STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676414	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MID VALLEY NURSING & REHABILITATION	601 N MILE 2 WEST MERCEDES, TX 78570

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 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that Medication Aides and LVNs were able to demonstrate competency and skill sets necessary to care for residents' needs, for two residents (R#42 and R#99) of seven residents reviewed during medication pass. 1) Medication Aide W did not check R#42's apical pulse (a measure of cardiac function that is completed by placing a stethoscope at the apex of the heart and counting for one minute) prior to administering [MEDICATION NAME]. 2) LVN N did not check R#99's blood pressure prior to administering [MEDICATION NAME] ointment (used to prevent chest pain). These failures could affect residents who received cardiac medications and could result in unsatisfactory therapeutic outcomes or significant adverse effects. The findings were: 1) Record review of R#42's March 2020 Order Summary Report revealed R#42 was an [AGE] year-old female who was admitted to the facility on [DATE]. R#42's [DIAGNOSES REDACTED]. Orders included: [MEDICATION NAME] Tablet (used to treat heart failure and [MEDICAL CONDITION]) 125 mcg give 1 tablet by mouth one time a day for cardiac pacemaker. Record review of R#42's Minimum Data Set Assessment, dated [DATE], revealed R#42: -had clear speech, -was usually understood by others, -was usually able to understand others, -had impaired vision, and -was able to complete a Mental Status Assessment. Record review of R#42's Care plan, date initiated [DATE], revealed: -I have a permanent pacemaker implant, potential for decreased cardiac output and [MEDICAL CONDITION]. -Goal: Will maintain heart rate within acceptable limits as determined by cardiologist and pacemaker check through next review. -Interventions included: --Coordinate pacer checks with cardiologist as needed. --Instruct resident to report s/s of potential malfunction such as dizziness, [MEDICAL CONDITION], fatigue, weakness, chest pain, or palpitations. --Monitor v/s as needed, notify MD for abnormalities. Observation of medication pass on 03/05/20 at 8:23 a.m., revealed Medication Aide W crushed one tablet of [MEDICATION NAME] and administered it to R#42 without first checking R#42's apical pulse. In an interview on 03/05/20 at 8:30 a.m., Medication Aide W said she normally checked R#42's pulse before giving the [MEDICATION NAME], since it was a medication for the heart. Medication Aide W said she did not have her watch with her. In an interview on 03/05/20 at 10:57 a.m., the DON said the apical pulse was supposed to be checked before giving [MEDICATION NAME]. Review of the website at https://www.drugguide.com/ddo/view/Davis-Drug-Guide/ /all/[MEDICATION NAME] revealed the following for the administration of [MEDICATION NAME]: Assessment Monitor apical pulse for 1 full min before administering. Withhold dose and notify health care professional if pulse rate is <60 (less than 60) bpm in an adult . Notify health care professional promptly of any significant changes in rate, rhythm, or quality of pulse. 2) Record review of R#99's Order Summary Report, dated 03/06/20, revealed R#99 was a [AGE] year-old female who was admitted to the facility on [DATE]. R#99's [DIAGNOSES REDACTED]. Physician orders [REDACTED]. Record review of R#99's Minimum Data Set assessment, dated 02/05/20, revealed R#99: -had clear speech, -was able to make herself understood, -was able to understand others, -had adequate vision, and -was able to complete a Mental Status Assessment. Observation of medication pass on 03/05/20 at 11:40 a.m., revealed LVN N administered one inch of [MEDICATION NAME] ointment 2% to R#99's chest area, without first checking R#99's blood pressure. In an interview on 03/05/20 at 3:14 p.m., LVN N said residents' vital signs were never checked before administering [MEDICATION NAME]. LVN N said that was her first time working with R#99 and [MEDICATION NAME] was normally given PRN. LVN N said when [MEDICATION NAME] was given PRN, a full set of vital signs were obtained, since it would indicate a change of condition for the resident. In an interview on 03/05/20 at 3:30 p.m., the DON said [MEDICATION NAME] was a [MEDICATION NAME] (medication that opens blood vessels) so the resident's pulse and blood pressure should be checked. The DON said, in her work experience, no vitals were checked before administering [MEDICATION NAME]. Review of the website at https://www.drugs.com/tips/[MEDICATION NAME]-patient-tips revealed: Dizziness, lightheadedness, headache, and low blood pressure may occur.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each residents' drug regimen was free from unnecessary [MEDICAL CONDITION] drugs (without adequate monitoring) for four Residents (R#1, R#5, R#6, and R#33) of four residents whose medications were reviewed in that: 1) The facility did not conduct behavior or side effect monitoring for the use of R#1's [MEDICATION NAME] (antidepressant medication), [MEDICATION NAME] (antidepressant medication), or [MED] [MEDICATION NAME] (antipsychotic medication). 2) The facility did not conduct behavior or side effect monitoring for the use of R#5's [MEDICATION NAME] (antipsychotic medication), [MEDICATION NAME] (antidepressant medication), or [MEDICATION NAME] (antidepressant medication). 3) The facility did not conduct behavior or side effect monitoring for the use of R#6's [MEDICATION NAME] (antipsychotic medication), or [MEDICATION NAME] (antidepressant medication). 4) The facility did not conduct behavior or side effect monitoring for the use of R#33's [MEDICATION NAME] (anti-anxiety medication), Duloxetine (antidepressant medication), or [MEDICATION NAME] (antipsychotic medication). These failures could place residents receiving psychoactive medications at risk for adverse consequences. The findings were: 1) Record review of R#1's March 2020 Order Summary Report (Physician Orders) revealed R#1 was [AGE] years-old and was admitted to the facility on [DATE]. R#1's [DIAGNOSES REDACTED]. Orders included: -[MEDICATION NAME] 20mg one tablet by mouth everyday -[MED] [MEDICATION NAME] 100mg one tablet by mouth everyday -[MEDICATION NAME] 100mg 0.5 tablet by mouth at bedtime Further review revealed the Physician orders [REDACTED].=None, 1=Sedation/Drowsiness, 2=Dizziness/Gait, 3=Tremors/Sweating/Rashes, 4=Increased Confusion or Agitation, 5=Appetite Change, 6=[MEDICAL CONDITION], 7=Constipation/[MEDICAL CONDITION], 8=Dry Mouth/Sore Throat, 9=Swallowing Difficulty, 10=BP and Cardiac Changes, 11=Abnormal Body Movements, 12=Blurred Vision, 13=Weakness, 14=Headache, 15=Other (document in progress note) Record review of R#1's Medication Administration Record [REDACTED]=None, 1=Sedation/Drowsiness, 2=Dizziness/Gait, 3=Tremors/Sweating/Rashes, 4=Increased Confusion or Agitation, 5=Appetite Change, 6=[MEDICAL CONDITION], 7=Constipation/[MEDICAL CONDITION], 8=Dry Mouth/Sore Throat, 9=Swallowing Difficulty, 10=BP and Cardiac Changes, 11=Abnormal Body Movements, 12=Blurred Vision, 13=Weakness, 14=Headache, 15=Other (document in progress note) There was no behavior or side effect tracking specific to the use of [MEDICATION NAME], Quietapine [MEDICATION NAME], and [MEDICATION NAME]. Record review of R#1's Quarterly MDS assessment, dated 02/07/20, revealed R#1: -had unclear speech, -was rarely or never understood by others, -was rarely or never able to understand others, -had impaired vision, -was unable to complete a Mental Status Interview, -used antipsychotic medications in the last seven days, and, -used antidepressant medications in the last seven days. Record review of R#1's Care Plan, initiated 09/25/19, related to R#1's use of antipsychotic medications for [MEDICAL CONDITION] revealed: I will need to be observed for side effects and adverse reactions of antipsychotic medications: [REDACTED]. Notify my MD as needed. Record review of R#1 Care Plan, initiated 11/13/18, related to R#1's use of anti-anxiety medication for anxiety revealed: -I am taking anti-anxiety meds which are associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia, please observe and assist me as needed -I need anti-anxiety medications ordered by physician. I will need to be observed for energy, clumsiness, slow reflexes, slurred speech, confusion, disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. Paradoxical side effects: Mania, hostility, and rage, Aggressive or impulsive behavior, hallucinations. Record review of R#1 Care Plan, initiated [DATE], related to R#1's use of anti-depressant medication related to depression

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 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) revealed: -I will need to be observed for s/sx of depression, unaltered by antidepressant meds: sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, [MEDICAL CONDITION], negative mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, or weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance. Report to my MD as needed. 2) Record review of R#5's Admission record revealed R#5 was admitted to the facility on [DATE]. R#5's [DIAGNOSES REDACTED]. Physician orders [REDACTED]. Record review of Physician orders [REDACTED].=None, 1=Sedation/Drowsiness, 2=Dizziness/Gait, 3=Tremors/Sweating/Rashes, 4=Increased Confusion or Agitation, 5=Appetite Change, 6=[MEDICAL CONDITION], 7=Constipation/[MEDICAL CONDITION], 8=Dry Mouth/Sore Throat, 9=Swallowing Difficulty, 10=BP and Cardiac Changes, 11=Abnormal Body Movements, 12=Blurred Vision, 13=Weakness, 14=Headache, 15=Other (document in progress note). Record review of R#5's MAR indicated [REDACTED]=None, 1=Sedation/Drowsiness, 2=Dizziness/Gait, 3=Tremors/Sweating/Rashes, 4=Increased Confusion or Agitation, 5=Appetite Change, 6=[MEDICAL CONDITION], 7=Constipation/[MEDICAL CONDITION], 8=Dry Mouth/Sore Throat, 9=Swallowing Difficulty, 10=BP and Cardiac Changes, 11=Abnormal Body Movements, 12=Blurred Vision, 13=Weakness, 14=Headache, 15=Other (document in progress note). There was no behavior or side effect tracking specific to the use of [MEDICATION NAME], and [MEDICATION NAME]. Record review of R#5's MDS assessment, dated 12/09/19, revealed R#5: -had unclear speech, -was usually understood by others, -was usually able to understand others, -had impaired vision, -used antipsychotic medication in the last six days, and -used antidepressant medication in the last six days. Record review of R#5's Care Plan, initiated 03/12/18, related to R#5's use of antipsychotic medication for hallucinations and mood disorder revealed: -I will need to be observed for side effects and adverse reactions of antipsychotic medications: [REDACTED]. Notify my MD as needed. -I will need to have my target behaviors identified. Addressed. Observed- Hallucinations and document per facility protocol to evaluate the effectiveness of my medication. 3) Record review of R#6's Admission Record, dated 03/06/20, revealed R#6 was an [AGE] year- old male who was admitted to the facility on [DATE]. R#6's [DIAGNOSES REDACTED]. Physician order [REDACTED].=None, 1=Sedation/Drowsiness, 2=Dizziness/Gait, 3=Tremors/Sweating/Rashes, 4=Increased Confusion or Agitation, 5=Appetite Change, 6=[MEDICAL CONDITION], 7=Constipation/[MEDICAL CONDITION], 8=Dry Mouth/Sore Throat, 9=Swallowing Difficulty, 10=BP and Cardiac Changes, 11=Abnormal Body Movements, 12=Blurred Vision, 13=Weakness, 14=Headache, 15=Other (document in progress note) Record review of R#6's MAR indicated [REDACTED]=None, 1=Sedation/Drowsiness, 2=Dizziness/Gait, 3=Tremors/Sweating/Rashes, 4=Increased Confusion or Agitation, 5=Appetite Change, 6=[MEDICAL CONDITION], 7=Constipation/[MEDICAL CONDITION], 8=Dry Mouth/Sore Throat, 9=Swallowing Difficulty, 10=BP and Cardiac Changes, 11=Abnormal Body Movements, 12=Blurred Vision, 13=Weakness, 14=Headache, 15=Other (document in progress note) There was no behavior or side effect tracking specific to the use of [MEDICATION NAME], Mirtazepine, and [MEDICATION NAME]. Record review of R#6's MDS assessment, dated 12/10/19, revealed R#6: -had unclear speech, -was sometimes understood by others, -sometimes understood others, -had impaired vision, -used antipsychotic medication in the last 7 days, and -used antidepressant medication in the last 7 days. Record review of R#6's Care Plan, initiated 02/14/20, related to R#6's use of antidepressant for depression revealed: -I will need to be observed for s/sx of depression, unaltered by antidepressant meds: Sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, [MEDICAL CONDITION], neg. mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition or weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance. Report to my MD as needed. -I will need to take my antidepressant medication as ordered by my physician. I will need to be observed for side effects and effectiveness of the medication. Antidepressant Side Effects: dry mouth, dry eyes, constipation, [MEDICAL CONDITIONS]. Report progress and any side effects to my physician. -Provide education for me/family/caregivers about risks, benefits and the side effects, and/or toxic symptoms. Record review of R#6's Care Plan, initiated 02/14/20, related to R#6's use of anti-anxiety medication for anxiety revealed: -I am taking anti-anxiety meds which are associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairments that looks like dementia, please observe and assist me as needed. -Educate me/family/caregivers about risks, benefits and the side effects and/or toxic symptoms. -I need anti-anxiety medications ordered by physician. I will need to be observed for side effects and effectiveness. Anti-anxiety side effects: drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgement, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision, paradoxical side effects: mania, hostility and rage, aggressive or impulsive behavior, hallucinations. -Record review of R#6's Care Plan, initiated 02/14/20, related to R#6's use of anti-psychotic medication for end of life prognosis revealed: -Discuss/evaluate with MD and family re ongoing need for use of medication. -I will need to be observed for side effects and adverse reactions of antipsychotic medications: [REDACTED]. Notify my MD as needed. -I will need to have medications administered as ordered. Observe for side effects and effectiveness of the medication. 4) Record review of R#33's Admission Record, dated 03/05/20, revealed R#33 was a [AGE] year- old female who was admitted to the facility on [DATE]. R#33 [DIAGNOSES REDACTED]. Physician orders [REDACTED].=None, 1=Sedation/Drowsiness, 2=Dizziness/Gait, 3=Tremors/Sweating/Rashes, 4=Increased Confusion or Agitation, 5=Appetite Change, 6=[MEDICAL CONDITION], 7=Constipation/[MEDICAL CONDITION], 8=Dry Mouth/Sore Throat, 9=Swallowing Difficulty, 10=BP and Cardiac Changes, 11=Abnormal Body Movements, 12=Blurred Vision, 13=Weakness, 14=Headache, 15=Other (document in progress note) Record review of R#33's MAR indicated [REDACTED]=None, 1=Sedation/Drowsiness, 2=Dizziness/Gait, 3=Tremors/Sweating/Rashes, 4=Increased Confusion or Agitation, 5=Appetite Change, 6=[MEDICAL CONDITION], 7=Constipation/[MEDICAL CONDITION], 8=Dry Mouth/Sore Throat, 9=Swallowing Difficulty, 10=BP and Cardiac Changes, 11=Abnormal Body Movements, 12=Blurred Vision, 13=Weakness, 14=Headache, 15=Other (document in progress note) There was no behavior or side effect tracking specific to the use of [MEDICATION NAME], Duloxetine, and [MEDICATION NAME]. Record review of R#33's MDS assessment, dated 01/16/20, revealed R#33: -had clear speech, -was usually understood by others, -usually understood others, -had adequate vision, -used antipsychotic medication in the last 6 days, -used antianxiety medication in the last 6 days, and -used antidepressant edications in the last 4 days. Record review of R#33's Care Plan, initiated [DATE], related to R#33's use of anti-depressant medication for sadness revealed: -Administer medications per MD orders -monitor for target behaviors/symptoms, feeling of sadness -Monitor/document/report to MD prn, ongoing s/sx of depression unaltered by antidepressant meds: sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, [MEDICAL CONDITION], neg. mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance. Record review of R#33's Care Plan, initiated [DATE], related to R#33's use of anti-anxiety medication for restlessness revealed: -Administer medications per MD orders -Monitor for target behaviors/symptoms -Monitor/document/report to MD PRN any adverse reactions to anti-anxiety therapy: drowsiness, lack of energy, clumsiness, slow reflexes, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired or double vision. Unexpected side effects: mania, hostility rage, aggressive or impulsive behavior, hallucinations. -psych (psychiatric) consult with doctor. Record review of R#33's Care Plan, date initiated [DATE], related to R#33's use of anti-psychotic medication for hallucinations revealed: -Administer medications as ordered by MD -Monitor for target behaviors/symptoms -Monitor/document/report to MD PRN s/sx of [MEDICAL CONDITION] drug complications: altered mental status, decline in mood or behavior, hallucinations, delusions, social isolation, withdrawal, decline in adls & continence & cognition, [MEDICAL CONDITION], constipation, impaction, [MEDICAL CONDITION]. Shuffling gait, rigid muscles, [MEDICAL CONDITION], accidents, dizziness, [MEDICAL CONDITION], motor agitation, tremors, tardive dyskinesia, poor balance, diarrhea, fatigue, [MEDICAL CONDITION], loss of appetite, weight loss, N&V. In an interview on 03/06/20 at 2:50 p.m., the DON said there were no different behavior or side effect tracking for each medication, there was only one for all medications. The DON said the side effects listed were all the possible side effects for anti-depressant, anti-anxiety, and anti-psychotic medications. The DON said if side effects occurred that were not one of the options, then the nurse was to choose the option other and indicate which medication was affecting the resident. The DON said that was the only option that system gave, but she would contact the company to see if it could be changed.

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, record review, and interview, the facility failed to 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, for two Residents (R#83 and R#3) of two residents reviewed for

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) infection control practices, in that: 1) CNA B and CNA D failed to perform hand hygiene between glove changes when providing care for R#83. 2) Restorative Aide J failed to perform hand hygiene after touching her hair and face when assisting R#3 during feeding. These failures could place residents at risk for contamination and infections. The findings were: 1) Record review of R#83's Admission Record, dated 03/06/20, revealed R#83 was [AGE] years-old and was admitted to the facility on [DATE]. R#83's [DIAGNOSES REDACTED]. Record review of R#83's Annual Minimum Data Set (MDS) assessment, dated 02/15/20, revealed R#83: -was usually able to make herself understood, -was usually able to understand others, -had severely impaired cognition, -needed extensive assistance for bed mobility, transfers, locomotion on unit, dressing, toilet use and personal hygiene, and -was always incontinent of bowel and bladder. Observation on 03/04/20 at 1:26 p.m. revealed CNA B and CNA D arrived to R#83's room to do incontinent care. The DON was present and observed the care. CNA B came into R#83's room wearing gloves. CNA B removed her gloves and, without washing or sanitizing her hands, put new gloves on. CNA D removed gloves and put new gloves on without washing or sanitizing her hands. CNA D held R#83 in a position on her left side so CNA B could do the incontinent care. CNA D handed CNA B wipes to wipe R#83. CNA B removed gloves and donned new gloves without without washing or sanitizing her hands. CNA B wiped R#83's buttocks. CNA B removed R#83's brief. CNA B then removed her gloves and put new gloves on without washing or sanitizing her hands. CNA B placed a clean brief under R#83, attached the brief, and pulled up R#83's pants. CNA B removed her gloves and put new gloves on without washing or sanitizing her hands. Both CNAs repositioned R#83 to the head of bed, removed their gloves and washed their hands. In an interview on 03/04/20 at 1:40 p.m., the DON said she missed the first part of R#83's incontinent care, but stated the end of it was ok and she did not see any problems. In an interview on 03/04/20 at 1:42 p.m., CNA B and CNA D said they came into R#83's room unprepared and did not have hand sanitizer with them. Both CNAs said they should have used hand sanitizer before putting gloves on and after removing gloves. 2) Record review of R#3's Order Summary Report, dated 03/06/20, revealed R#3 was a [AGE] year-old female with [DIAGNOSES REDACTED]. Record review of R#3's MDS assessment, dated 11/25/19, revealed R#6: -had clear speech, -was usually understood by others, -was usually able to understand others, -had adequate vision, -needed extensive assistance from staff for bed mobility, transfers, dressing, toilet use, and personal hygiene, and -needed limited assistance on staff for eating. Observation on [DATE] at 12:25 p.m. revealed Restorative Aide J was feeding R#3 when she stopped, picked up her own hair, and put it back down, then continued to feed R#3. CNA J stopped, touched her face, and continued to feed R#3. CNA J did not perform hand hygiene after touching her hair or face. In an interview on [DATE] at 12:32 p.m. Restorative AideJ said, You are not supposed to touch your hair or face when feeding a resident. In an interview on 03/04/20 at 10:42 a.m., the DON said staff should not touch their hair or face when feeding a resident. The DON said, if they did, they should sanitize their hands after. In an interview on 03/04/20 at 2:09 p.m., the Administrator said there was no written policy for infection control during feeding, but it was addressed on the CNA skills checkoff list. Record review of the facility's undated policy titled, Handwashing-Hand Hygiene, revealed: This facility considers hand hygiene the primary means to prevent the spread of infections. 1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare associated infections. .7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively soap (antimicrobial or non-antimicrobial) and water when necessary. .9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. 10. Single-use disposable gloves should be used: a. Before aseptic procedures; b. When anticipating contact with blood or body fluids; and c. When in contact with a resident, or the equipment or environment of a resident, who is on contact precautions.