STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **555494**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **12/21/2018**
NAME OF PROVIDER OF SUPPLIER **CEDAR MOUNTAIN POST ACUTE**		STREET ADDRESS, CITY, STATE, ZIP **11970 4TH STREET YUCAIPA, CA 92399**	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff provided care according to facility's policy and procedure and acceptable standards of clinical practice when: 1. For Resident 15, the oxygen (a gas essential to living organisms) tubing was not connected to the oxygen concentrator (medical device used to deliver oxygen) per physician's orders [REDACTED]. 2. For Resident 12, the oxygen flow rate administered did not match the physician's orders [REDACTED]. 3. For Resident 47, the oxygen therapy (a treatment that delivers supplemental oxygen gas to breathe) was not administered continously as ordered by the physcian. This failure had the potential to result in a respiratory emergency and death due to Resident 47 not receiving necessary oxygen therapy. Findings: 1. During an observation of Resident 15's room on (MONTH) 17, (YEAR), at 10:00 AM, Resident 15 was in a semi-upright position, in bed wearing a nasal cannula (a device to deliver supplemental oxygen) and was observed restless. The oxygen concentrator was observed and it indicated, 2 LPM (liters per minute, a unit of measure). During a concurrent interview with Resident 15, Resident 15 was short of breath and unable to finish his sentences. During a concurrent observation and interview with a Licensed Vocational Nurse (LVN 1) inside Resident 15's room, the oxygen tubing was not connected to the portable oxygen concentrator. LVN 1 confirmed air was heard leaking through Resident 15's concentrator and the oxygen tubing was not connected to the concentrator. LVN 1 further stated the oxygen tubing should be connected to the concentrator to prevent Resident 15's from becoming short of breath. A clinical record review of Resident 15's face sheet (demographic information) indicated Resident 15 was admitted on (MONTH) 27, (YEAR) with [DIAGNOSES REDACTED]. During an interview with the Director of Nursing (DON) on (MONTH) 21, (YEAR), at 10:30 AM, when asked what her expectation was for nursing to ensure oxygen therapy was correctly administered to residents, the DON stated nursing should double check if oxygen tubing's are properly connected. The DON further stated nursing did not ensure the oxygen tubing was properly connected on Resident 15. A facility policy and procedure titled, Oxygen Administration, dated, (MONTH) 2010, indicated . The purpose of this procedure is to provide guidelines for safe oxygen administration .7. Check the tubing connected to the oxygen cylinder . A review of an undated facility job description titled, Charge Nurse (RN (Registered Nurse) or LVN/LPN (Licensed Practical Nurse)), under Personnel Functions indicated Make daily rounds of your unit/shift to ensure that nursing service personnel are performing their work assignments in accordance with acceptable nursing standards. 2. During an observation of Resident 12 on (MONTH) 17, (YEAR), at 10:15 AM, Resident 12 was in a semi- upright position, in bed wearing a nasal cannula connected to an oxygen concentrator. The oxygen flow rate (amount of oxygen delivered per minute inside the body) was observed and it indicated 4 LPM (liters per minute - unit of measurement for oxygen flow). During a concurrent interview with the Certified Nursing Assistant (CNA 1), CNA 1 confirmed Resident 12's current oxygen flow rate was at 4 LPM. During a concurrent observation and interview with LVN 1, she confirmed Resident 12's oxygen flow rate was set to 4 LPM. When asked what the expectation was for nurses to ensure the correct flow rate was administered, LVN 1 stated nursing should check the oxygen flow rate in the beginning of the shift. LVN 1 further stated Resident 12's oxygen flow rate should be at 2 LPM and further stated she did not check it this morning during rounds. During a concurrent record review of Resident 12's physician order [REDACTED]. LVN 1 stated Resident 12's oxygen flow rate did not match the physician's orders [REDACTED]. During an interview with the DON on (MONTH) 21, (YEAR), at 10:30 AM, when asked what her expectation was in ensuring residents were receiving the correct oxygen flow rate, she stated the staff should double check residents' oxygen flow rate settings during their rounds. The DON further stated the staff did not check Resident 12's oxygen which resulted to an incorrect oxygen flow rate setting. A facility policy and procedure titled, Oxygen Administration, dated, (MONTH) 2010, indicated . The purpose of this procedure is to provide guidelines for safe oxygen administration . Review the physician's orders [REDACTED]. 10. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. A facility policy and procedure titled, Orders, dated (MONTH) 2014, indicated 7. All orders will be carried out as written. A review of an undated facility job description titled, Charge Nurse (RN (Registered Nurse) or LVN/LPN (Licensed Practical Nurse)), under Personnel Functions indicated Make daily rounds of your unit/shift to ensure that nursing service personnel are performing their work assignments in accordance with acceptable nursing standards. 3. During a record review of Resident 47's Admission Record (demographic information), it indicated Resident 47 was admitted on (MONTH) 12, (YEAR) with [DIAGNOSES REDACTED]. During an observation on (MONTH) 19, (YEAR), at 8:24 AM, in front of the nursing station, Resident 47 was sitting in a wheelchair wearing oxygen tubing connected to a portable oxygen tank. Upon further observation, the oxygen tank's regulator (a device for controlling the amount of oxygen being administered) was set to administer 2 liters of oxygen per minute (LPM-a unit of measurement) and the indicator pointed to a marked red line which indicated the oxygen tank was empty and needed to be refilled or replaced. During an interview with the Registered Nurse (RN 1) on (MONTH) 19, (YEAR), at 8:25 AM, RN 1 reviewed Resident 47's physician orders [REDACTED]. While RN 1 observed Resident 47's oxygen tank, RN 1 stated the oxygen tank was empty. She stated all staff are responsible for ensuring Resident 47 oxygen tank is always filled with oxygen so the resident can breathe better and receive her oxygen therapy continuously. During an interview with the Director of Nursing (DON) on (MONTH) 19, (YEAR), at 12:50 PM, the DON stated everyone who interacts with residents on oxygen therapy are supposed to monitor the delivery of oxygen. During a review of Resident 47's Physician order [REDACTED]. The facility policy and procedure titled Oxygen Administration revised (MONTH) 2010, indicated, Check the tank to be sure they are in good working order
F 0679 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure quarterly activity assessments (a tool used to determine individualized activity programs for residents) were completed for two of 18 sampled residents (Residents 81 and 10) when: 1. For Resident 81, three quarterly assessments were not completed. 2. For Resident 10, three quarterly assessments were not completed.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0679 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) These failures resulted in missed evaluations of activity programs that could potentially result in ineffective resident-centered activities and psychosocial harm affecting Residents 81 and 10. Findings: 1. A clinical record review of Resident 81's face sheet (demographic information) indicated Resident 81 was admitted on (MONTH) 14, 2012 with [DIAGNOSES REDACTED]. During a record review of Resident 81's Activity Assessment with the Activities Director (AD), it indicated the last quarterly assessment was done on (MONTH) (YEAR). There were no documented evidences of quarterly assessments in the months of (MONTH) (YEAR), (MONTH) (YEAR), and (MONTH) of (YEAR). During an interview with the AD on (MONTH) 21, (YEAR) at 10:00 AM, when asked how often activity assessments were done for the residents, she stated, Activity assessments are done on admission, annually, when there is a significant change of condition and quarterly. The AD confirmed, Resident 81 did not have quarterly assessments in the months of (MONTH) (YEAR), (MONTH) (YEAR), and (MONTH) of (YEAR). During a concurrent interview with the Director of Nursing (DON), when asked what her expectation was for the staff to ensure timely assessments were done for the residents, she stated the AD should be completing quarterly assessments to ensure the activities provided are resident-centered. The DON further stated staff cannot evaluate activities provided if assessments were not completed. A facility policy and procedure titled, Documentation, Activities, dated (MONTH) 2009, indicated, The Activity Director/Coordinator is responsible for maintaining appropriate departmental documentation. 1. Recordkeeping is a vital part of the activity programs; 2. The following records, at a minimum, are maintained by Activity Department personnel: Activity assessment . 2. A clinical record review of Resident 10's face sheet indicated Resident 10 was admitted on (MONTH) 23, (YEAR) with [DIAGNOSES REDACTED]. During a record review of Resident 10's Activity Assessment with the AD, it indicated the last quarterly assessment was done on (MONTH) (YEAR). There were no documented evidences of quarterly assessments in the months of (MONTH) and (MONTH) of (YEAR). A further review of Resident 10's Activity Assessment with the AD indicated the last assessment for significant change was done on (MONTH) 10, (YEAR). There was no documented evidence of a quarterly assessment done on (MONTH) of (YEAR). During an interview with the AD on (MONTH) 21, (YEAR) at 10:00 AM, when asked how often activity assessments were done for the residents, she stated, Activity assessments are done on admission, annually, when there is a significant change of condition and quarterly. The AD confirmed Resident 10 did not have quarterly assessments done on February, (MONTH) and (MONTH) of (YEAR). During a concurrent interview with the Director of Nursing (DON), when asked what her expectation was for the staff to ensure timely assessments were done for the residents, she stated the AD should be completing quarterly assessments to ensure the activities provided are resident-centered. The DON further stated staff cannot evaluate activities provided if assessments were not completed. A facility policy and procedure titled, Documentation, Activities, dated (MONTH) 2009, indicated, The Activity Director/Coordinator is responsible for maintaining appropriate departmental documentation. 1. Recordkeeping is a vital part of the activity programs; 2. The following records, at a minimum, are maintained by Activity Department personnel: Activity assessment .
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe environment for one of 18 sampled residents (Resident 239). This failure resulted in unsafe oxygen (a gas essential to living organisms) administration that could potentially cause fire and injury affecting residents on oxygen therapy. Findings: During an observation on (MONTH) 17, (YEAR) at 10:00 AM, Resident 239 was seen in bed wearing a nasal cannula (a tubing that delivers oxygen thru the nostril) connected to an oxygen concentrator. The oxygen flow rate was inspected, and it indicated, 2 LPM (liters per minute, a unit of measure). Resident 239 did not have a No Smoking/Oxygen In-Use sign posted outside the entrance door. During a concurrent interview with the Licensed Vocational Nurse (LVN 2), she confirmed the No Smoking/Oxygen In-Use sign was not posted in Resident 239's entrance door. LVN 2 further stated, The sign should have been placed as a precautionary measure. During a record review of Resident 239's physician order [REDACTED]. During an interview with the Director of Nursing (DON) on (MONTH) 21, (YEAR) at 10:30 AM, when asked what her expectation was for staff in providing a safe environment for the residents, the DON stated it is the staff's responsibility to place a No Smoking/Oxygen In-Use sign outside the resident's entrance door when the resident is on oxygen therapy. A facility policy and procedure titled, Oxygen Administration, dated (MONTH) 2010, it indicated, The purpose of this procedure is to provide guidelines for safe oxygen administration . 2. Place a No Smoking/Oxygen In-Use sign on the outside of the room entrance door .
F 0698 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow physician's orders for [MEDICAL TREATMENT] (process of removing waste products and excess fluid from the body) for one of two sampled residents (Resident 74) when staff was taking blood pressure's (B/P- pressure of circulating blood on the walls of blood vessels) on Resident 74's left upper arm (LUA) that had a arteriovenous fistula (AV shunt, a surgically created connection between an artery (a blood vessel that carries blood away from the heart to the rest of the body) and vein (a blood vessel that carries blood to the heart from the rest of the body) used to remove and return blood during [MEDICAL TREATMENT]). This failure could potentially cause Resident 74's AV shunt to clog and need to be surgically replaced. Findings: During an observation on (MONTH) 19, (YEAR), at 6:18 AM, Resident 74 was awake with his bed in low position with a floor mat in place. Resident 74 had an AV shunt in his left upper arm. During a record review of Resident 74's clinical records, indicated Resident 74 was admitted to the facility on (MONTH) 6, (YEAR) with [DIAGNOSES REDACTED]. A review of Resident 74's physician's order summary report (a summary of reconciled medication orders that is recapitulated on a monthly basis) dated (MONTH) (YEAR), indicated an order for [REDACTED]. A review of Resident 74's weekly summaries (Complete head to toe assessment completed by a licensed nurse) with Registered Nurse (RN 1), indicated Resident 74's blood pressure were taken on either arms, on the left arm with AV shunt and on the right arm. The weekly summaries indicated the following: 1. (MONTH) 19, (YEAR) at 2:35 PM-B/P:101/60 Position: lying right (RT/Arm) 2. (MONTH) 11, (YEAR) at 6:17 PM-B/P: 163/78 Position: lying right (RT/Arm) 3. (MONTH) 4, (YEAR) at 8:38 AM-B/P: 148/78 Position: lying left (LT/Arm) 4. (MONTH) 28, (YEAR) at 1:05 PM-B/P: 100/60 Position: lying left (LT/Arm) 5. (MONTH) 20, (YEAR) at 4:55 PM-B/P: 133/68 Position: lying right (RT/Arm) 6. (MONTH) 13, (YEAR) at 11:24 AM-B/P: 176/80 Position: lying left (LT/Arm) 7. (MONTH) 7, (YEAR) at 2:10 PM-B/P: 144/78 Position: lying right (RT/Arm) During an interview with RN 1 on (MONTH) 20, (YEAR) at 12:15 PM, RN 1 confirmed Resident 74 had an AV shunt in his LU[NAME] RN 1 stated there was a physician orders for no B/P's to be taken on his left arm. RN 1 verified staff had been taking

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F 0698

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

(continued... from page 2)
B/P's on Resident 74's left arm with the AV shunt. RN 1 stated and by taking B/P's on Resident 74's left arm, it could cause his AV shunt to clog.
During an interview with the Director of Nurses (DON), on (MONTH) 20, (YEAR) at 3:41 PM, the DON stated Resident 74 had a shunt in his left upper arm and staff should take his B/P in his right arm (without the AV shunt). The weekly summaries was reviewed with the DON, dated (MONTH) 7, (YEAR) through (MONTH) 19, (YEAR), the DON verified staff have been taking the resident's B/P on his left arm with the AVshunt and stated it could cause the shunt to clog.
The facility policy and procedure titled, Orders, Revised date (MONTH) 2014, indicated, All orders will be carried out as written.
The facility job description titled, Charge Nurse (Registered Nurse or Licensed Vocational Nurse), undated, indicated .Duties and responsibilities: Ensure that all nursing service personnel comply with the procedures set forth in the Nursing Service Procedure Manual. Make daily rounds of your unit/shift to ensure that nursing service personnel are performing their assignments in accordance with acceptable nursing standards. Administer professional services such as taking blood, and taking blood pressure.
The facility policy and procedure titled, [MEDICAL TREATMENT], Revised (MONTH) 2010, Indicated . Post [MEDICAL TREATMENT]:
Time Left, Vital Signs: Temperature, Respirations, B/P, Pain Scale and Recent falls or Trauma. Post [MEDICAL TREATMENT]: Time returned, Vital Signs: Temperature, Pulse, Respirations, B/P, and Pain Scale. Check access site: Bruit/Thrill, redness, swelling and Drainage.

F 0842

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on interview and record review, the facility failed to ensure the code status (used to describe the type of treatment a resident should receive if their heart stops beating or they stop breathing) was accurately documented in the clinical record for one of three sampled residents (Resident 79).
This failure had the potential to result in inaccurate care and not meeting the type of life-sustaining treatment requested by the resident.
Findings:
During a closed record review for Resident 79, the Physician order [REDACTED]. on (MONTH) 26, (YEAR), indicated Do Not Attempt Resuscitation (Allow Natural Death) or DNR.
A review of Resident 79's physician's history and physical dated, (MONTH) 14, (YEAR), indicated Code Status: POLST: Do Not Attempt Resuscitation.
A review of Resident 79's face sheet (demographic information) dated (MONTH) 21, (YEAR), under advance directive (record of someone's medical preferences) column indicated Full Code (all possible measures are taken to revive a person and sustain life).
During an interview with the Director of Nursing (DON), on (MONTH) 21, (YEAR), at 8:52 AM, when asked about POLST information such as DNR not updated on Resident 79's face sheet, the DON stated, They (staff) should update the record.
During an interview with the Licensed Vocational Nurse (LVN 4), on (MONTH) 21, (YEAR), at 12:05 PM, she reviewed the electronic record for Resident 79 and it indicated Code Status: Full Code. When asked if it would confuse her if POLST indicated DNR, while full code was documented on the computer record, LVN 4 stated, Right. I'm not sure about that.
The facility policy and procedure titled Orders dated (MONTH) 2014, indicated .7. All orders will be carried out as written.

F 0880

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide and implement an infection prevention and control program.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on observation, interview, and record review, the facility failed to ensure staff performed hand hygiene to prevent spread of infection among the residents in accordance to the facility's policy and procedure during the following incidents:1. Medication pass observation when Licensed Vocational Nurse (LVN 3) did not perform hand hygiene in between medication pass affecting six of 18 sampled residents (Resident 42, 86, 40, 344, 38, and 17).
2. Dining room observation when staff used the hand sanitizer and immediately served the food without completely drying their hands after using the alcohol gel.
These failures had the potential to result in cross - contamination and spread of infection to medically compromised residents in the facility.
Findings:
1. During an observation on (MONTH) 19, (YEAR), at 5:21 AM, LVN 3 prepared [MEDICATION NAME] (medication to relieve anxiety) one tablet for Resident 42. LVN 3 went inside the resident's room, took water from the pitcher, and touched the control button to elevate the head part of the bed. [MEDICATION NAME] was administered to Resident 42. She went back to the medication cart, and entered data on the computer. She then proceeded to another room, and prepared another medication for the next resident. LVN 3 did not perform hand hygiene in between these task.
During an observation on (MONTH) 19, (YEAR), at 5:27 AM, LVN 3 after administering medication to Resident 42, LVN 3 prepared [MEDICATION NAME] (medication for pain) one tablet for Resident 86. LVN 3 elevated the head of the bed and administered [MEDICATION NAME]. LVN 3 went back to the medication cart, and entered data on the computer. She then prepared another medication for the next resident without sanitizing her hands.
During an observation on (MONTH) 19, (YEAR), at 5:34 AM, LVN 3 did not sanitize her hands before preparing medications for Resident 40. LVN 3 prepared [MEDICATION NAME] ([MEDICAL CONDITION] medication) one tablet, Pantoprazole (decreases the
amount of acid in the stomach) one tablet, and [MEDICATION NAME] (used to improve the symptoms of a certain blood flow problem in the legs) one tablet. LVN 3 closed the curtain, checked the resident's name on her bracelet, and elevated the head of the bed and gave all the medications to Resident 40 without performing hand hygiene in between these task. LVN 3 proceeded to the next resident.
During an observation on (MONTH) 19, (YEAR), at 6:03 AM, LVN 3 did not sanitize her hands before preparing Resident 344's medications. LVN 3 prepared [MEDICATION NAME] one tablet and [MEDICATION NAME] (used to treat and prevent ulcers in the
stomach and intestines) one tablet. LVN 3 closed the curtain, touched bedside table, turned the lights on, and checked for resident's name on her bracelet. Resident 344 took both medications. LVN 3 went back to the medication cart, and entered data on the computer. She then prepared another medication for the next resident without performing hand hygiene.
During an observation on (MONTH) 19, (YEAR), at 6:11 AM, LVN 3 did not sanitize her hands after administration of medication to Resident 344. LVN 3 prepared [MEDICATION NAME] with [MEDICATION NAME] (pain medication) one tablet for Resident 38. LVN
3 closed the curtain and administered the medication. There was no hand hygiene performed in between these tasks.
During an observation on (MONTH) 19, (YEAR), at 6:17 AM, LVN 3 did not sanitize her hands after administration of medication to Resident 38. LVN 3 prepared [MEDICATION NAME] with [MEDICATION NAME] (pain medication) one tablet and Pantoprazole one
tablet for Resident 17. LVN 3 closed the curtain and administered the medication. LVN 3 did not sanitize her hands, went back to the medication cart and touched the computer.
During an interview with LVN 3, on (MONTH) 19, (YEAR), at 6:25 AM, when asked how often she needs to sanitize her hands during medication administration, LVN 3 stated, We sanitize every three patients. If it's P.O. (medication taken by mouth) we sanitize first, then wash our hands every three patients.
During an interview with the Director of Nursing (DON), on (MONTH) 20, (YEAR), at 10:51 AM, when asked if it is the facility's policy to sanitize hands every three residents during medication administration, the DON stated, They should sanitize their hands every time.
The facility policy and procedure titled Handwashing/Hand Hygiene revised (MONTH) (YEAR), indicated .7. Use an alcohol-base hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: .b. Before and after direct contact with the residents. c. Before preparing or handling medications .l. After contact with objects in the vicinity of the resident.
2. During a dining observation on (MONTH) 17, (YEAR), at 11:39 AM, an alcohol gel based hand sanitizer container was on the wall and available for staff's use. The servers were observed serving the resident's plates, taking the lids off of the

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) trays and placing the plate on the table in front of the resident. They used the hand sanitizer and immediately served the food without completely drying their hands after using the alcohol gel. Certified Nurses Assistants (CNA) and Restorative Nurses Assistant (RNA) were also observed using the gel sanitizer, without completely drying their hands and then assisting the residents during the lunch meal. During an interview with RNA 1,on (MONTH) 17, (YEAR), at 12:30 PM, RNA 1 stated, I pass out trays and assist the residents with setting up their trays. RNA 1 stated she uses gel based alcohol hand sanitizer after passing each tray and assisting each resident. RNA 1 confirmed she does not know about any drying time when using gel based alcohol hand sanitizer and does not use soap and water to sanitize her hands when coming in direct contact with the residents. RNA 1 stated she has had training in hand hygiene and infection control but, does not remember when it was last done. During an interview with the Director of Nursing (DON), on (MONTH) 21,2018, at 12:20 PM, the DON verified if staff use gel based alcohol hand sanitizer in the dining hall, staff can only use it when passing trays and must allow for drying time. The DON further stated if staff come in direct contact with residents, they must wash their hands with soap and water. The facility policy and procedure titled Handwashing/Hand Hygiene revised (MONTH) (YEAR), indicated Use an alcohol-base hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: b. Before and after direct contact with the residents. c. Before preparing or handling medications l. After contact with objects in the vicinity of the resident.