STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495302	A. BUILDING _____ B. WING _____	C 06/15/2022

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FOREST HEALTH & REHAB CENTER	2406 ATHERHOLT ROAD LYNCHBURG, VA 24501

(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 6/14/2022 through 6/15/2022. The facility was in substantial compliance with 42 CFR 483.73, Requirement for Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 06/14/2022 through 06/15/2022. One complaint was investigated during the survey. VA00053731 was unsubstantiated without any deficiencies. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The LIfe Safety Code will follow. The census in this 89 certified bed facility was 49 at the time of the survey. The survey sample consisted of 16 current resident reviews and 2 closed record reviews.	F 000		
F 684 SS=E	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 observation, resident interview, staff interview and clinical record review, the facility staff failed to implement a physician's order for	F 684	Forest Health and Rehab is filing this plan of correction for the purpose of regulatory compliance. The facility is submitting this	7/11/22

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

Electronically Signed | 07/01/2022

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F 684	Continued From page 1 one of eighteen residents in the survey sample, Resdient #29. Resident #29's physician ordered eye drops were not administered for three weeks. The findings include: Resident #29 was admitted to the facility with diagnoses that included COPD (chronic obstructive pulmonary disease), diabetes, congestive heart failure, chronic kidney disease, bipolar disorder, anxiety, atrial fibrillation, insomnia, hypertension, and osteoporosis. The minimum data set (MDS) dated 4/26/22 assessed Resident #29 as cognitively intact. On 6/14/22 at 11:58 a.m., Resident #29 was interviewed about quality of care in the facility. Resident #29 stated he had seen an eye doctor several weeks ago who prescribed eye drops but he was not receiving the drops. Resident #29 stated he was supposed to get eye drops about four to five times per day to help with eye irritation. Resident #29's eyes were observed at this time with redness noted on edges of the upper and lower lids. Resident #29's clinical record documented a physician's order dated 5/24/22 for, "Preservative free tears 1 drop both eyes 6 times a day..." The clinical record documented a nursing note dated 5/25/22 at 9:35 a.m. stating, "Resident seen by (eye physician). new order for artificial tears 1 drop to both eyes 6x (times per) day..." Resident #29's medication administration record (MAR) for May 2022 and June 2022 documented no entries for the preservative-free eye drops. The clinical record documented no administration	F 684	plan of correction to comply with the applicable law. The submission of this plan of correction does not represent an admission or statement of agreement with respect to the alleged deficiencies. F684 A. Corrective action accomplished for the resident found to have been affected by the alleged deficient practice: 1. The MD was notified of resident #29 got getting his eye gtts as ordered on 5/24/22. The order was entered into PCC and the gtts were obtained and given as ordered. Resident #29 had no ill effects from this error. B. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: 1. The facility will look at all consults for the past 30 days to see if any other orders were not entered as MD ordered. C. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: 1. DON and/or designee will educate all licensed nurses how to review all orders that were written from resident consultations. D. Monitoring of corrective action to ensure the deficient practice will not reoccur; 1. The DON and/or designee will audit all new orders for week x 1 month and	

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F 684	Continued From page 2 of the eye drops from 5/24/22 through 6/14/22 as ordered. On 6/15/22 at 9:17 a.m., the registered nurse (RN #3) administering medications to Resident #29 was interviewed about the eye drops. RN #3 stated she was not aware of an order for scheduled eye drops for Resident #29 and the MAR had no order listed for the drops. On 6/15/22 at 9:20 a.m., the unit manager (RN #1) was interviewed about Resident #29's eye drops. After reviewing the clinical record, RN #1 stated the order for the preservative-free eye drops was not entered into the health record and the order did not show on the MAR for administration. RN #1 stated the floor nurse receiving the order was responsible for initiating the order for the medication. Resident #29's plan of care (revised 3/8/22) documented the resident had potential for eye irritation due to dry eyes. Interventions to decrease and/or eliminate eye irritation and dry eyes included, "Instill/apply eye medication as per physician orders...Obtain eye exam consultation as needed..." This finding was reviewed with the administrator and director of nursing during a meeting on 6/15/22 at 11:15 a.m.	F 684	then monthly for 2 months. 2. The DON and/or designee will audit 5 residents receiving eye gtts weekly x 1 month and then 10 monthly for 2 months. 3. All findings will be reported to the Administrator. 4. Failure to adhere to facility policy will be considered a violation. Violations will resulting disciplinary action in accordance with the facility progressive disciplinary policy. 5. All findings will be reviewed in the monthly QAPI x 2 months for further recommendations and follow up. E. Date of Completion - 07/11/22	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 755		7/11/22

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F 755	Continued From page 3 §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on medication pass and pour observation, staff interview, and facility document review, the facility failed to ensure medications were available for one of 18 residents in the survey sample, Resident #32. Resident #32's Omeprazole10 milligrams (for reflux) was not available for administration. The Findings Include:	F 755	F755 A. Corrective action accomplished for the resident found to have been affected by the alleged deficient practice: 1. Resident #32□s Omeprazole was not available at 0900. Med was obtained and given before 1200. MD was notified of the med not being available in tablet form and it was changed to capsule. The medication is being filled by the	

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F 755	Continued From page 4 Resident #32 was admitted with diagnoses which included: End stage renal failure, reflux, peripheral vascular disease, and diabetes. The most current MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 4/27/22. Resident #32's cognitive score was a 5 indicating severely impaired cognitively. On 06/15/22 at 8:04 AM, a medication pass and pour observation was conducted. Resident #32's Omeprozole 10 milligrams was ordered to be given at 9:00 AM. Registered nurse (RN #2) could not find Resident #32's Omeprozole in the medication cart. RN #2 stated that the medication was not available over the counter (because of the dosage) and had to be ordered through the pharmacy. RN #2 stated that pharmacy was going to send the medication later in the day. On 06/15/22 at 10:36 AM, the director of nursing (DON) was interviewed regarding reordering medications through the pharmacy. The DON stated medications should be reordered when a resident gets down to a three day supply. The physician's order for Resident #32's Omeprozole documented, "Omeprozole Tablet 10 MG (milligrams) by mouth in the morning...dispense 9:00 AM." The facility policy, Ordering and Receiving Non-Controlled Medications, documented "...Reorder medications based on the estimated refill date on the pharmacy RX (prescription) label, or at least three days in advance to ensure an adequate supply is on hand..."	F 755	pharmacy. Resident #32 did not miss any doses of her medication and there were no ill effects from this deficient practice. B. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: 1. All residents have the potential to be affected by this deficient practice 2. 100% MAR to cart audit was conducted to ensure that all meds are available as ordered C. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: 1. DON or designee will educate all licensed nurses on pharmacy services and ordering medications timely. D. Monitoring of corrective action to ensure the deficient practice will not reoccur; 1. DON or designee will audit med availability by randomly choosing 5 residents per week and do a MAR to cart check from their med list to ensure med availability. 2. This will be done weekly for 3 months. 3. All results will be reported to QAPI for review, recommendations and follow up x 3 months. E. Date of Completion - 07/11/22	

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F 755	Continued From page 5 On 06/15/22 at 11:22 AM, the above finding was presented to the director of nursing, administrator, and nurse consultant. No other information was presented prior to exit conference on 6/15/22.	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on medication pass and pour observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure a medication error rate less than 5 percent. There were two errors out of 38 opportunities resulting in a medication error rate of 5.26 percent. The Findings Include: On 06/15/22 at 8:04 AM a medication pass and pour observation was conducted with RN #2. Resident #32's Omeprozole 10 milligrams was ordered to be given at 9:00 AM. Registered nurse (RN #2) could not find Resident #32's Omeprozole in the medication cart. RN #2 said that the medication was not available over the counter (because of the dosage) and had to be ordered through the pharmacy. RN #2 stated that pharmacy was going to send the medication later in the day.	F 759	A. Corrective action accomplished for the resident found to have been affected by the alleged deficient practice: 1. Resident #32 Omeprazole was given on 6/15/22 at 1200 after being obtained from the pharmacy. 2. Resident #44□s MD was notified of the medication error r/t giving the wrong dose of Propranolol. The 40mg card was removed from the cart, leaving only the 20mg card. There was no harm to either resident with these errors. B. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: 1. All residents have the potential to be affected by this deficient practice 2. 100% MAR to cart audit was conducted to ensure that all meds are available as ordered.	7/11/22

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F 759	Continued From page 6 The physician's order for Resident #32's Omeprozole documented, "Omeprozole Tablet 10 MG (milligrams) by mouth in the morning...dispense 9:00 AM." RN #2 began pulling medications to be given to Resident #44. One of the medications was labeled, "Propranolol 40 MG give one tablet..." RN #2 then popped the Propranolol into a medicine cup along with other medications and gave the medications to Resident #44. After the medication observation was complete, all the medications given by RN #2 were then reconciled with the physician's orders. Resident #44's Propranolol order read "Propranolol Tablet 20 MG give one tablet by mouth..." On 06/15/22 at 9:05 AM, the order was reviewed with RN #2. RN #2 then pulled the medication given (Propranolol 40 MG) from the medication cart and realized that she had given the wrong dose. After looking at all of Resident #44's medications, RN #2 found the correct dose of Propranolol and said the 40 MG dose of Propranolol shouldn't have been on the cart for distribution. On 06/15/22 at 11:22 AM, the above finding was presented to the director of nursing, administrator, and nurse consultant. No other information was presented prior to exit conference on 6/15/22.	F 759	C. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: 1. DON or designee will re- educate all licensed nurses on medication pass and med availability. D. Monitoring of corrective action to ensure the deficient practice will not reoccur; 1. DON or designee will randomly audit 5 residents weekly and do a MAR to cart check against their orders to ensure that all meds are available. 2. This will be done weekly for 3 months. 3. All findings will be reported to QAPI for further review, follow up and recommendations weekly for 3 months. E. Date of Completion - 07/11/22	
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy.	F 803		7/11/22

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F 803	Continued From page 7 Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility policy review and clinical record review, the facility staff failed to provide food items per the menu and/or meal ticket for two of eighteen residents in the survey sample, Resident #29 and #32. Resident #29 and 32 were not routinely provided food per their meal ticket or as listed on the menu. The findings include: 1. Resident #29 was admitted to the facility with	F 803	A. Corrective action accomplished for the resident found to have been affected by the alleged deficient practice: 1. Resident #29 and #32 likes and dislikes were reviewed with the residents by dietary and their tray cards were updated. Dietary staff were educated on following tray tickets. B. Identify other residents who have the potential to be affected by the same deficient practice and what corrective	

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F 803	Continued From page 8	F 803		

diagnoses that included COPD (chronic obstructive pulmonary disease), diabetes, congestive heart failure, chronic kidney disease, bipolar disorder, anxiety, atrial fibrillation, insomnia, hypertension, and osteoporosis. The minimum data set (MDS) dated 4/26/22 assessed Resident #29 as cognitively intact.

On 6/14/22 at 11:58 a.m., Resident #29 was interviewed about quality of life/care in the facility. Resident #29 stated that he did not get drinks and/or food items as listed on the meal ticket and this happened on a routine basis. Resident #29 stated he was supposed to get a diet ginger ale or cola on each meal tray and he frequently did not receive the cola. The resident stated bread items like rolls and/or toast were not routinely provided with meals.

On 6/14/22 at 12:30 p.m., Resident #29 was observed with his lunch tray. The lunch ticket dated 6/14/22 documented the resident's order as regular, thin liquids with "standing orders" of 4 ounces whole milk, 4 ounces diet cola, a grilled cheese sandwich with tomato and mayonnaise and an alert listed as "send extra vegetables." The resident's lunch tray had pork bites on rice, double portion of corn, milk and a diet cola. There was no grilled cheese sandwich with tomato/mayonnaise as listed on the meal ticket and no other bread of any type.

On 6/15/22 at 8:28 a.m., Resident #29 was served breakfast in his room. The meal ticket listed food items as 4 ounces of whole milk, 4 ounces of orange juice, 4 ounces diet cola, 1 cup cold cereal, 8 ounces oatmeal and 1/2 cup scrambled eggs. The resident's breakfast tray had no diet cola, no cold cereal and no

action taken:
1. All residents have the potential to be affected by this deficient practice.
2. The Registered Dietician and Dietary Manager reviewed 100% of the resident□s tray tickets to ensure that likes and dislikes are accurate as of 6/16/22.

C. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur:
1. RD educated the Dietary Manager about following tray cards and how to update as needed. Dietary Manager will educate dietary staff on following tray cards to ensure residents are on the tray.
2. DON or designee will educate nursing staff on reading the tray cards to ensure that all requested items are on the tray.

D. Monitoring of corrective action to ensure the deficient practice will not reoccur;
Administrator will randomly select 5 trays per week to ensure the tray card matches the meal being served. The Administrator will report all findings to QAPI weekly, then monthly for 3 months for further review, follow up and recommendations.

E. Date of Completion - 07/11/22

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F 803	Continued From page 9	F 803		

toast/bread. The resident stated the serving of scrambled eggs was very small and he would prefer some type of meat and toast. Resident #29 stated he hated to ask for food/drink items that were not on his tray. The resident stated by the time the requested items were served he was done with eating. The resident stated not getting food/drink items on his tray happened "almost every day." Resident #29 stated butter was frequently on his tray but bread was rarely provided.

The facility's regular menu/diet spreadsheet for 6/14/22 included an English muffin for breakfast but no bread for the lunch and dinner meal. The menu/diet spreadsheet for breakfast on 6/15/22 listed toast and/or a biscuit was supposed to be served in addition to juice, cereal, scrambled eggs with cheese, milk and coffee or tea.

On 6/15/22 at 8:35 a.m., the dietary manager (other staff #1) and the registered dietitian (RD - other staff #2) were interviewed about Resident #29's food concerns and not getting food/drink items as listed on the meal ticket. The dietary manager stated the grilled cheese sandwich and the diet cola must have been omitted in error from the tray line. The dietary manager stated rolls, bread and/or toast were routinely available for residents. The RD stated the meal tickets did not print the "day to day" menu but included the resident's preferences. The dietary manager stated "all of the preferences don't show" on the meal tickets. The dietary manager stated he was not familiar with the meal ticket printing system and was working to figure it out. The dietary manager stated again the staff on the tray line did not plate the resident's food according to the ticket and that residents should be getting rolls,

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bread and/or toast with meals. The RD stated the facility followed the corporate menus.

Resident #29's clinical record documented a physician's order dated a 7/20/21 for a regular diet with thin liquids. The resident's plan of care (revised 3/8/22) listed the resident had increased nutrition/hydration risks due to COPD, congestive heart failure and use of multiple diuretics. Interventions to support acceptable lab values included, "...Provide diet per order...Respect resident dietary choices, likes Diet Coke, 2% milk..."

The facility's policy titled Menu Planning Policy (revised 7/27/20) documented, "...Based on a facility's reasonable efforts, menus will reflect the religious, cultural, and ethnic needs of the resident population, as well as individual resident and resident groups..."

This finding was reviewed with the administrator and director of nursing during a meeting on 6/15/22 at 11:15 a.m.

2. Resident # 32 was admitted with diagnoses that included end stage renal disease, anemia, coronary artery disease, hypertension, orthostatic hypotension, peripheral disease, gastroesophageal reflux disease, diabetes mellitus, hypokalemia, arthritis, cerebrovascular accident with right sided hemiplegia, seizure disorder, dysphagia, hypertrophy, cardiomyopathy, insomnia, and generalized muscle weakness. According to an Annual Minimum Data Set with an Assessment Reference Date of 4/27/2022, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 05 out of 15.

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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 803	Continued From page 11	F 803		

At 12:20 p.m. on 6/14/2022, during observation of lunch in the main dining room, the resident was observed at a table, seated in a wheelchair. The lunch tray was placed in front of Resident # 32 and set-up for eating. The entree on the resident's tray consisted on pork bites over rice, multi-colored green beans, and a grilled cheese sandwich.

Resident # 32 picked up a pork bite with her fingers and placed it in her mouth. After eating the pork, the resident made a face and pushed the tray away. Asked if there was something wrong, Resident # 32 mumbled "No good." Asked about getting a substitute meal, Resident # 32 declined to ask for one.

Review of the meal ticket on Resident # 32's meal tray revealed the following: "Standing Orders: > 3 oz (ounce)/2 sl Deli Sandwich (5 slices meat)." There was no deli sandwich on Resident # 32's meal tray.

At 8:50 a.m. on 6/15/2022, the Dietary Manager was interviewed regarding standing orders on the meal tickets. According to the Dietary Manager, residents "...should get the standing order item and the main menu meal items." When told Resident # 32 got a grilled cheese sandwich instead of a deli sandwich, the Dietary Manager said the grilled cheese sandwich was not a deli sandwich, and the resident should have gotten the deli sandwich.

The findings was discussed during a meeting at 11:15 a.m. on 6/15/2022 that included the Administrator, Director of Nursing, and the survey team.

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	495302	A. BUILDING _____ B. WING _____	C 06/15/2022

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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, 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:	F 880		7/11/22

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F 880	Continued From page 13 (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 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 observation, staff interview and facility document review, the facility staff failed to follow infection control protocols regarding hand hygiene. A staff member failed to perform hand hygiene between resident contacts during a dining observation on 6/14/22. The findings include: A dining observation was conducted in the main dining room on 6/14/22 starting at 12:40 p.m.	F 880	A. Corrective action accomplished for the resident found to have been affected by the alleged deficient practice: 1. C.N.A. #1 received a 1:1 education and discipline from the DON on 6/14/22. B. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: 1. All residents have the potential to be affected by deficient practice.	

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F 880	Continued From page 14 Resident #30, seated at a table near the center of the room, attempted to take his shirt off during the meal service. Certified nurses' aide (CNA) #1 assisted Resident #30 with putting his shirt back on. Without hand hygiene, CNA #1 then retrieved a lunch tray from the cart and served a tray to another resident. CNA #1 set up the meal tray touching the utensils, wrapped cookie and drinking glass. CNA #1 proceeded to provide assistance with tray service and meal set-up to three additional residents. CNA #1 touched the resident's tray, utensils, applied seasonings, opened milk cartons, discarded trash and placed thermal tops on the counter. CNA #1 performed no hand hygiene between any of these residents or after contact with the utensils and/or food items. On 6/14/22 at 12:47 p.m., CNA #1 was interviewed about hand hygiene. CNA #1 stated she was supposed to use hand sanitizer between residents. CNA #1 stated, "I was just trying to keep him (Resident #30) from stripping." CNA #1 stated hand sanitizer was available on the meal carts and in the dining room. The facility's policy titled Hand Hygiene/Handwashing Policy (revised 7/14/21) documented, "Hand washing is the most important component for preventing the spread of infection...Perform hand hygiene...Before and after having direct contact with residents...After contact with inanimate objects (including medical equipment) in the immediate vicinity of the resident...Wash hands with either plain or antimicrobial soap and water or rub hands with an alcohol-based formulation before handling medication and preparing food..."	F 880	C. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: 1. All nursing staff were provided pocket sized hand sanitizer on 6/14/22. 2. The DON and/or designee have in-serviced all staff on the Hand Hygiene policy 3. C.N.A.s will be tracked and trended for compliance with proper hand hygiene by the RN Unit Manager or designee. D. Monitoring of corrective action to ensure the deficient practice will not reoccur: 1. Director of Nursing or designee will audit 5 C.N.A.s as they complete hand washing/sanitizing procedures for the dining process weekly for one month and then 5 monthly for two months. 2. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. 3. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. 4. The Administrator will be responsible for overseeing all audit of findings and subsequent disciplinary action, if applicable. All findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of plan. E. Date of Completion □ 07/11/22	

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F 880	Continued From page 15 This finding was reviewed with the administrator and director of nursing during a meeting on 6/15/22 at 11:15 a.m.	F 880		