by QA Coordinator. The QA data will be reviewed by the QA committee. 5.Completion Date: December 19, 2016.	

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F 441	Continued From page 31 CNA F was then observed wiping the resident's left buttock and rectal area and positioned a new brief under the resident while keeping on the same soiled (dirty) gloves. After the resident was turned to his back, CNA E proceeded to wipe the resident's front groin area and remove stool from around the catheter. The CNA reported that the resident had drainage from around the catheter and the area was red. She told CNA F the resident needed cream to this area and his buttocks. She was then observed touching the resident's bedside drawer to find the Barrier cream with the same soiled (dirty) gloves. Then not seeing it in the drawer, she removed her soiled gloves to get the cream from the resident's bathroom. She then donned gloves without hand washing and applied the Barrier cream. She had instructed CNA F not to remove his gloves as he needed to tie up the garbage. The CNAs then continued pulling up the resident's pants and position the sling for the lift under the resident with same soiled gloves. The lift was then used to transfer the resident into the wheelchair. Staff was observed to touch wheelchair, lift and bed with soiled gloves. Then CNA F emptied the resident's catheter and was handed an alcohol wipe by CNA E to wipe the end of the catheter bag port before placing it back into its holder. CNA F then tied up the garbage, left the room, opened the door to soiled utility room with same soiled (dirty) gloves. The CNA then removed the dirty gloves and returned to the resident's room.	F 441		

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F 441	Continued From page 32 2. Record review on 11/15/16 of resident #4's Diagnosis and Allergy form in the electronic health record (EHR) revealed diagnoses that included dementia with behavioral disturbances (8/23/16), anxiety disorder, essential hypertension, COPD, gout, generalized osteoarthritis, GERD, depression, and history of falling. Review of the resident's 8/25/16 annual Minimum Data Set (MDS) assessment evidenced that the resident required extensive assistance for bed mobility, transfer, walk in room, locomotion on and off unit, dressing, toilet use, personal hygiene, and bathing. The resident was assessed to be incontinent of bowel and bladder. On 11/15/16 at 10:45 AM, an observation of the provision of care was made with CNA J. The resident was assisted to transfer to the wheelchair and then to the toilet. The CNA pulled the resident's pants and brief down and commented his pants and shirt were wet and needed to be changed. The CNA changed her gloves several times without washing her hands before putting on new gloves. The CNA removed her gloves and did handwashing two times - once after she removed the resident's pants and then after she had taken the trash into the soiled utility room and then placed the resident's dirty laundry in the soiled laundry room and returned to the nurses' station. 3. On 11/16/16 at 8:50 AM, nurse G was observed preparing medications to give to resident #13. In the process of pouring the medications, the nurse dropped a tablet on the top of the medication cart (which was not observed to have been sanitized prior to the	F 441		

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F 441	Continued From page 33 medication pour for this resident). She picked the tablet up using two spoons and placed it with the medications which were administered to the resident. After the nurse administered the resident's medications via tube, she cleaned the tube in the resident's sink. The tube was observed to touch the inside of the sink several times. (Sinks are considered dirty.)	F 441		