STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345169	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Greens at Gastonia	969 Cox Road Gastonia, NC 28054

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37019 Based on record reviews, and staff interviews the facility failed to complete and document weekly skin assessments as ordered by the physician for a resident with a known stage IV pressure ulcer to the sacrum and a known stage III pressure ulcer to the right heel for 1 of 3 residents (Resident #3) reviewed for the treatment and prevention of pressure ulcers. The findings included: Resident #3 was admitted to the facility on [DATE] with diagnoses which included cerebrovascular accident (CVA or stroke), left side hemiparesis, and pressure ulcer of the sacral region, unstageable. Review of Resident #3's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was severely cognitively impaired and was dependent on staff for all activities of daily living. Additionally, the assessment revealed Resident #3 had two unhealed, unstageable pressure ulcers, was receiving pressure ulcer care and had pressure reducing devices in his chair and on his bed. Review of Resident #3's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was severely cognitively impaired and was dependent on staff for all activities of daily living. Additionally, the assessment revealed Resident #3 had two unhealed stage III pressure ulcers, was receiving pressure ulcer care and had pressure reducing devices in his chair and on his bed. Review of Resident #3's physician orders for 02/01/24 through 05/01/24 revealed the following order: - Skin checks weekly Thursday one time a day every Thursday 7:00 AM to 3:00 PM and document: I = Intact, E = Existing, N = New and complete skin User Defined Assessment (UDA). Review of Resident #3's February Medication Administration Record (MAR) and electronic medical record (EMR) revealed there was no skin assessment documented for 02/18/24. A telephone interview was attempted numerous times and voicemails left for Nurse #5 who was assigned to care for Resident #3 on the 7:00 AM to 7:00 PM shift on 02/18/24. The voicemails and calls were not returned by Nurse #5. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's March MAR and EMR revealed there were no skin assessments documented for 03/07/24 or 03/14/24. A telephone interview was attempted for Nurse #6 who was assigned to care for Resident #3 on the 7:00 AM to 7:00 PM shift on 03/07/24 and 03/13/24 but was not successful. Review of Resident #3's April MAR and EMR revealed there were no skin assessments documented for 04/04/24 or 04/19/24. A telephone interview was attempted numerous times and voicemails left for Nurse #7 who was assigned to care for Resident #3 on the 7:00 AM to 7:00 PM shift on 04/04/24. The voicemails and calls were not returned by Nurse #7. An observation of wound care for Resident #3 by the Treatment Nurse with the oncoming Director of Nursing (DON) present in the room was made on 05/14/24 at 10:45 AM. The only open areas or pressure ulcers noted were on Resident #3's right heel and sacrum. A telephone interview on 05/16/24 at 11:25 AM with Nurse #8 who was assigned to care for Resident #3 on the 7:00 AM to 7:00 PM shift on 04/19/24 revealed she was not sure why she would not have completed and documented a skin assessment on the resident on 04/19/24. Nurse #8 stated the only thing she could think of was that it was a busy day, and she was swamped and just did not get to it but said she just couldn't remember that far back in April. She further stated she tried to get all her charting done before leaving for the day but if it was not in the EMR she had not completed it that day. An interview on 05/16/24 at 6:45 PM with the interim Director of Nursing (DON) and the oncoming DON revealed their expectation was for skin assessments to be completed weekly and documented in the resident's EMR when they are done. The interim DON stated the expectation with weekly skin assessments was for residents to be assessed from head to toe and the assessment be documented in the EMR for the resident. She explained the weekly skin assessments should flag in the EMR for the nurse to complete the assessment on the shift it was due and said she was not sure if the system didn't flag or if the nurse omitted the skin assessment. The interim DON further explained that if the assessment was due it should flag in the system and remain flagged until completed but said she had not run a report to see if the skin assessments flagged and were not done or if they didn't flag in the system to be done because she was not aware there was an issue with Resident #3's skin assessments being completed. The interim DON stated it was especially important for residents with pressure ulcers to have weekly skin assessments to ensure no new areas of pressure were developing and they would be providing additional education to the nurses about the importance of completing weekly skin assessments. A telephone interview on 05/15/24 with the Medical Director (MD) revealed he was very familiar with Resident #3 and said he felt like he and the facility were doing everything they could for the resident with promoting wound healing. The MD stated he had ordered the resident Vitamin D, Zinc and Vitamin A to attempt to build up his protein stores but said it was difficult to avoid wounds when residents were unable to move themselves in bed and unable to take nutrition by mouth. He further stated therapy was working with Resident #3 on bed mobility to see if he was capable of moving himself in the bed to offload his wounds. The MD explained that he was not aware Resident #3 was not getting his skin assessments weekly as ordered and would expect the staff to follow the orders and complete and document weekly skin assessments for the resident.

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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** 37019 Based on record review, and staff interviews, the facility failed to prevent a resident (Resident #3) from being fed when his diet order was nothing by mouth (NPO) with continuous enteral tube feeding for 1 of 2 residents reviewed for gastrostomy tube care. The findings included: Resident #3 was admitted to the facility on [DATE] with diagnoses which included cerebrovascular accident (stroke), hemiplegia, aphasia, dysphagia, stenosis of carotid arteries, muscle weakness, and gastrostomy tube (G-tube) for feedings. Review of Resident #3's orders for 04/01/24 revealed the following: -Diet: NPO (nothing by mouth). - Enteral Feed Order every shift Enteral Nutrition via Pump - Jevity 1.5 at 50 cubic centimeters (cc)/milliliters (ml) per hour for 24 hours via pump per PEG tube. - Enteral Feed Order every 4 hours auto pump 100 ml flush. - Enteral Feed Order one time a day for hydration 240 cc water flush. Review of Resident #3's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was severely cognitively impaired and was dependent on staff for all activities of daily living. Review of Resident #3's care plan dated 04/10/24 revealed a focus area for the resident requiring tube feedings due to dysphagia. The interventions included check for tube placement and gastric contents/residual volume per facility protocol and record, hold feed if at risk for aspiration, discuss with family/caregivers/resident any concerns about tube feeding, advantages, disadvantages, and potential complications, listen to lung sounds, monitor/document/report to Medical Doctor (MD) prn - aspiration - fever, shortness of breath, tube dislodgement, infection at tube site, self-dislodgement, tube dysfunction or malfunction, abnormal breath/lung sounds, abnormal lab values, abdominal pain, distention, tenderness, constipation or fecal impaction, diarrhea, nausea/vomiting or dehydration, provide local care to gastrostomy tube (G-tube) site as ordered and monitor for signs and symptoms of infection, Registered Dietician (RD) to evaluation quarterly and as needed (prn) to monitor caloric intake, estimate needs and make recommendations for changes to tube feeding as needed and speech therapy evaluation and treatment as ordered. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Situation, Background, Appearance, Review and Notify (SBAR) Communication Form revealed on 04/24/24, Resident #3 received intake by mouth while on a NPO diet. The resident received 2 spoonsful of grits, 1 spoonful of eggs and approximately 2 ounces of orange juice. According to the report, the resident did not exhibit any coughing, shortness of breath, gurgling, lung sounds were clear to auscultation, and his speech pattern remained the same. The report indicated the responsible party for Resident #3 was contacted and he requested the resident be sent out to the hospital emergency department for evaluation and treatment despite the facility offering to perform a chest x-ray and speech evaluation in the facility. Review of the emergency department records dated 04/24/24, Resident #3 received a chest x-ray which was read by the radiologist as clear, and the resident returned to the facility after evaluation and treatment. According to the documented notes the resident did not suffer any ill effects from the intake. While in the hospital at the request of the family, Resident #3 was ordered a modified barium swallow test which was scheduled for 05/16/24 at the hospital. Interview on 05/15/24 at 4:08 PM with Nurse #4 who was assigned to care for Resident #3 on 04/24/24 was conducted. Nurse #4 stated on 04/24/24 she had entered Resident #3's room to provide morning medications through his G-tube and Nurse Aide (NA) #3 was feeding the resident from a tray on his bedside table. Nurse #4 further stated she immediately told NA #3 the resident was NPO and was not to have anything by mouth. Nurse #4 said NA #3 stopped feeding the resident and left the room to provide care to another resident. She indicated a few minutes later the Medical Records/Central Supply representative came to her with a tray in hand and said she had found another resident's tray in Resident #3's room and had removed it during her angel rounds. Nurse #4 explained that angel rounds were rounds done by administrative staff and inter-disciplinary team members on residents assigned to them to check on the residents every morning and every afternoon to be sure the residents did not have any care needs. She stated she told the Medical Records/Central Supply representative that she had already informed NA #3 who was assigned to Resident #3 that he was NPO and not to receive or be fed a tray. The Medical Records/Central Supply representative then pointed out to Nurse #4 that Resident #3 had received another resident's tray. Nurse #4 indicated she then went to the other resident's room to ensure he had received a tray and he had received another tray from the kitchen. Nurse #4 further indicated she reported the incident to the interim Director of Nursing (DON). A telephone interview on 05/16/24 with Nurse Aide (NA) #3 revealed she was assigned to Resident #3 on 04/24/24. She stated she went into his room that morning and found a tray on his bedside table, so she began to feed him. She said after she had fed him a couple of spoons of food, Nurse #4 came into the room to give him his morning medications and told her he was not supposed to have anything by mouth and was NPO. NA #3 further stated she immediately stopped feeding him and left the room to provide care to another resident. She indicated she just left his room and forgot to remove the tray but said a few minutes later, the Medical Records/Central Supply representative removed the tray while doing her angel rounds and informed her that the resident was not supposed to receive a tray and had in fact received another resident's tray. NA #3 further indicated she didn't know how the tray got into his room but admitted she had not checked the name on the ticket before she started feeding the tray to Resident #3. She stated it was the first time she had taken care of Resident #3 and she was not aware until Nurse #4 told her that he was NPO and could not have anything by mouth. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 05/15/24 at 6:40 PM with the Medical Records/Central Supply representative revealed she was assigned to make angel rounds on Resident #3. She stated angel rounds are made by the administrative staff and inter-disciplinary team members on residents to check their rooms for cleanliness, check the residents for cleanliness, monitor for smells, residents needing care or to be changed, check nails to see if they need to be clipped or if residents need referring to podiatry, check for facial hair and grooming and report their findings in morning meetings and afternoon stand down meetings. The Medical Records/Central Supply representative further stated she had gone into Resident #3's room the morning of 04/24/24 and found a tray on his overbed table and said she thought she remembered he was to receive nothing by mouth because he was being fed through his G-tube so she removed the tray from the room and reported it to Nurse #4 who was assigned to Resident #3 on that day. She said she confirmed with Nurse #4 that he was not to receive a tray and told her the tray appeared to have been opened and some of it fed to the resident. The Medical Records/Central Supply representative then said Nurse #4 informed her she had already told NA #3 who was assigned to the resident that he was NPO and not to receive anything by mouth. She explained she then found NA #3 on the hall and told her she had removed the tray from Resident #3's room. The Medical Records/Central Supply representative explained since this incident had occurred, a plan had been put into place for the administrative staff to assist with delivering trays and assisting at mealtime for lunch and dinner when residents were assigned agency NAs. She further explained that she did not come in early enough to assist with delivery of breakfast trays but said the Unit Managers were usually there early and assisted with breakfast trays being passed to residents. An interview on 05/15/24 at 4:17 PM with Unit Manager #1 revealed she was the unit manager for the long-term care halls on which Resident #3 resided. She stated Resident #3 had been NPO (nothing by mouth) since his admission on 11/17/23. Unit Manager #1 further stated she was not aware of the incident of Resident #3 being fed by NA #3 until it was brought up and discussed in morning meeting on 04/24/24. She indicated when she had found out about the incident the Medical Doctor and resident representative had already been informed and the resident representative had requested Resident #3 be sent out to the hospital for evaluation and treatment rather than wait at the facility for chest x-ray and speech therapy consult. Unit Manager #1 further indicated she did not know why the resident had received a tray that morning but said she later found out it was another resident's tray and explained they had done education with the agency NA who had been assigned to the resident that morning and fed him on checking the tickets before serving trays to the resident's because the tray had another resident's name on the ticket. She indicated she had verified that Resident #3 was indicated as being NPO on the care tracker that the NAs use for their documentation and said she didn't understand why NA #3 had not known that Resident #3 was NPO. An interview on 05/15/24 at 5:45 PM with the Medical Director revealed he was not aware Resident #3 had been fed on 04/24/24 but said the Nurse Practitioner had probably been notified instead of him. The MD stated he was not sure being fed a small amount of food would cause any adverse effects for the resident but said he would expect the staff to follow Resident #3's orders for nothing by mouth (NPO). A telephone interview was attempted with the former Nurse Practitioner with no return call received. The current Nurse Practitioner's first day was 05/14/24 and he had no knowledge of the incident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 05/15/24 at 6:45 PM with the interim Director of Nursing (DON) and the oncoming DON revealed it was their expectation that residents who were NPO or nothing by mouth wound not receive and be fed from a tray for any meal. The interim DON stated they had educated staff on NPO status since the incident and were monitoring NPO residents to ensure they were not being fed at mealtime.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45358 Based on record review, family and staff interviews the facility failed to provide food in the form to meet individual needs of 1 of 1 resident (Resident # 2) reviewed for nutrition. The findings included: Resident #2 was admitted to the facility on [DATE] and discharged on [DATE]. A review of physician orders revealed a regular diet with no end date for Resident #2. Review of Resident #2's dental extraction report dated 12/4/23 revealed the resident had all remaining teeth extracted. The report did not indicate diet consistency changes. A quarterly minimum data set (MDS) dated [DATE] indicated Resident #2 was cognitively intact and required set up with eating. A Nurse Practitioner progress note dated 2/20/24 indicated Resident #2 explained her current biggest concern was her teeth since she was no longer a candidate for dentures and was having difficulty adjusting to her new diet. During a phone interview on 5/14 /24 at 10:16 am Resident #2's family member revealed while visiting during lunch on 3/9/24, the Resident had fried pork chop that was not chopped and the resident had no teeth to chew the meat, even if it was chopped. The family member further revealed she fed the Resident some jello and some chicken noodle soup instead that she brought in from home. The family member also stated the Resident was unable to have dentures due to bone loss. During a phone interview on 5/15/24 at 10:50 am the previous Registered Dietitian (RD) revealed she was unaware why Resident #2 remained on a regular diet after she had all her teeth extracted in December 2023. During a phone interview on 5/14/24 at 5:11 pm the RD indicated she began working at the facility in April 2024, after Resident #2 discharged from the facility. The RD further indicated she reviewed Resident #2's medical record and concluded that the Resident remained on a regular diet after all her teeth were extracted in December 2023. She did not locate any dietary documentation about teeth being removed. During an interview on 5/15/24 at 1:54 pm the Dietary Manager (DM) indicated Resident #2 preferred bacon, boiled eggs, toast, and juice for breakfast, was on a regular diet and she was unaware of a diet change after the Resident's teeth were extracted. The DM further indicated she would have been informed of a diet change by nursing staff. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/24 at 3:42 pm Nurse #2 revealed Resident #2 couldn't eat anything hard after all her teeth were pulled and she would always request pudding and applesauce. Nurse #2 could not recall what diet was ordered for the Resident after her teeth were pulled. Nurse #2 further revealed Resident #2 took her medications crushed with applesauce. During an interview on 5/15/24 at 7:37 pm the interim Director of Nursing indicated she began at the facility after Resident #2's discharged and her expectation would been to determine how the Resident tolerated the regular diet then follow recommendations. Attempts to contact the previous DON were unsuccessful.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	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** 45358 Based on record review and staff interviews, the facility failed to maintain an accurate Treatment Assessment Record (TAR) for skin assessments for 1 of 2 residents (Resident #2) sampled for accuracy of resident records (skin assessments). The findings included: Resident #2 was admitted to the facility on [DATE]. A quarterly minimum data set (MDS) dated [DATE] indicated Resident #2 was cognitively intact and required set up with eating, supervision with oral hygiene, dressing and bed mobility; Resident # 2 was dependent for transfers. A review of a physician's order dated 1/1/24 indicated weekly skin assessments were to be completed every Wednesday on day shift. A review of February 2024 TAR indicated the 2/7/24 skin assessment was completed but the nurse who initialed/signed the TAR for 2/7/24 could not be identified. Nurse # 3 signed that skin assessments were completed for Resident #2 on 2/14/24 and 2/21/24 (day shifts). The nurse who initialed/ signed the TAR on the 2/7/24 skin assessment, could not be identified. Further review of the medical record indicated there were no weekly skin assessment documentation diagram sheets completed for Resident #2 on 2/7/24, 2/14/24, and 2/21/24. Due to the lack of documentation diagram sheets, there was no record of what potential skin concerns may have been discovered during the skin assessments. During a phone interview on 5/15/24 at 3:35 pm Nurse #3 revealed she worked with Resident #2 on 2/14/24 and 2/21/24 if the TAR indicated her initials were on those days. Nurse #2 further indicated she usually completed skin assessment documentation diagram forms while she performed the skin the assessment. However, Nurse #2 stated she could not recall why she did not complete the documentation diagram forms (2/14/24 & 2/21/24) that were required when she initialed/signed the TAR. During an interview on 5/15/24 at 7:37 pm the interim Director of Nursing, (DON) # 1, indicated she began working at the facility on 5/1/24 and her expectation was for skin assessment documentation to be completed and documented as completed in the medical record. An attempt to contact the previous DON, DON #2, was unsuccessful.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37019 Based on observations, record review, and staff interviews, the facility failed to implement their Infection Control Policy for hand hygiene/handwashing when the Treatment Nurse did not perform hand hygiene according to the facility's policy and procedure when providing wound care to 1 of 3 residents (Resident #3) and when Unit Manager #1 did not perform hand hygiene according to the facility's policy and procedure when providing gastrostomy tube site care for 1 of 2 residents (Resident #3) reviewed for infection control practices. The findings included: The facility's policy entitled Handwashing/Hand Hygiene which is part of their Infection Control Policies and Procedures last revised 08/2019 under Policy Interpretation read in part: 7. Use an alcohol-based hand rub (ABHR) containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents; g. Before handling clean or soiled dressings, gauze pads, etc.; m. After removing gloves; 8. Hand hygiene is the final step after removing and disposing of personal protective equipment (PPE). 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. a. An observation of wound care by the Treatment Nurse with the oncoming Director of Nursing (DON) present in the room was made on 05/14/24 at 10:45 AM. The Treatment Nurse had her supplies laid out on a clean surface on the overbed table in Resident #3's room. The Treatment Nurse sanitized her hands, donned clean gloves, and proceeded to remove the old dressing with a small amount of serosanguinous drainage on it from Resident #3's right heel and disposed of it in the trash can. She then doffed her gloves and without sanitizing her hands, donned new gloves, and proceeded to clean the heel wound with wound cleanser. After cleaning the wound bed, she doffed her gloves, sanitized her hands, and donned clean gloves and applied silver alginate to the wound bed and covered it with a bordered gauzed dressing. The Treatment Nurse then doffed her gloves, sanitized her hands, donned clean gloves, and proceeded to the sacral wound. After completing care of the sacral wound, she doffed her gloves, sanitized her hands, donned new gloves, and collected her supplies and the trash and left the room. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 05/14/24 at 5:40 PM with the Treatment Nurse revealed she realized she should have sanitized her hands after she removed the old dressing and before donning clean gloves before proceeding to clean the heel wound. She stated it was her error and she knew better and knew that she was supposed to sanitize her hands every time she removed her gloves but said she forgot to do it. A telephone interview on 05/15/24 at 10:23 AM with the Infection Preventionist (IP) revealed any time gloves were removed the Treatment Nurse was supposed to sanitize her hands. The IP stated she had observed the Treatment Nurse performing wound care during her audits and she had done it correctly and was not sure why she had not performed it correctly but said she knew the Treatment Nurse knew the proper procedure for hand hygiene during wound care. An interview on 05/16/24 at 1:07 PM with the interim Director of Nursing (DON) and the oncoming DON revealed it was the interim DON's expectation that the Treatment Nurse follow the proper procedure according to the policy and procedure for hand hygiene while providing wound care. The DON stated she had audited the Treatment Nurse and when audited she had followed the proper procedure for hand hygiene and did not understand why she had not followed the policy and procedure while being observed. b. An observation of gastrostomy tube care by Unit Manager #1 with the oncoming Director of Nursing (DON) present in the room was made on 05/14/24 at 12:38 PM. Unit Manager #1 had her supplies laid out on a clean surface on the overbed table in Resident #3's room. She began by removing the towel with old tube feeding on it from around the gastrostomy tube and moved his shirt to expose the site to be cleaned. She proceeded to doff her gloves, and without sanitizing her hands donned new gloves and began cleansing the area around the tube insertion site with normal saline and gauze. After cleansing the site, she put a clean towel around the gastrostomy tube site, adjusted the resident's clothing and covered him with his bed covers. Unit Manager #1 doffed her gloves, sanitized her hands, and donned clean gloves and gathered the trash and left the room. An interview on 05/14/24 at 3:31 PM with Unit Manager #1 revealed she knew she should have sanitized her hands after doffing her gloves and before donning clean gloves to provide gastrostomy tube site care to Resident #3. She stated she knew better but just forgot to do it. A telephone interview on 05/15/24 at 10:23 AM with the Infection Preventionist (IP) revealed any time gloves were removed Unit Manager #1 was supposed to sanitize her hands. The IP stated she knew Unit Manager #1 knew the proper procedure for hand hygiene during gastrostomy site care and was not sure why she had not done the procedure correctly according to the hand hygiene policy and procedure. An interview on 05/16/24 at 1:07 PM with the interim Director of Nursing (DON) and the oncoming DON revealed it was the interim DON's expectation that Unit Manager #1 follow the proper procedure according to the policy and procedure for hand hygiene while providing gastrostomy tube site care. The DON stated she knew Unit Manager #1 knew the proper procedure for hand hygiene and did not understand why she had not followed the policy and procedure while being observed.