STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475019	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Johnsbury Health & Rehab	1248 Hospital Drive Saint Johnsbury, VT 05819

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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 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 and interview, the facility failed to ensure that food items were stored in accordance with professional standards for food service safety by having unlabeled food available for use and not ensuring proper refrigerator temperatures. Findings include:Per review of the facility's Food Procurement policy [revised date 11/2025] states: RESPONSIBILITIES: Food Service Director maintains the approved vendor list. Oversees purchasing and receiving practices. Ensures regulatory compliance. Dietary staff inspect deliveries up receipt. Reject unacceptable products. Ensure proper storage of accepted item. Receiving 1. All food deliveries shall be inspected at the time of receipt for: *proper temperatures. *Signs of spoilage, contamination, or damage. *Expiration or use-by dates. 2.Products not meeting standards shall be rejected and documented. 3.Accepted food items shall be labeled and stored immediately according to temperature and storage requirements. During the initial tour of the food service department on 1/25/26 at 4:22pm there was a very strong offensive odor noted on entry to the kitchen. At 4:35pm, a dirty bucket of liquid laundry stain remover was noted on some crates outside of the walk-in fridge. The Food Service Director was asked what it was and why it was there. She said that it should have been thrown away as they were using it for cleaning their dishwasher which was having some trouble getting up to temp. Per observation on 01/26/26 at approximately 11:21am, observed Balsamic vinaigrette in Wing B kitchenette with an expiration date of 1/18/26 11:24 AM Licensed Nurse #1 confirmed the Balsamic vinaigrette was expired with an expiration date of 1/18/26 and threw it away. Per observation on 01/27/26 at 10:33am, the refrigerator and freezer in the activity room was observed with activity staff and a bag of cookies was in the freezer with no dates. Staff stated that those were recently baked and someone will be getting a label for it. Unpackaged frozen bananas were also found in the freezer. The staff member confirmed she is not sure who's they were and thought they might be for residents. A bucket of ice with a water bottle was found in the freezer of which staff confirmed that she was not sure who's it was or who put it there. The items were not removed. On 01/28/2026 at 8:48am, the bag of cookies in the freezer were still not dated after the initial observation. Per interview on 01/28/2026 at 9:06am, the Food Service Director verbalized that she didn't know there were cookies in the freezer and thought that the residents had a bake day last Thursday and advised to check with the Activity Director. Per interview on 01/28/26 at 9:11am, the Maintenance Director verbalized that they do not keep temperature logs and that housekeeping is the one that takes care of that. Per unit observations made on 1/27/2026 and 1/28/2026 it was noted that Resident #37 had a personal in room refrigerator. There was no evidence of a temperature log seen in the room. Per interview on 1/28/26 at 9:38am, a housekeeping staff member was asked if they keep temp log forms for the refrigerator for Resident #37. She stated that they do and took surveyors to the laundry department where the logs where kept. There we found the logs for several residents' fridges. The Housekeeping Director was asked why some of the dates were missing and she stated that it was because her office was locked one weekend and so staff could not access the logs. Per record review of the fridge temperature logs, there were six personal refrigerators that had missing documentation on 1/1, 1/17, 1/18, and 1/22/26. According to the facility temperature logs the fridge should be in a range between 32 to 40 (continued on next page)

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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	degrees F (Fahrenheit). There were multiple days on each fridge that were elevated above 40 degrees. Per interview on 1/28/2026 at 10:06am, the Housekeeping Director confirmed that the temperatures were out of range. When asked what interventions were implemented when this occurs, she verbalized that they inform maintenance. Per interview on 1/28/2026 at 10:10am, the Maintenance Director confirmed that staff should be coming to him if they encounter any temps that are out of range. When asked if he has received any reports of temps being out of range, he verbalized no he has not.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review the facility failed to ensure that 2 of 4 sampled residents were free from accident hazards related to supervision and fall hazards (Resident #25), wheelchair and device maintenance (Residents #25 and Resident #50), and smoking safety for 1 of 1 sampled resident (Resident #71). This is a repeat deficiency for this facility, with the violation cited during the previous recertification survey dated 12/11/24 and two partial surveys dated 3/28/25 and 7/24/25. Findings include: 1. Per a record review, Resident #25 has diagnoses that include Alzheimer's disease, cognitive communication deficit, abnormalities of gait and mobility, lack of coordination, muscle weakness, and history of falling. Resident #25 has a care plan focus of ADL [activities of daily living] self-care deficit related to physical limitations with an intervention dated 9/19/25 for extensive assist of 1 with transfers. Resident #25 also has a care plan focus of At risk for falls due to history of falls, impaired balance/poor coordination with interventions dated 9/19/25 of call bell in reach, encourage to transfer and change positions slowly, and therapy evaluation and treatment per physician orders. A nursing progress note dated 9/25/25 reflects that Resident #25 sustained a fall while attempting to self-transfer and states, It was brought to this writers attention by staff that resident slid to the floor in front of the nursing station. Resident was trying to stand and grab on to the snack cart. This was a witnessed fall. Resident was assisted by staff back to wheelchair. There was no new fall interventions added to Resident #25's care plan at this time. A nursing progress note dated 1/18/26 references periods that the resident had been transferring themself to bed without staff assistance and reads, Resident presented with increased confusion, weakness and foul smelling urine. new orders for u/a [urinalysis] to be obtained. spoke with [Resident #25's responsible party] via telephone and updated on orders and plan of care. Also spoke regarding periods of putting self into bed and removing own brief. There was no new fall interventions added to Resident #25's care plan at this time. Per observation on 1/25/2026 at 4:55 PM Resident #25 was self-propelling around the unit in a wheelchair. The wheelchair was noted to have an anti-rollback device (a safety mechanism that functions as a break and prevents backward movement of the wheelchair when a person attempts to stand from a seated position) installed. When the Resident was asked how s/he was s/he stated, I fell today. S/he denied having any pain. The Director of Nursing approached and confirmed that the Resident had experienced a fall earlier that day. Per observation on 1/25/26 at 5:50 PM, Resident #25 was observed walking alone in his/her room. An LNA (Licensed Nursing Assistant) entered the room and assisted her/him to the wheelchair and wheeled her/him out of their room. The LNA then parked her/him in the hall outside of her/his room, locked the left brake of the wheelchair, and walked away. As soon as the LNA walked away, Resident #25 began to self-propel down to the other nursing unit without difficulty with the left brake engaged. At 6:07 pm, Resident #25 returned to the nursing unit and was observed self-propelling their wheelchair backwards down the hallway without difficulty, with the left brake still engaged. Review of Resident #25's care plan revealed that the focus At risk for falls due to history of falls, impaired balance/poor coordination was updated on 1/25/26 with an intervention stating, Reinforce wheelchair safety as needed such as locking brakes. However, the left brake was currently defective. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A late entry nursing progress note written on 1/26/26 states, Late entry from 1/25/2026. At 1330 [1:30 PM] resident had an unwitnessed fall in [her/his] room. [S/he] was attempting to get out of bed with no assist. [S/he] was assessed for injury at this time with an abrasion noted to [his/her] left shoulder with no complaints of pain and or discomfort at this time. [S/he] was assisted up to [his/her] wheelchair. Per observations made on 1/26/26 at 2:49 pm, Resident #25's anti-rollback device was not engaging when the wheelchair was pulled backward without the Resident in it. Further observation revealed that when attempting to engage the left-hand standard brake it was very loose and unable to engage properly allowing the wheel to move freely. During an interview with the DON (Director of Nursing) and the Regional Director of Quality and Compliance on 1/26/26 at 3:49 pm, the Regional Director of Quality and Compliance confirmed that anti-rollback devices should engage when the person removes their weight by standing up prohibiting the chair from moving. The DON stated that the anti-rollback device had already been installed on Resident #25's wheelchair prior to the fall on 1/25/26, but it had been added to the care plan when she noted it was already on the wheelchair. She also stated that the devices are installed by their maintenance department after a work order is initiated. During the interview with the DON, Resident #25's wheelchair was observed by the DON who confirmed that the anti-rollbacks did not engage when the empty wheelchair was pulled backwards. The DON also confirmed that the left standard break was loose and did not engage correctly, allowing the wheelchair to move when the left break appeared to be locked. Per observation of the unit on 1/27/2026 at 8:51 AM Resident #25 was seen self-propelling into her/his room. The Resident stood from her/his wheelchair and self-transferred onto the unmade bed. There was an overbed table with the table-top positioned across the bed between the head and foot of the bed, impeding the Resident from putting their legs up on the bed. While lying on the bed, the Resident raised her/his legs and put them on top of the over-bed table. The Resident then took their legs off the over-bed table and brought themself to a sitting position on the window side of the bed and attempting to move the over-bed table out of their way. S/he stood up from the bed and tried to move the over-bed table without success. Resident #25 then lay down on their back positioned with their knees bent up on the top half of the bed. At 8:59 AM staff were unaware that the Resident had self-transferred into bed. At 9:00 AM the Resident was moving about in bed shifting around to move the over-bed table. At 9:01 AM an LNA entered the room with linens and closed the door. Per interview on 1/27/2026 at approximately 2:00 PM the DON stated that Resident #25 was being placed on 1-1 staff supervision for safety. Per interview on 1/28/26 at 8:41 am with the facility Director of Maintenance, when discussing the facilities preventative maintenance (PM) program he stated that wheelchairs are not inspected as part of their PM program. He stated that when a Resident requires anti-rollback devices to be installed, nurses complete a work order. The Director of Maintenance confirmed that on 1/27/2026 when he inspected Resident #25's anti-rollback device, they found that it was not working correctly. He stated that when the devices are installed, they are tested. If nursing staff or therapy add a cushion to the wheelchair, it changes the spring tension on the anti-rollback device making it ineffective. The wheelchair should be returned to maintenance for installation of a different spring and re-testing. He stated that they inspected 21 wheelchairs in the facility on the prior day (1/27/26) and found 2 or 3 more with the same issue. The Director of Maintenance stated he had not inspected or repaired the loose ineffective left standard brake on Resident #25's wheelchair as he had not been (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	told to do so. Per observation with the Director of Nursing on 1/28/26 at 12:46 pm, she confirmed that the left standard brake on Resident #25's wheelchair was still not operating correctly. 2. Per observation on 1/26/26 at 2:52 pm, there was a carpeted/rubber entry style mat seen between Resident #25's bed and window. The mat was placed in a way that one corner of it was lifted several inches on the corner of the bed, creating a trip hazard. When the mat was lifted, it was revealed that the flooring was damaged with a large portion of flooring missing. Per interview with the DON on 1/26/26 at 3:49 pm, when asked if there were any repairs planned for Resident #25's room she was aware of the mat and the damaged flooring in Resident #25's room she stated that the plan was to move Resident #25 out of the room with the damaged floor but that right now, the highly visible room is safer. During the interview the mat was observed with the corner still lifted on the corner of the bed and she confirmed that it should not be. Per interview on 1/27/2026 at 2:10 PM the facility Administrator stated that he had not been aware of the damaged flooring. He confirmed that there should not be a mat over the damaged flooring and that it should have been fixed when it occurred. Per an interview on 1/28/26 at 8:41 am with the facility Director of Maintenance, he became aware of the damaged floor in June 2025. There had been a plan to purchase the flooring, and a maintenance director from another one of their facilities would come and show them how to install the new floor. The Director of Maintenance stated there was communication back and forth for 5 to 6 weeks and it never happened. 3. Per record review Resident #71 has a BIMS [Brief Interview of Mental Status] score of 13 as of 11/5/25, indicating they have little cognitive impairment. Resident #71 has major medical diagnoses of hemiplegia (paralysis that affects one side of the body), nicotine dependence, and MDD [Major depressive Disorder]. S/he is independent with ADLs [Activities of Daily Living] and hygiene. Per record review, Resident #71 is a cigarette smoker. Resident #71's care plan states, [Resident #71] may smoke independently per smoking evaluation. Goal: [Resident #71] will smoke safely per smoking assessment through the next review. Lighters, lighter fluid or matches must be maintained by center staff. An interview was conducted with Resident #71 on 1/28/26 at 12:10 PM. Resident #71 stated s/he keeps his/her cigarettes and lighter in his/her room. The resident was observed coming back into the facility after smoking and returning to his/her room without handing his/her cigarettes or lighter to a staff member on the unit. Per record review of the facility's Smoking Policy-Residents policy [last revised 3/21/16] states, Residents who have independent smoking privileges shall not be permitted to keep cigarettes, pipes, tobacco, or other smoking articles in their possession. Resident smoking paraphernalia will be maintained in a locked area in the smoking cart to be distributed to the smoking monitors as per the smoking schedule. Residents will have limited access to smoking materials except as per policy and smoking schedule. Per observation of Resident #71's room on 1/27/26 at approximately 12:50 PM there was a used (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cigarette on the resident's bedside table. RN [Registered Nurse] #1 confirmed that the cigarette should not be in the resident's room. An interview was conducted with the Unit Manager on 1/27/26 at 12:46 PM. She stated the resident's cigarettes were kept in the medication room; and confirmed that the cigarettes were missing from the medication room.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review the facility failed to ensure that a resident was provided informed consent for 1 of 5 residents (Resident #43). Findings include:Per record review, Resident #43 has a BIMS [Brief Interview of Mental Status] score of 15 as of 1/15/26, indicating they had no cognitive impairment. Resident #43 has major diagnoses of Type II Diabetes and a BKA [Below the knee amputation]. They are independent with ADLs [Activities of Daily Living] and hygiene. Per record review of Resident #43's MAR [Medication Administration Record] contains an order stating, Venlafaxine HCl [a medication used to treat depression] ER [extended release] Oral Capsule Extended Release 24 Hour 75 MG [milligrams]: Give 75 mg [milligrams] by mouth one time a day. Per record review, the medication was written on 7/3/25 and was discontinued completely on 7/21/25. Per record review, a psychiatric note dated 7/2/25 at 9:19 AM states, MDD [Major Depressive Disorder], severe, recurrent-start Venlafaxine as above, also helps anxiety. Per record review of the facility's Psychotropic Medication Administration Disclosure form [no revision date] states, It is important that you are fully informed about psychotropic medications. If you have any questions regarding the information contained herein, please direct them to your attending physician or psychiatrist. An interview was conducted with Resident #43 on 1/25/26 at 5:49 PM. The resident discussed that they did not receive notice of being put on Venlafaxine, and did not sign a consent form for this medication. On 1/28/26 at 8:49 AM a second interview was conducted with Resident #43. S/he discussed that s/he noticed an extra pill in his/her pill cup during medication administration. S/he was told it was Venlafaxine. S/he stated s/he never signed a consent form and the physician did not speak to him/her about adding Effexor. S/he stated that the facility then removed it from his/her medication list and never spoke to him/her about the medication. Per record review, there was no documented evidence that the resident was provided informed consent An interview was conducted with the DON [Director of Nursing] on 1/27/26 at approximately 1:35 PM. The DON confirmed they did not have a psychotropic consent form for the resident for his/her Venlafaxine.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accurate advanced directive choices were indicated in the electronic medical record for 1 of 3 sampled residents (Resident #3). This is a repeat deficiency for this facility, with the violation cited during the previous recertification survey dated [DATE]. Findings include:Per record review of Resident # 3's COLST (Clinicians Orders for Life-Sustaining Treatment) form dated [DATE] revealed the resident chose to decline CPR (cardiopulmonary resuscitation) and desires DNR (do not resuscitate) status. Resident # 3's care plan initiated [DATE] and revised [DATE] stated Resident #3 is a full code indicating the resident would want CPR. A physician's order dated [DATE] reads full code. The EMR (electronic medical record) care profile for Resident #3 has a section for code status that reads full code. This does not match Resident #3's COLST.Per interview with RN Unit Manager of B wing on [DATE] at 2:33 PM stated that they use the residents care profile to identify code status. The unit manager confirmed that the care profile, physician order and care plan did not match Resident #3's COLST form in the EMR.Per interview on [DATE] at 10:40 AM LPN on B wing stated they use the residents care profile to obtain and confirm a resident's code status.Per interview on [DATE] at 10:48 AM with Director of Nursing (DON) confirmed that a resident's code status in the care plan, physician orders, and care profile should match their current COLST form in the EMR.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review the facility failed to provide notice of bed hold to 1 of 1 residents in the sample (Resident #22). This is a repeat deficiency for this facility, with the violation cited during a previous partial survey dated 5/28/25. Findings include: Per record review a nursing progress note dated 6/15/25 reflects that Resident #22 was sent to the hospital emergency department during an emergent medical event. Per record review there was no bed hold notice in the resident's chart. There was no documented evidence showing the Long-Term Care Ombudsman was notified of the hospitalization. Per review of the facility's Bed Holds and Returns policy [no revision date] states, In the event of an emergency transfer of a resident, the facility will provide written notice of the facility's bed hold policies to the resident and/or the resident representative as soon as practicable.The facility will keep a copy of the bed hold notice information given to the resident and/or resident representative in the medical records. The facility's policy did not include information related to informing the LTC ombudsman of transfers and discharges. On 1/27/26 at 11:58 AM the social worker confirmed that she could not find a bed-hold on computer or hard copy. On 1/27/26 at 3:00 PM the DON [Director of Nursing] and social worker confirmed the Ombudsman was not notified and that there was no bed-hold.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review the facility failed to ensure that Medication Regimen Reviews were performed by the Consulting Pharmacist and acted on for one of five sampled residents (Resident #49). Findings include:1.Per record review, Resident #49 did not have MRRs (Medication Regimen Reviews, a review of the resident's medications with recommendations from the pharmacist) for January 2025, February 2025, March 2025, and May 2025.Per review of Pharmacy Consultant Policy & Procedure policy [no revised or reviewed date] states, The pharmacist will report any irregularities to the attending physician and the Director of Nursing, and these reports must be acted upon. The attending physicians are not required to agree with the pharmacist's report, nor are they required to provide a rationale for their acceptance or rejection of the report. They must, however, act upon the report. This may be accomplished by indicating acceptance or rejection of the report and signing their name. Additionally, it states The pharmacy consultant will do a monthly review of the medication administration record to assure the accurate acquiring, receiving, dispensing, and administration of all drugs and biologicals to meet the needs of each individual resident. Per interview on 1/27/26 at 12:30pm, The Director of Nursing confirmed that there was no evidence that MRRs for the months of January, February, March, and May of 2025 had been conducted.

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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 observations and interviews the facility failed to ensure that drugs and biologicals used in the facility are within their expiration date and failed to secure medications for 1 of 2 medication treatment carts. This is a repeat deficiency for this facility, with the violation cited during a previous partial survey dated [DATE]. Findings include:1. Per observation on [DATE] at 10:14AM Unit B's medication room contained five covid-19 vaccinations with an expiration date of [DATE] in the freezer. Review of a policy titled Storage of Medications states: Unused medications: The pharmacy and all medication rooms are inspected by the pharmacist consultant for discontinued, outdated, defective or deteriorated medications. Per interview on [DATE] at approximately 10:30 AM the Registered Nurse (RN) Unit Manager of B wing confirmed the items were ready for use and expired. 2. Per observation on [DATE] at 3:52 PM, the medication treatment cart was observed to be unlocked at the nursing station. There were two residents at the nursing station, one who self-propels via wheelchair, and one who walked with a rolling walker. At 4:02 PM, nursing staff left the nursing station, no staff were observed interacting with the medication treatment cart. The medications observed in the medication treatment cart with a Licensed Practical Nurse (LPN) included a wound wash, nystatin, and medicated hemorrhoid cream. Per interview on [DATE] at 4:08 PM, a Licensed Practical Nurse (LPN) confirmed that there were medications in the treatment cart and stated that the medication treatment cart should be locked and then locked the medication treatment cart. Per review of the facility policy titled Storage of Medications policy [no revised or reviewed date] states, All drugs and biologicals will be stored in locked compartments.Only authorized personnel will have access to the keys to locked compartments. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. Per review of the facility policy titled Administering Medications [no revised or reviewed date] states, During administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse or aid.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475019	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Johnsbury Health & Rehab	1248 Hospital Drive Saint Johnsbury, VT 05819

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. Based on observation and interview, the facility failed to ensure proper infection prevention measures of hand hygiene were performed during medication administration for one of four residents in the applicable sample (Resident #24). This is a repeat deficiency for this facility, with the violation cited during a previous partial survey dated 4/25/25. Findings include:Per observation on 1/27/26 at 8:37 AM of medication administration the Licensed Practical Nurse (LPN) did not perform hand hygiene before or after administering Resident # 24 their medications. The LPN returned to her cart and proceeded with medication administration with non-washed hands. Per interview on 1/27/26 at approximately 8:45 AM, the LPN confirmed that she did not perform hand hygiene before or after medication administration.Per record review of the facility's Administering Oral Medications policy [no revised date] states: Wash your hands. prior to administration, and Perform hand antisepsis. after administration.