STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676456	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE MEDICAL RESORT AT WOODLANDS	**24854 CATHEDRAL LAKES PKWY SPRING, TX 77386**

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 0557 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the residents were treated with respect and dignity for 3 (Residents #1, #2, #3) of 3 reviewed for resident rights. -The facility failed to ensure the staff did not stand while they assisted residents to eat during meals. These failures could affect all residents who needed eating assistance and placed them at risk of a loss of self-esteem. Findings included Resident #1 Record review of Resident #1's face sheet revealed she was an [AGE] year-old woman admitted on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #1's quarterly MDS dated [DATE] revealed her cognitive skills for daily decision making was severely impaired as determined by staff. She needed total help of 2 staff for toileting, bed mobility, transfers, and was incontinent of bowel/bladder. Record review of Resident #1's care plan dated [DATE]20 read in part . the resident requires, (1) staff participation to eat limited assist . Resident #2 Record review of Resident #2's face sheet revealed she an [AGE] year-old woman admitted on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #2's care plan dated 3/11/20 revealed she needed assistance with eating. She was cognitively impaired and used a wheelchair for locomotion. She needed assistance with eating and could not communicate with staff clearly. Record review of Resident #2's MDS was not completed due to recent admission [DATE]. Resident #3 Record review of Resident #3 face sheet dated 3/12/20 revealed he was an [AGE] year-old male admitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #3 care plan dated 11/[DATE]9 read in part . Interventions . monitor during eating for pocketing, choking, coughing . holding food in mouth, several attempts a swallowing . The care plan did not note level of assistance needed for eating. Record review of Resident #3's admission MDS dated [DATE] revealed the BI[CONDITION] assessment blank, he needed help of 1 staff with eating, had upper and lower extremity impairment, and used a wheelchair. Observation on 3/12/20 from 12:31 to 12:40 p.m. of the Act. Dir. assisting Residents #1, #2 and #3 with lunch and was not wearing gloves. -Resident #1 was assisted by Act. Dir., she used a fork and fed her two portions of food while standing next to the resident. -Resident #3 was assisted by Act. Dir. at the same table as Resident #1, she placed her left hand on his back and used her right hand to feed him a portion of food, while standing next to him. The resident coughed during this time. -The Act. Dir. returned to Resident #1 and #3 twice more while standing to assist with eating. - Resident #2 was assisted by Act. Dir. at a different table with her food and drink while standing. Interview on 3/12/20 at 12:39 p.m. with LVN A, he said staff should sit down next to the resident when helping the resident to eat. Interview on 3/12/20 at 12:44 with the Act. Dir., she said there was normally help for the residents from a Restorative Aide or CNA. She said she was not sure why those staff were not available today. Interview on 3/12/20 at 1:32 with the DON, he said feeding residents is considered resident contact and staff should wash their hands or sanitize in between interactions. He said staff should sit next to a resident when feeding them because if a staff stands, it could make the resident feel like they were being rushed. Interview on 3/12/20 at 5:00 p.m. with the Admin., he said staff should not stand while feeding a resident. He said when staff helped to feed a resident, they would need to use hand hygiene so as not to spread germs in case the resident had a cold or something else. Record review of facility policy on Assistance with Meals dated 2/2014 read in part . c. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: 1. Not standing over residents while assisting them with meals . .
F 0684 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that a resident received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan, for one (Resident #1) of 6 residents reviewed for physician orders. -The facility failed to obtain Resident #1's urine sample for lab analysis as ordered by her physician causing a delay in UTI [DIAGNOSES REDACTED].#1 to suffer pain and confusion, and required a hospitalization due to the UTI not being diagnosed promptly and treated. This failure could affect all residents who needed laboratory testing and placed them at risk of injury or health complications. Findings included: Resident #1 Record review of Resident #1's face sheet revealed she was an [AGE] year-old woman admitted on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #1's quarterly MDS dated [DATE] revealed her cognitive skills for daily decision making was severely impaired as determined by staff. She needed total help of 2 staff for toileting, bed mobility, transfers, and was incontinent of bowel/bladder. Record review of Resident #1's care plan dated [DATE] read in part . (Resident #1) is incontinent of bowel and bladder . Intervention . Monitor/document/report to MD PRN possible medical causes of incontinence, bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, stroke, medication side effects . (Resident #1) is on diuretic therapy ([MEDICATION NAME]) r/t [MEDICAL CONDITION] . Intervention . Report pertinent lab results to MD . (Especially HCT, Na+, K+) . incontinent care . the resident was to be checked frequently . monitor/document/report MD PRN possible medical issues causes of incontinence: bladder infection . Record review of Resident #1's Nurse's Notes dated 1/28/20 read in part .UA sample collected at 7 p.m., via straight Cath . sample placed in bio-fridge and picked up by lab at 7:21 p.m.; awaiting results . Record review of Resident #1's uranalysis lab paperwork dated 1/29/20 revealed the following in part . Improper specimen submitted. Please re-submit . Record review of Resident #1's Nurses Note dated 2/17/20 read in part . she showed signs of restlessness . Record review of Resident #1's Nurse's Note dated 2/23/20 read in part . she was swinging and combative with CNA and angrily shouting . Record review of nurse's notes dated [DATE] revealed . patient was transferred to [LOC] per daughter's request to check for presence of UTI . Interview on 3/11/20 at 3:37 p.m. with Resident #1's family member, she said the resident was acting differently and she wanted her to be tested for an UTI since she had history of frequent UTI's. She said the Resident #1 was not able to tell staff if she was in pain. She said the doctor prescribed a barrier cream to alleviate irritation. Record review of nurse's note dated [DATE]20 read in part . (Resident #1) returned from ER; new order received [MED] 500 mg po qid x 7 day for UTI . Interview on 3/12/20 at 9:58 a.m. with LVN A, he said lab orders should be completed as soon as they are received. He said after the lab results come back, the doctor would be notified. He said there was a log book with the competed resident labs. Interview on 3/12/20 at 12:20 p.m. with DON, he said the urine analysis lab work should have been followed-up on the same or the next day since the collected sample could not be used. He said the staff did not document if they tried to obtain a urine sample again. He said documentation has been a problem. He said they should have notified the doctor and could have collected the sample again. He said the nurse should have notified him so that he could follow-up on the urine sample collection. He was not sure who reviewed the lab report that indicated

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676456	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE MEDICAL RESORT AT WOODLANDS	24854 CATHEDRAL LAKES PKWY SPRING, TX 77386

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 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) the urine specimen was unabled to be used. He said it should not have taken almost a month to get a urine sample from Resident #1. Interview on 3/12/20 at 1:32 a.m. with ADON, she said she did not see documentation that a urine sample for Resident #1 was collected again. She said the NP should have been notified that the sample collected could not be used. She said ordered lab work should be completed immediately. Interview on 3/12/20 at 5:00 p.m. with the Administrator, he said the lab work for Resident #1 should have been completed as soon as possible. He said if there was something wrong with the collected sample, it should have been immediately collected again and sent to the lab again. He said if there was a delay in getting the lab work completed then the PCP or NP should have been notified. He said staff should have documented in Resident #1's chart and obtained another urine sample. He said it should not have taken more than 1-2 days after the sample was not able to be used to send in a new one. He did not have a specific policy for timeliness in lab work. Interview on 3/12/20 at 5:19 p.m. with LVN A, she said staff should document and notify the physician, if they needed to collect the urine sample again. She said Resident #1 was at risk for infection and it could have worsened or she could have had additional complications if lab work was delayed. Record review of facility policy Medication and Treatment Orders dated (2/14) read in part . orders for medication treatments will be consistent . and recorded immediately . .
F 0690 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that resident who is incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 (Resident #1) of 6 residents reviewed for incontinence. -The facility failed to obtain urine analysis for Resident #1 as ordered by her physician which prevented appropriate treatment for [REDACTED].#1 to suffer pain, confusion, and required a hospitalization due to the UTI not being diagnosed promptly and treated. This failure could affect all residents who needed labatory testing to assist the doctor in making appropriate [DIAGNOSES REDACTED]. Findings included: Resident #1 Record review of Resident #1's face sheet revealed she was an [AGE] year-old woman admitted on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #1's quarterly MDS dated [DATE] revealed her cognitive skills for daily decision making was severely impaired as determined by staff. She needed total help of 2 staff for toileting, bed mobility, transfers, and was incontinent of bowel/bladder. Record review of Resident #1's care plan dated [DATE] read in part . (Resident #1) is incontinent of bowel and bladder . Intervention . Monitor/document/report to MD PRN possible medical causes of incontinence, bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, stroke, medication side effects . (Resident #1) is on diuretic therapy ([MEDICATION NAME]) r/t [MEDICAL CONDITION] . Intervention . Report pertinent lab results to MD . (Especially HCT, Na+, K+) . incontinent care . the resident was to be checked frequently . monitor/document/report MD PRN possible medical issues causes of incontinence: bladder infection . Record review of Resident #1's uranalysis lab paperwork dated 1/29/2020 read in part . Improper specimen submitted. Please re-submit . Record review of Resident #1's Nurse's Note dated 1/28/20 read in part . UA sample collected at 7 p.m., via straight Cath . sample placed in bio-fridge and picked up by lab at 7:21 p.m.; awaiting results . Record review of Resident #1's Nurses Note dated 2/17/20 revealed in part the following . she showed signs of restlessness . Record review of Resident #1's Nurse's Note dated 2/23/20 revealed in part the following . she was swinging and combative with CNA and angrily shouting . Interview on 3/11/20 at 3:37 p.m. with Resident #1's family member, she said the resident was acting differently and she wanted her to be tested for an UTI since she had history of frequent UTI's. She said the Resident #1 was not able to tell staff if she was in pain. She said the doctor prescibed a barrier cream to alleviate irritation. Record review of Resident #1's Nurse's Note dated [DATE] read in part . patient was transferred to [LOC] per daughter's request to check for presence of UTI . Record review of Resident #1's Nurse's Note dated [DATE] read in part . (Resident #1) returned from ER; new order received [MED] 500 mg po qid x 7 day for UTI . Interview on 3/12/20 at 9:58 a.m. with LVN A, he said lab orders should be completed as soon as the order was received. He said after the lab results come back, the doctor should be notified. He said they have a log book with the competed labs. Interview on 3/12/20 at 12:20 p.m. with DON, he said the urine analysis lab work should have been followed-up on the same or the next day since the collected sample could not be used. He said the staff did not document if they tried to obtain a urine sample again. He said documentation has been a problem. He said they should have notified the doctor and could have collected the sample again. He said the nurse should have notified him so that he could follow-up on the urine sample collection. He said he was not sure who reviewed the lab report that indicated the urine specimen was unabled to be used. He said it should not have taken almost a month to get a urine sample from Resident #1. Interview on 3/12/20 at 1:32 a.m. with ADON, she said she did not see documentation that the urine sample for Resident #1 was collected again. She said the NP should have been notified that the sample collected could not be used. She said the requested lab work should have been completed immediately. Interview on 3/12/20 at 5:00 p.m. with the Administrator, he said the lab work for Resident #1 should have been completed as soon as possible. He said if there was something wrong with the collected sample, it should have been collected again immediately and sent in again. He said if there was a delay in getting the lab work completed, the PCP or NP should have been notified. He said staff should have documented and followed-up. He said it should not have taken more than 1-2 days after the sample was not able to be used to send in a new one. Interview on 3/12/20 at 5:19 p.m. with RN A, she said staff should have documented the lab information and notified the physician if the facility needed to collect the urine sample again. She said Resident #1 was at risk for infection and her health could worsen or have additional complications if lab work was delayed. Record review of facility policy Medication and Treatment Orders dated (2/14) read in part . orders for medication treatments will be consistent . and recorded immediately . .
F 0770 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide timely, quality laboratory services/tests to meet the needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to to provide or obtain laboratory services to meet the needs for 1 (Resident #1) of 6 residents reviewed for quality and timeliness of the services. -The facility failed to obtain Resident #1's urine sample for lab analysis as ordered by her physician causing a delay in UTI [DIAGNOSES REDACTED].#1 to suffer pain and confusion, and required a hospitalization due to the UTI not being diagnosed promptly and treated. This failure could affect all residents who needed laboratory testing and placed them at risk of injury or health complications. Findings included: Resident #1 Record review of Resident #1's face sheet revealed she was an [AGE] year-old woman admitted on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #1's quarterly MDS dated [DATE] revealed her cognitive skills for daily decision making was severely impaired as determined by staff. She needed total help of 2 staff for toileting, bed mobility, transfers, and was incontinent of bowel/bladder. Record review of Resident #1's care plan dated [DATE] read in part . (Resident #1) is incontinent of bowel and bladder . Intervention . Monitor/document/report to MD PRN possible medical causes of incontinence, bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, stroke, medication side effects . (Resident #1) is on diuretic therapy ([MEDICATION NAME]) r/t [MEDICAL CONDITION] . Intervention . Report pertinent lab results to MD . (Especially HCT, Na+, K+) . incontinent care . the resident was to be checked frequently . monitor/document/report MD PRN possible medical issues causes of incontinence: bladder infection . Record review of Resident #1's Nurse's Notes dated 1/28/20 read in part .UA sample collected at 7 p.m., via straight Cath . sample placed in bio-fridge and picked up by lab at 7:21 p.m.; awaiting results . Record review of Resident #1's uranalysis lab paperwork dated 1/29/20 revealed the following in part . Improper specimen submitted. Please re-submit . Record review of Resident #1's Nurses Note dated 2/17/20 read in part . she showed showed signs of restlessness . Record review of Resident #1's Nurse's Note dated 2/23/20 read in part . she was swinging and combative with CNA and angrily shouting . Record review of nurse's notes dated [DATE] revealed . patient was transferred to [LOC] per daughter's request to check for presence of UTI . Interview on 3/11/20 at 3:37 p.m. with Resident #1's family member, she said the resident was acting differently and she wanted her to be tested for an UTI since she had history of frequent UTI's. She said the Resident #1 was not able to tell staff if she was in pain. She said the doctor prescibed a barrier cream to alleviate irritation. Record review of nurse's note dated [DATE]20 read in part . (Resident #1) returned from ER; new order received [MED] 500 mg po qid x 7 day for UTI . Interview on 3/12/20 at 9:58 a.m. with LVN A, he said lab orders should be completed as soon as they are received. He said after the lab results come back, the doctor would be notified. He said there was a log book with the competed resident labs. Interview on 3/12/20 at 12:20 p.m. with DON, he said the urine analysis lab work should have been followed-up on the same or the next day since the collected

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676456	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE MEDICAL RESORT AT WOODLANDS	24854 CATHEDRAL LAKES PKWY SPRING, TX 77386

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 0770 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) sample could not be used. He said the staff did not document if they tried to obtain a urine sample again. He said documentation has been a problem. He said they should have notified the doctor and could have collected the sample again. He said the nurse should have notified him so that he could follow-up on the urine sample collection. He was not sure who reviewed the lab report that indicated the urine specimen was unabled to be used. He said it should not have taken almost a month to get a urine sample from Resident #1. Interview on 3/12/20 at 1:32 a.m. with ADON, she said she did not see documentation that a urine sample for Resident #1 was collected again. She said the NP should have been notified that the sample collected could not be used. She said ordered lab work should be completed immediately. Interview on 3/12/20 at 5:00 p.m. with the Administrator, he said the lab work for Resident #1 should have been completed as soon as possible. He said if there was something wrong with the collected sample, it should have been immediately collected again and sent to the lab again. He said if there was a delay in getting the lab work completed then the PCP or NP should have been notified. He said staff should have documented in Resident #1's chart and obtained another urine sample. He said it should not have taken more than 1-2 days after the sample was not able to be used to send in a new one. He did not have a specific policy for timeliness in lab work. Interview on 3/12/20 at 5:19 p.m. with LVN A, she said staff should document and notify the physician, if they needed to collect the urine sample again. She said Resident #1 was at risk for infection and it could have worsened or she could have had additional complications if lab work was delayed. Record review of facility policy Medication and Treatment Orders dated (2/14) read in part . orders for medication treatments will be consistent . and recorded immediately .
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 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 for 3 (Residents #1, #2, #3) of 3 residents reviewed for Infection Control. -The facility failed to ensure staff washed their hands using soap or hand sanitizer when providing feeding assistance to Residents #1, #2, and #3 during a meal. -The facility failed to ensure a system of surveillance designed to identify possible communicable diseases or infections before they could spread to other persons in the facility These failures could affect all residents and placed them at risk of reduced self-esteem and infections due to cross-contamination. Findings included Observation on 3/12/20 from 12:31 to 12:40 p.m. of the Act. Dir. assisting Residents #1, #2 and #3 with lunch and was not wearing gloves. -Resident #1 was assisted by Act. Dir., she used a fork and fed her two portions of food while standing next to the resident. -Resident #3 was assisted by Act. Dir. at the same table as Resident #1, she placed her left hand on his back and used her right hand to feed him a portion of food, while standing next to him. The resident coughed during this time. -The Act. Dir. returned to Resident #1 and #3 twice more while standing to assist with eating. - Resident #2 was assisted by Act. Dir. at a different table with her food and drink while standing. -The Act. Dir. moved Resident #1 in her wheelchair and her plate to Resident #2's table. She sat in between Resident #1 and #2 and assisted them with eating, picking up their cups and adjusting their straws in their cups. -The Act. Dir. did not wash her hands or use hand sanitizer between assisting the three residents or moving Resident #1's wheelchair and plate. Resident #1 Record review of Resident #1's face sheet revealed she was an [AGE] year-old woman admitted on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #1's quarterly MDS dated [DATE] revealed her cognitive skills for daily decision making was severely impaired as determined by staff. She needed total help of 2 staff for toileting, bed mobility, transfers, and was incontinent of bowel/bladder. Record review of Resident #1's care plan dated [DATE] read in part . (Resident #1) is incontinent of bowel and bladder . Intervention . Monitor/document/report to MD PRN possible medical causes of incontinence, bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, stroke, medication side effects . (Resident #1) is on diuretic therapy ([MEDICATION NAME]) r/t [MEDICAL CONDITION] . Intervention . Report pertinent lab results to MD . (Especially HCT, Na+, K+) . incontinent care . the resident was to be checked frequently . monitor/document/report MD PRN possible medical issues causes of incontinence: bladder infection . Record review of nurse's notes dated [DATE] revealed . patient was transferred to local hospital per family member's request to check for presence of UTI . Record review of nurse's note dated [DATE]20 read in part . (Resident #1) returned from ER; new order received [MED] 500 mg po qid x 7 day for UTI . Resident #2 Record review of Resident #2's face sheet revealed she an [AGE] year-old woman admitted on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #2's care plan dated 3/11/20 revealed she needed assistance with eating. She was cognitively impaired and used a wheelchair for locomotion. She needed assistance with eating and could not communicate with staff clearly. Record review of Resident #2's MDS was not completed due to recent admission [DATE]. Resident #3 Record review of Resident #3 face sheet dated 3/12/20 revealed he was an [AGE] year-old male admitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #3 care plan dated 11/[DATE]9 read in part . Interventions . monitor during eating for pocketing, choking, coughing . holding food in mouth, several attempts a swallowing . Record review of Resident #3's admission MDS dated [DATE] revealed the BI[CONDITION] assessment blank, he needed help of 1 staff with eating, had upper and lower extremity impairment, and used a wheelchair. Interview on 3/12/20 at 12:39 p.m. with LVN A, she said staff should use sanitizer when assisting multiple residents. He said a staff should not touch multiple surfaces and assist residents with eating without sanitizing their hands. Interview on 3/12/20 at 12:44 with the Act. Dir. said there was normally help from the Restorative Aide or a CNA. She said today she was not sure why they were not available. She said she did not sanitize before she assisted each resident. She said she touched Resident #1's wheelchair and continued to assist with helping to feed the residents. She said she should have washed her hands or sanitized in-between each of them. She said she has had training on infection control and was told that not washing hands or sanitizing could expose residents to cross-contamination. Interview on 3/12/20 at 1:32 p.m. with the DON, he said he did the last in-service on hand washing last month. He said staff should sanitize or wash their hands before and after resident contact. He said feeding residents was considered resident contact. He said staff should wash their hands or sanitize in between interactions. He said staff could put residents at risk for infection from cross-contamination. Interview on 3/12/20 at 5:00 p.m. with the Administrator, he said staff should wash their hands or sanitize between touching residents. He said if staff were helping to feed a resident, they would need to use hand hygiene so not to spread germs in case the resident has a cold or something else. Record review of the facility's Infection control log dated 1/2020, 2/2020, 3/2020 revealed the following: -1/2020 - 2 residents with UTI's developed in the facility -2/2020 - 4 resident with UTI's developed in the facility -3/2020 - 1 resident with UTI developed in the facility -All 7 residents resided on the [LOC]. Record review of Monthly Infection Report by Site dated 1/2020 and 2/2020 revealed the following: -1/2020 Hall 200's infection percentage was 53% -2/2020 Hall 200's infection percentage was 67% Record review of 7 Infection Control Surveillance reports (200 with UTI's developed in the facility) revealed the organism present was not completed. Record review of facility policy on Assistance with Meals dated 2/2014, read in part . c. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: 1. Not standing over residents while assisting them with meals . Record review of facility policy on Infection Control and Food Safety dated 3/2013, read in part . Avoid touching, hair, face or other body parts during feeding process . Record review of facility policy on Infection Control Guidelines for all Nursing Procedures 8/2012, read in part . General Guidelines . 3. Employees must wash their hands . a. Before and after direct contact with residents . 4. If hands are not visibly soiled, use an alcohol-based hand rub . in the following situations: . a. Before and after direct contact with residents . i. After contact with objects (e.g., medical equipment) in immediate vicinity of the resident . Record review of facility in-service on Infection Control and Hand Hygiene dated 2/20/2020, read in part . The hands are the conduits for almost every transfer of potential pathogens from one patient to another, from contaminated objects to a patient . Using an alcohol-based hand rub is appropriate for decontaminating thee hands before direct patient contact . .