STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366157	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dunbar Health & Rehab Center	320 Albany Street Dayton, OH 45417

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on the review of Resident Council meeting minutes, resident interview, and staff interviews, the facility failed to document and follow up on resident concerns from the resident council meetings. This affected 10 out of 10 members of Resident council who regularly attended the meetings and had the potential to affect all residents residing at the facility. The facility census is 63. Findings include: Review of Resident Council meetings minutes from August 2024 to March 2025 revealed the facility did not follow up on concerns brought forward at the Resident Council meetings. Review of the meeting minutes revealed the resolutions from the last meeting concerns were left blank. The meeting concerns that had not been addressed included more outings, a higher activities budget, loud music in other residents' rooms, a pop up facility store, bed linen changes, call lights, and snacks for residents including fresh fruit. Interview on 04/30/25 at 3:14 P.M. with Resident Council President #12 verified that the previous meeting concerns had not been addressed and stated that they do not know when and if the facility will make a resolution to the council's concerns. Interview on 04/30/25 at 4:32 P.M. with Staff Member #655 verified the facility has not followed up with her or the residents on the concerns brought forward in Resident Council meetings. Interview on 05/01/25 at 9:26 A.M. with Administrator #72 verified the resolution sheets were not filled out, therefore the Resident Council committee members have not been provided a resolution to their concerns. This deficiency represents non-compliance investigated under Complaint Number OH00163645.

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.

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

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview, family interview, review of the facility's self-reported incident (SRI), staff interview, and policy review, the facility failed to ensure a thorough investigation was conducted on abuse and misappropriation allegations. This affected three (#38, #117, and #12) of three residents reviewed for abuse and misappropriation. The facility census was 63. Findings include: 1. Review of the medical record of Resident #38 revealed an admission date of 03/17/23. Diagnoses included unspecified intracranial injury with loss of consciousness, quadriplegia, depression, dysphagia, anxiety. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had moderately impaired cognition. The resident required setup/clean-up assistance with eating and was dependent on staff for all other activities of daily living. 2. Review of the medical record of Resident #117 revealed an admission date of 04/22/22. The resident discharged to another facility 03/21/25. Diagnoses included hemiplegia and hemiparesis following cerebrovascular disease affecting left non-dominant side, type 2 diabetes mellitus, essential hypertension, cerebral infarction, schizoaffective disorder, vascular dementia, drug induced subacute dyskinesia, and anxiety disorder. Review of the annual MDS assessment dated [DATE] revealed the resident had intact cognition. The resident exhibited physical and verbal behaviors during the assessment period. The behaviors were identified as putting others at significant risk for physical injury, significantly intruding on the privacy or activity of others, and significantly disrupting care or living environment. The resident was independent with mobility. Review of the facility self reported incident (SRI) dated 02/26/25 revealed Residents #117 and #38 were in the dining room joking around when Resident #38 said something to Resident #117 that Resident #117 did not like. Resident #38 said he was joking, however, Resident #117 went up to Resident #38 and hit him in the face. The residents were immediately separated. Resident #117 stated she was joking and did not mean to hit Resident #38 as hard as she did. Neither resident had any injury. Review of the investigation revealed there was no information regarding who else was present at the time of the incident. There was no evidence of witness statements being obtained from staff or other residents, nor was there any evidence of other residents being assessed for any injury or psychosocial impact. Interview on 04/28/25 at 10:46 A.M., Resident #38 had no recollection of the event involving Resident #117 hitting him in the face. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/01/25 at 11:40 A.M., the Administrator verified the investigation did not contain any information on who else was present at the time of the altercation, information about any events leading up to the altercation, witness statements regarding the altercation, nor assessment of other residents. The Administrator stated there were a lot of other residents present at the time of the altercation and stated she talked with the other residents but did not document these conversations. The Administrator stated she was unsure of if staff were present. The Administrator stated she did not do any further investigation on the incident as she felt the altercation was cut and dry, Review of the facility policy titled, Ohio Resident Abuse Policy, dated 07/11/24, revealed, as part of the investigation, residents, the accused, and all witnesses would be interviewed and written statements obtained. Witnesses include anyone who witnessed or heard the incident, came in close contact with the residents on the day of the incident (including residents, family members), and employees who worked closely with the victim the day of the incident. If there are no direct witnesses, then the interviews should be expanded to cover all employees on the unit or shift. 3. Review of the medical record for Resident #12 revealed the resident admitted to the facility on [DATE], diagnoses included chronic obstructive pulmonary disease, type two diabetes mellitus with hyperglycemia, hypertension, peripheral vascular disease, anemia, major depressive disorder, neuropathy, acquired absence of left leg above the knee, and generalized anxiety disorder. Review of the most recent MDS assessment for Resident #12 dated 03/25/25 revealed the resident was cognitively intact. During an interview with Resident #12 on 04/29/25 at 08:55 A.M., it was disclosed the resident had an iPad mini stolen from her room in February 2025, the incident was reported to the facility Administrator. Resident #12 stated she was offered $200.00 if she could provide proof of purchase from either the original receipt or a replacement receipt. Resident #12 reported being dissatisfied with the lack of investigation including the lack of a police report, for which she requested, and the financial reimbursement offer. Resident #12 reported she received the iPad mini for Christmas, a gift from her daughter, and at this time Resident #12 was unable to go out and purchase a replacement without receiving reimbursement in advance. Resident #12 further reported she was recently told by a night aide, there were two new aides working the night the iPad mini went missing and neither of them have returned to work since that night. Resident #12 did not disclose the name of the aide who shared the information. Interview on 04/29/25 at 2:45 P.M. with the Administrator revealed Resident #12 initially reported the iPad missing, then stolen and changed her story several times. Resident #12 never made it known to the facility she had an iPad, and while conducting staff interviews, no one could confirm or recall seeing Resident #12 with an iPad. Interview, via phone, on 05/01/25 at 12:27 P.M., with Resident #12's daughter confirmed she purchased a rose colored iPad mini from a cousin for $300.00 and gifted it to Resident #12 at Christmas. The daughter of Resident #12 verbalized how displeased she was the facilities investigation, claiming she had inquired if anything was seen on the facility cameras and was not provided a follow up from the facility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further record review of the facility incident report revealed the theft occurred on 02/09/25 at 03:00 A.M. Documentation of investigation revealed Resident #12 reported she was sleeping when the iPad went missing. Staff were interviewed but the investigation report lacked any details of the dates or time of interview and the line of questioning. Review of an electronic message sent to Resident #12 by the Administrator dated 03/05/25 and timed 3:08 P. M., revealed the Administrator met with Resident #12 and let the resident know the facility would provide reimbursement around $200.00 for the iPad mini that went missing however a receipt would have to be provided for the reimbursement and that the reimbursement could take up to three months. The communication read that Resident #12 stated she understood. Follow up interview with the Administrator on 05/01/25 at 09:30 A.M., the Administrator verified the facility did not file a police report and the documentation of the incident investigation was lacking pertinent details. The Administrator verbalized she needs to document everything related to the investigation process with date and time stamps including conversations, and interviews. Review of the Ohio Resident Abuse Policy revealed the facility will contact the police for any allegation of misappropriation of resident property. Review of the Crime Reporting Policy reveals the facility is required to report any reasonable suspicion of a crime against any individual who is a resident or receiving care from the facility.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on medical record review, observations, staff interviews and policy review. The facility failed to provide nail care for one (#167) dependent resident of two sampled for activities of daily living. The facility census was 63. Findings include: Review of Resident #167's medical record revealed an admission date of 03/13/25. Diagnoses included respiratory failure with ventilator dependence, diabetes, and anxiety. Resident #167 required nutrition through a gastrostomy tube. The most recent Minimum Date Set (MDS) dated 03/18/25 revealed the resident was totally dependent on staff for all care. Review of the residents activities of daily living plan of care dated 03/18/25 noted the resident is to get nail care weekly with his bath. During an observation of wound care on 04/30/25 at 9:30 A.M., Resident #167 was observed to have long fingernails that were growing downward into his finger tips. Interview with Licensed Practical Nurse (LPN #48) 04/30/25 at 9:35 A.M. verified the residents nails were too long. LPN #48 stated they would be taken care of. Review of the facility policy titled Morning Care/AM Care dated 01/11 stated the facility was to provide nail care daily. This deficiency represents non-compliance investigated under Complaint Number OH00163057.

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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** Based on medical record review, hospital record review, staff interview, and policy review, the facility failed to ensure falls were thoroughly and timely investigated. This affected two (#46 and #66) of four residents reviewed for falls. The facility census was 63. Findings include: 1. Review of the medical record of Resident #46 revealed an admission date of 11/01/24. The resident transferred to the hospital on [DATE] and readmitted to the facility on [DATE]. Diagnoses included chronic diastolic (congestive) heart failure, vascular dementia, left femur fracture, and age-related osteoporosis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had moderately impaired cognition. Resident #46 was dependent on staff for transfers and toileting and required substantial/maximal assistance with bed mobility. Review of the Fall Risk Assessments dated 11/01/24 and 02/21/25 revealed Resident #46 was a high fall risk. Review of the care plan dated 04/28/25 revealed Resident #46 was at risk for falls related to cognitive deficit, muscle weakness, difficulty walking, pain, anxiety, and non-compliance with using call light for assistance. Interventions included a reacher, non-skid footwear when out of bed, keep familiar objects/commonly used items within reach, and keep bed in lowest position with brakes locked while the resident is in bed. Review of a progress note dated 02/09/25 revealed Licensed Practical Nurse (LPN) #85 was passing medications when she heard a resident call for help. The nurse immediately responded to the call and found Resident #46 lying on the floor on her side. When asked what happened, Resident #46 stated she was trying to get into her chair and further stated she knew she could not do it but tried anyway. The nurse and another staff member attempted to assist Resident #46 back to bed and Resident #46 began to scream in pain, stating she thought she had broken her hip and wanted to be sent to the hospital. The physician, Director of Nursing (DON) and family were notified and the resident was sent to the hospital for evaluation. Review of the hospital History and Physical (H&P) dated 02/09/25, revealed Resident #46 admitted to the hospital with a displaced intertrochanteric fracture of the left femur and a mechanical fall. Further review of the medical record revealed no evidence of a post-fall evaluation being completed for Resident #46's fall on 02/09/25. (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 the facility's fall investigation revealed a statement was obtained from LPN #85, which contained the same information as the progress note dated 02/09/25 and the resident had last been seen 25 minutes prior when LPN #85 gave Resident #46 her medications. The investigation also contained the hospital H&P and LPN #85's progress note, dated 02/09/25. There was no additional information regarding the fall, including interventions in place at the time of the fall and the events leading up to the fall. Interview on 04/30/25 at 2:40 P.M., the DON stated she did not have any additional information regarding the fall investigation for Resident #46. The DON confirmed there was not a thorough investigation completed following Resident #46's fall. The DON stated the immediate intervention was to send Resident #46 to the hospital and was found to have a hip fracture. The DON stated, when Resident #46 returned from the hospital, all previous interventions were resumed, no additional interventions were implemented, with the exception of educating Resident #46, which was not documented. The DON further confirmed Resident #46 had moderately impaired cognition would not likely be able to recall education provided. 2. Review of the medical record of Resident #46 revealed an admission date of 11/01/24. The resident transferred to the hospital on [DATE] and readmitted to the facility on [DATE]. Diagnoses included chronic diastolic (congestive) heart failure, vascular dementia, left femur fracture, and age-related osteoporosis. Review of the quarterly MDS assessment dated [DATE] revealed Resident #66 had intact cognition. The resident was independent for eating, setup or cleanup for oral hygiene, supervision for showering and bathing, supervision for dressing, and setup for personal hygiene. The resident was occasionally incontinent of urinary & frequently incontinent of bowels. Review of the Fall Risk Assessments dated 1/22/25 revealed Resident #66 was moderate fall risk. Review of a progress note dated 02/10/25 revealed on 02/07/25 Resident #66 was sent to the hospital. A bed hold letter was provided once the immediate transfer was initiated. Review of event incident report dated on 02/07/25 revealed there was a unwitnessed fall and the investigation was not closed until 03/25/25. Review of the hospital Discharge summary dated [DATE], revealed Resident #66 was transferred to the hospital for a mechanical fall from his bed sustaining a facial injury, laceration to the left scalp, right arm and knee. Resident #66 was then admitted to the hospital for syncope versus fall with a scalp laceration and left knee abrasion. Resident #66 passed away on 02/07/25. Further review of the medical record revealed no evidence of a fall documented in the progress notes. Review of the facility's fall investigation revealed a statement was obtained from LPN #2005, which contained information that an unwitnessed fall occurred, and the resident was alert and oriented at the time staff responded. There was no additional information regarding the fall, including interventions in place at the time of the fall and the events leading up to the fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/30/25 at 10:49 A.M. with Certified Nursing Assistant (CNA) #90., the CNA stated Resident #66 he was sitting on the edge of bed eating breakfast when she last saw him. The staff heard a cry of help and responded, in less than a minute, to find Resident #66 on the floor. CNA #90 stated that the same thing as what was contained in the witness statement, that Resident 66 was alert and talking to staff members. Interview on 04/30/25 at 11:10 A.M. with the DON, the DON stated she did not have any additional information regarding the fall investigation for Resident #66. The DON confirmed there was not a thorough investigation completed following Resident #66's fall. The DON stated the immediate intervention was to send Resident #66 to the hospital. The DON stated they do not have a timeline for when a fall investigation needs to be completed and can have as much time as they need to complete the investigation. Review of the facility policy titled, Fall Prevention and Management, dated 08/06/24, revealed all falls would be reviewed and investigated by an interdisciplinary team and any new interventions would be implemented, and the care plan updated as necessary. Such review should include the results of the new fall risk assessment, discussion with resident and/or any witnessing parties as to potential causal factors, review of the environment where the fall occurred, and discussion as to any new interventions which may help to prevent further falls.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview and review of facility policy, the facility failed to ensure residents are observed taking medications and medications were not left with residents. This affected one (#31) of 21 residents observed in the sample. The census was 63. Findings include: 1. Review of Resident #31's medical record revealed an admission date of 02/03/20. Diagnoses listed included encephalopathy, malnutrition, psychotic disorder with hallucinations, major depression, and insomnia. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 had moderately impaired cognition. Observation on 05/01/25 at 9:40 A.M. revealed Resident #31 was in bed holding a medication cup that contained three pills. Resident #31's eyes were closed. Resident #31 could not be verbally aroused. During an interview on 05/01/25 at 9:43 A.M. Licensed Practical Nurse (LPN) #220 confirmed he had not observed Resident #31 consume the medications. LPN #220 identified the medications as two 2.5 milligram (mg) tablets of Olanzapine (antipsychotic) and one 10 mg tablet of Baclofen (muscle relaxant). LPN #220 verified residents should be observed taking medications. Further review of Resident #31's medical record revealed an order dated 04/24/25 for Olanzapine 5 mg twice day and an order dated 08/10/23 for 10 mg of Baclofen twice a day. Review of the facility policy titled, General Dose Preparation and Medication Administration dated revised 11/15/24 revealed staff should observe the resident's consumption of the medication(s) when administering medications.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, staff interview, and record review, the facility failed to ensure portion sizes were served as planned. This had the potential to affect 57 of 63 residents in the facility. The facility identified six residents (#167, #54, #62, #48, #49, and #43) who did not receive food from the kitchen. The facility census was 63. Findings include: Review of the dietary spreadsheet for the lunch meal on 04/30/25 revealed the serving size for the rice was 1/2 cup, sliced carrots was 1/2 cup, and ground chicken was 3 ounces. Observation on 04/30/25 at 11:04 A.M. revealed [NAME] #735 making plates for the lunch meal. [NAME] #735 utilized a #12 scoop (1/3 cup) for the sliced carrots, a #20 scoop (1 5/8 ounces) for the ground chicken, and a #16 scoop (1/4 cup) for the rice. Observation on 04/30/25 at 11:12 A.M. revealed the first cart of trays was complete and left the kitchen to be delivered to the unit. Interview on 04/30/25 at 11:12 A.M., [NAME] #735 verified she was using a #12 scoop for the sliced carrots, a #20 scoop for the ground chicken, and a #16 scoop for the rice. [NAME] #735 continued on to plate food for the next cart of trays. [NAME] #735 stated she utilized the spreadsheets to determine the appropriate scoop size. Interview on 04/30/25 at 11:15 A.M., Dietary Manager (DM) #38 verified [NAME] #735 was utilizing the wrong size scoop for the sliced carrots, ground chicken, and rice.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and record review, the facility failed to ensure the steam table was maintained in a clean and sanitary manner. This had the potential to affect 57 of 63 residents in the facility. The facility identified six residents (#167, #54, #62, #48, #49, and #43) who did not receive food from the kitchen. The facility census was 63. Findings include: Observation on 04/30/25 at 10:26 A.M. revealed the water wells of the steam table in the kitchen contained a yellowish-brown liquid with debris floating at the top and brown sediment around the bottom and edges of each well. Interview at the same time, [NAME] #735 verified the water wells of the steam table contained a yellowish-brown liquid and there was debris floating at the top of the liquid and brown sediment around the bottom and edges of each well. [NAME] #735 described the liquid as grimey and attributed the color to grease falling into the well when taking pans in and out of the steam table. [NAME] #735 stated she planned on cleaning the steam table wells the following day (05/01/25) and stated the steam table was cleaned weekly. Observations on 04/30/25 between 11:04 A.M. and 11:30 A.M. revealed [NAME] #735 serving food from the steam table for the lunch meal. Interview on 04/30/25 at 11:43 A.M., Dietary Manager (DM) #38 verified the steam table wells were in need of cleaning. DM #38 stated the last time the steam table wells were drained was 04/24/25 and stated the wells were drained and cleaned on a weekly basis. Interview on 05/01/25 at 12:12 P.M., Senior Registered Dietitian (SRD) #08 stated the expectation is for the steam table wells to be drained and cleaned daily and deep cleaned weekly. Review of the manual for the steam table, as provided by the facility, dated 10/27/08, revealed maintenance of the steam table included daily cleaning, consisting of draining or removing water from the well, utilizing a soft cloth or sponge with a mild detergent to clean the entire warmer assembly. Rinse completely with warm water and then dry. Utilize a plastic scouring pad and mild detergent to remove hardened food. Review of the [NAME] Daily Task schedule revealed the steam table was to be drained and cleaned at 6:45 P.M. daily.

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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	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and review of facility policy, the facility failed to ensure enhanced barrier precautions (EBP) were followed and also failed to ensure staff sanitized hands after providing care to a resident and delivering meal trays. This affected three Residents (#19, #54, and #55) observed during dining. The census was 63. Findings include: Review of Resident #54's medical record revealed an admission date of 09/30/24. Diagnoses listed included traumatic brain injury, anxiety, brain cancer, and obstructive sleep apnea. Review of a quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #54 was severely cognitively impaired and had a feeding tube. Review of physician orders revealed an order dated 02/24/25 for Isolation/Transmission-Based Precautions: Enhanced Barrier Precautions (EBP). Observation on 04/29/25 at 7:42 A.M. revealed Certified Nurse Aide (CNA) #160 and CNA #760 repositioning Resident #54 in bed. Neither CNA #160 or CNA #760 were wearing gloves or gowns. CNA #160 then exited Resident #54's room and delivered a meal tray from a cart to Resident #55 who was across the hall from Resident #54. CNA #160 did not sanitize hands before exiting Resident #54's room or before obtaining Resident #55's meal tray. CNA #760 also exited Resident #54's room and delivered a meal tray from a cart to Resident #19 who was across the hall from Resident #54. CNA #760 did not sanitize hands before exiting Resident #54's room or before obtaining Resident #19's meal tray. During interviews on 04/29/25 at 7:46 A.M. CNA #160 and CNA #760 confirmed that they had not wore a gown or gloves when repositioning Resident #54. CNA #160 and CNA #760 also confirmed Resident #54 was on EBP and they had not sanitized their hands before exiting Resident #54's room and before delivering meal trays to Resident #19 and Resident #55. The Administrator was present during the interviews and confirmed the observations. Review of the facility's policy titled, Transmission-Based Precautions and Isolation Policy dated last revised 03/20/25 revealed EBP are intended to prevent transmission of multi-drug resistant organisms (MDROs) via contaminated hands and clothing of healthcare workers to high risk residents. EBP are indicated for high contact care activities for residents with chronic wounds and indwelling devices (such as central lines, urinary catheters, and tracheostomies) and for all those colonized or infected with a MDRO currently targeted by the Centers of Disease Control and Prevention (CDC). Other MDROs may be included at the discretion of the facility Infection Control Committee unless required by state guidance. Review of the facility's policy titled, Serving Meals dated revised December 2016 revealed staff would wash hands before delivering meals.