

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/13/2016
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GREENSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 N LINCOLN ST GREENSBURG, IN 47240
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00199818.</p> <p>Complaint IN00199818-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: June 06, 07, 08, 09, 10, and 13, 2016</p> <p>Facility number: 000244 Provider number: 155353 AIM number: 100288790</p> <p>Census bed type: SNF/NF: 31 Total:31</p> <p>Census payor type: Medicare: 1 Medicaid: 25 Other: 5 Total: 31</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality re view completed by 30576 on</p>	F 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0323 SS=E Bldg. 00	<p>June 20, 2016</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure the residents' environment was free of possible hazards related to unsecured chemicals, unsecured sharps, and improperly disposed of medications. This deficient practice had the potential to affect 10 of 31 residents who were independently mobile.</p> <p>Findings include:</p> <p>1. During an observation on 06/07/2016 at 12:08 A.M., the laundry room door was unlocked with the key in the lock and no staff inside or within view. Inside the room there were unsecured chemicals including, but not limited to, one can of disinfectant deodorizer and 13 bottles of premium laundry suds, laundry pre-spotter, laundry sour, and laundry break.</p> <p>During an observation on 06/07/2016 at 12:11 A.M., the soiled utility room was</p>	F 0323	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, the submission of the Plan of Correction is not an admission that a deficiency exists or that one is cited correctly. This Plan of Correction is submitted to meet the requirements established by the state and federal law. Hickory Creek at Greensburg desires this Plan of Correction to be considered the facility's allegation of compliance. Compliance is effective 7/13/16</p> <p>F323</p> <p>It is the policy of this facility to follow current acceptable practice for preventing accidental hazards, including the securing of chemicals and sharps, as well as the proper disposal of medications.</p> <p>#1 How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</p> <p>No residents were affected by this deficient practice. The keys were</p>	07/13/2016	

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	<p>unlocked with the key in the door and no staff inside or within view. In the unlocked cabinet there were supplies including, but not limited to, one box of disposable razors.</p> <p>During an observation on 06/08/2016 at 1:25 P.M., the soiled utility room was unlocked with the key in the door and no staff inside or within view. On the counter there was one tub of sanitizing wipes, containing ammonium chloride. In an unlocked cabinet there were supplies including, but not limited to, one box of disposable razors.</p> <p>During an interview on 06/07/2016 at 12:12 A.M., CNA (Certified Nursing Assistant) #2 indicated the soiled utility room was not supposed to be unlocked.</p> <p>During an observation and interview on 06/08/2016 at 1:27 P.M., the DON (Director of Nursing) locked the unlocked soiled utility room and indicated the soiled utility room was supposed to be kept locked.</p> <p>2. During an observation on 06/10/2016 from 3:22 A.M. to 3:55 A.M., an open plastic container filled with unused lancets was sitting on top of a cart in the hallway outside the nurses station door. Staff did not stay with the container or</p>		<p>removed from the soiled utility room and the laundry room door frames on 6/14/16.</p> <p><u>#2 How will the facility identify other residents having the potential to be affected by the same deficient practice?</u></p> <p>All residents who are mobile have the potential to be affected by this practice; however, no issues or concerns regarding unsecured items have been identified.</p> <p>If the Administrator, DON, or other member of the IDT (interdisciplinary team) find an unsecured chemical or sharps, find that medications have not been disposed of appropriately, or identify any other situation that could cause harm to a resident, he/she will secure or remove the source of the concern immediately. Once that is done, the department manager of the involved staff will re-train them as to the facility policy and will address the issue with written counseling as indicated by the situation.</p> <p><u>#3 What measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur?</u></p> <p>The keys are now being kept at the nurse's station for the C.N.As to check out on each shift. The C.N.As will return the keys at the end of the shift. C.N.As were educated to the new procedure. The razors are placed behind the</p>	

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	<p>have it in view.</p> <p>During an interview on 06/13/2016 at 12:21 P.M., the Administrator indicated chemicals, including laundry chemicals, were kept locked in the laundry room or housekeeping closet. She further indicated sharps and other supplies were to be kept locked in storage rooms.</p> <p>The current facility policy, titled "Chemical Storage" and dated 01/01/2016, was provided by the DON (Director of Nursing) on 06/13/2016 at 11:46 A.M. and was reviewed at that time. The policy indicated, "...It is the policy of this facility to store chemicals in a safe manner...doors will have locks for security purposes."</p> <p>3. During an observation on 06/10/2016 at 4:55 A.M., LPN #1 picked up a round orange tablet off of the floor and threw the tablet into the trash can on the side of the medication cart.</p> <p>During an interview on 06/10/2016 at 4:57 A.M., LPN #1 indicated she did not know " pills " could not be disposed of in the trash can other than controlled substances. She did not feel the tablet on the floor was a controlled medication.</p> <p>During an interview on 06/10/2016 at</p>		<p>lockedcabinet in the soiled utility room behind the locked door. The nurses have beenin-serviced as to the facility policy for the proper disposal of medication bythe DON.</p> <p>In addition to the daily rounds that all members of the IDT make as part of each ones tour of duty, the DON/Designee will check to ensure this practice is being followed onetime weekly on each shift to ensure that all C.N.As are following the proper procedure for keys and placement of razor blades, and that medications arebeing disposed as per policy. Any identified issues will be addressed asoutlined in question #2.</p> <p><u>#4 How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</u></p> <p>Results of weekly audits will be brought to the weekly Standard of Care meeting by the DON/Designee for 3 months for review by the IDT. Results of weekly audits will be brought toQA meeting monthly for further review and recommendation for 3 months. At the end of that time, if 100% compliance is reached, the committee may decide to stop the documented audits; however, the practice of monitoring of these areas will continue on an ongoing basis.</p> <p>Date of Compliance: 7/13/16</p>		

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F 0425 SS=D Bldg. 00	<p>5:15 A.M., the DON (Director of Nursing) indicated any and all medications being disposed of should never go into the trash can.</p> <p>A document, titled "Ambulatory residents", was provided by the DON on 06/13/2016 at 11:27 A.M. The document indicated there were 10 independently mobile residents who would be at risk due to unsecured chemicals and sharps, and improperly disposed of medication.</p> <p>The current facility policy, titled "Medication Disposition" and dated 09/2012, was provided by the DON 06/10/2016 at 8:49 A.M. and was reviewed at that time. The policy indicated, "...Medications...placed in the locked pharmacy sharps container...These medications include tablets and capsules, patches, ointments, liquids, vials, ampules, and all other forms of medication."</p> <p>3.1-45(1)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and</p>				

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	<p>emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview and record review, the facility failed to provide routine medications related to Omeprazole for 1 of 6 residents reviewed for pharmaceutical services. (Resident #31)</p> <p>Findings include:</p> <p>During an observation on 06/10/2016 at 4:46 A.M., LPN (Licensed Practical Nurse) #1 prepared Resident #31's medications. The resident had Omeprazole 20 mg (milligram) capsules located in the medication cart.</p> <p>During an interview on 06/10/2016 at 4:47 A.M., LPN #1 indicated Resident #31's Omeprazole 10 mg had not been</p>	F 0425	<p>F425</p> <p>It is the policy of this facility to follow current acceptable practice for administering medications, including provision of routine medications as ordered by the physician.</p> <p><u>#1 How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>LPN # 1 was suspended on 6-10-16 until investigation was completed. LPN #1 was terminated on 6-14-16. Any other related issues that were identified in staff performance as a result of the investigation were dealt with by re-training and written counseling where indicated.</p> <p>All nurses were in-serviced on</p>	07/13/2016			

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	<p>received from the pharmacy and she would not be able to administer the medication until the pharmacy delivered the prescription.</p> <p>During an interview on 06/10/2016 at 6:21 A.M., the DON (Director of Nursing) indicated Resident #31's physician ordered a change in the resident's dose of Omeprazole from 20 mg to 10 mg on 05/26/2016. The DON could not find documentation which indicated the Omeprazole 10 mg order was faxed to the pharmacy.</p> <p>During an interview on 06/10/2016 at 8:23 A.M., the DON indicated the night shift nurse should have been checking the orders against the medications received from the pharmacy and prior to administering medications the nurse should check the physician orders.</p> <p>During an interview on 06/10/2016 at 8:33 A.M., the Administrator indicated it should not take several days to receive medication changes from the pharmacy.</p> <p>Review of Resident #31's MAR (Medication Administration Record) and the medication card on 06/10/2016 at 5:28 A.M., indicated the resident received Omeprazole 20 mg every day from 06/02/2016 to 06/09/2016.</p>		<p>proper procedure for Medication Administration and Medication Destruction on 6-10-16. All nurses will be re-in-serviced on 7/06/16 regarding proper procedure for medication administration and medication destruction. The pharmacy has been notified and medication has been obtained for Resident #31.</p> <p><u>#2 How will the facility identify other residents having the potential to be affected by the same deficient practice?</u></p> <p>All residents have the potential to be affected by this practice. The DON will complete an audit on all new medication orders dating back to 5/1/16 to make sure that the medications have been ordered, received, and administered appropriately. If any issues are identified, she will notify the physician and clarify the order with him. Once that is done, the family and pharmacy will be notified and the resulting corrections made to the resident's record, including the MAR.</p> <p>When completed and the resident is taken care of, the DON will re-train the staff involved in the facility policy for provision of medications and will issue written counseling/disciplinary action as indicated by the situation. This same response will be followed through by the DON for any medication-related issues identified in the future.</p>	

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	<p>Review of the physician's order dated 05/26/2016 indicated the resident was to receive Omeprazole 10 mg one capsule by mouth in the morning for GERD. (Gastroesophageal reflux disease)</p> <p>The Quarterly MDS (Minimum Data Set) assessment, dated 04/28/2016, indicated Resident #31's BIMS (Brief Interview for Mental Status) score was 12 signifying the resident was cognitively impaired.</p> <p>The current facility policy, titled "Medication Disposition" and dated 09/2012, was provided by the DON on 06/10/2016 at 8:49 A.M. and was reviewed at that time. The policy indicated, "...Any medication for which there is no active order shall be disposed of as soon as possible..."</p> <p>3.1-25(a)</p>		<p><u>#3What measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur?</u></p> <p>A revised check in procedure of medication was reviewed with nurses, see attachment #1: Nurses are to keep copies of new orders on the clip board until the medications arrives from the pharmacy. Night shift nurse will be responsible to check medications against new orders to ensure that medications have arrived. Medications are expected to arrive within 24 hours of order.</p> <p>If a new medication has not arrived, the night shift nurse will call the Pharmacy to inquire why the medication was not sent. This nurse will log this on the Missing Medication log sheet (see attached #2) indicating that the medication did not arrive and what actions were taken for the medication to be delivered. Night shift nurse is to notify the DON if she is unable to resolve the reason for the medication not arriving from the pharmacy by the end of the shift. DON will review log 3 times a week for patterns that medications are not arriving in a timely manner. If the DON or any licensed nurse finds that a medication was not given as ordered, a medication error report will be completed, and the DON will follow up as indicated in questions #2.</p>	

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F 0441 SS=E Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.		#4 How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? Results of weekly audits will be brought to the weekly Standard of Care meeting by the DON/Designee for IDT review for 3 months. Results of weekly audits will be brought to QA meeting monthly for review and recommendation for 3 months. At the end of that time, if 100% compliance is reached, the committee may decide to stop the documented audits; however, the weekly checking by the DON and the monthly checking by the pharmacy and nurses will continue on an ongoing basis. Date of Compliance: 7-13-16	

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	<p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to ensure proper infection control measures were maintained related to glucometer cleaning and handwashing for 8 of 15 residents observed during personal care and medication administration. (Resident #3, 7, 9, 11, 19, 21, 33, 34)</p> <p>Findings include:</p> <p>1. During an observation on 06/10/2016 at 4:16 A.M., LPN (Licensed Practical Nurse) #1 removed the glucometer from the medication cart and wiped the glucometer off with one alcohol pad. LPN #1 then used the glucometer to check Resident #19's blood sugar. After</p>	F 0441	<p>F441 It is the policy of this facility to follow current acceptable practice for Infection Control, including the cleaning of glucometers, as well as proper hand washing and glove use. <u>#1</u> <u>How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</u> LPN # 1 was suspended on 6-10-16 until investigation was completed. LPN #1 was terminated on 6-14-16. All other Nurses will be in-serviced on proper procedure for cleaning and disinfecting of glucometers by 7/13/16. All staff will also be in-serviced on proper hand washing techniques and glove use by 7/13/16. <u>#2</u> <u>How will the facility identify</u></p>	07/13/2016
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	<p>checking the resident's blood sugar, LPN #1 placed the soiled glucometer directly on top of the medication cart. Prior to using the glucometer for Resident #11, LPN #1 wiped the glucometer off with one alcohol pad.</p> <p>During an interview on 06/06/2016 at 11:42 A.M., RN (Registered Nurse) #3 indicated the glucometer was to be cleaned with a sani cloth and left to soak for two minutes between each resident use.</p> <p>During an interview on 06/10/2016 at 5:20 A.M., the DON (Director of Nursing) indicated alcohol wipes were not to be used to clean/sanitize the glucometer.</p> <p>The current facility policy, titled "Maintenance Cleaning & Disinfecting Guidelines", was provided by the DON on 06/10/2016 at 8:49 A.M. and was reviewed at that time. The policy indicated, "...policy to advise health care professionals to clean and disinfect the meter between patient use...disinfect the meter, dilute 1 ml of household bleach...Super Sani-Cloth..."</p> <p>The current facility policy, titled "Diabetic Testing" and dated 8/13, was provided by the DON on 06/10/2016 at</p>		<p><u>other resident having the potential to be affected by the same deficient practice?</u> All resident who require blood glucose checks have the potential to be affected by this deficient practice. None of the residents who receive glucometer checks have exhibited any illness, infection, or other difficulty as a result of this practice. If the DON observes that a nurse is not following the appropriate procedure for glucose meter cleaning, she will stop the nurse at that time and re-train her once again regarding the facility policy and procedure for this process. The nurse will return demonstrate her understanding of the correct cleaning procedure for the DON at that time. Once completed, the DON will also render written counseling/disciplinary action for continued noncompliance. The DON will also follow this same procedure for observed concerns regarding glove use and hand washing. <u>#3 What measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur?</u> DON/Designee will observe glucometer cleaning one time weekly on each shift to ensure that all nurses are following proper procedure for Glucometer cleaning x 3 months. DON/Designee will observe nursing staff one time weekly on each shift x 3 months to ensure that staff is following proper hand</p>		

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	<p>8:49 A.M. and was reviewed at that time. The policy indicated, "...clean the blood glucose meter with Super Sani-Cloth wipe and place it in the storage container after wrapping it for 2 minutes, then allowing it to air dry..."</p> <p>2. During an observation on 06/07/2016 at 1:28 A.M., CNA (Certified Nursing Assistant) #2 and LPN #1 assisted Resident #9 with personal hygiene care. LPN #1 was observed rubbing her face and readjusting her glasses prior to entering Resident #9's room. Without washing her hands LPN #1 used her bare hands and a cleaning cloth to wipe the resident's buttocks. The resident had been incontinent of bowel and the LPN's bare hands were directly touching the resident's feces. Without washing her hands, the LPN readjusted her glasses and moved her own hair behind her ears. After completing the resident's personal hygiene the LPN washed her hands for a total of eight seconds. LPN #1 then walked down the hallway and readjusted Resident #34's top by touching the residents shoulder.</p> <p>During an interview on 06/07/2016 at 1:35 A.M., LPN #1 indicated she was "old school" and never used to wear gloves. She further indicated she should have been wearing gloves.</p>		<p>washing techniques and glove use. If staff is observed with improper procedures, (hand washing/glucometercleaning), the DON will address these issues as outlined in question #2. <u>#4 How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</u> Results of weekly audits will be brought to the weekly Standard of Care meeting by the DON/Designee for IDT review for 3 months. Results of weekly audits, will be brought to QA meeting monthly for review and recommendation for 3 months. At the end of that time, if 100% compliance is reached, the committee may decide to stop the documented audits; however, the DON will continue to observe the staff performance in hand washing, glove use, and glucometer cleaning on an ongoing basis. Date of Compliance: 7-13-16</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/13/2016
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GREENSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 N LINCOLN ST GREENSBURG, IN 47240
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	<p>3. During an observation of medication administration on 06/10/2016 at 4:02 A.M. LPN #1 washed her hands for 11 seconds then prepared Resident #21's medications to be administered.</p> <p>4. During an observation of medication pass on 06/10/2016 at 4:28 A.M., LPN #1 wiped her nose with her bare hand then rubbed the side of her face and, after adjusting her glasses, the LPN walked into Resident #19's room to administer the residents medication. LPN #1 donned gloves without washing her hands and placed medication into the resident's eyes. After LPN #1 removed her gloves she used hand gel.</p> <p>5. During an observation of medication administration on 06/10/2016 at 4:33 A.M., LPN #1 rubbed her face, placed her hair behind her ears and, without washing her hands, prepared Resident #3's medications for administration.</p> <p>6. During an observation on 06/07/2016 at 12:45 A.M., LPN (Licensed Practical Nurse) #1 picked up two cups of pudding, a used insulin syringe and a spoon. The nurse, holding the syringe against the spoon, moved out of the nurse's station, dropped the syringe into the sharps container, moved to sit next to</p>			

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	<p>Resident #9, and used the hand holding the spoon to pull up Resident #9's sock. Without washing her hands or using hand sanitizer, LPN #1 opened one pudding cup and put the soiled spoon in the pudding. The nurse then removed the spoon, got a new spoon, and started feeding Resident #9 the pudding that had the soiled spoon in it. After feeding the resident, LPN #1 returned to the nurse's station and continued working on the computer without washing her hands or using hand sanitizer.</p> <p>7. During an observation on 06/07/2016 at 12:57 A.M., LPN #1 assisted Resident #7 to the restroom. After assisting the resident in the restroom and back to bed, and without washing her hands or using hand sanitizer, LPN #1 went to answer a call light for Resident #33. The LPN assisted Resident #33 to change his shirt, entered the laundry room and washed her hands for a total of eight seconds.</p> <p>The current facility policy, titled "Infection Control" and dated 10/2004, was provided by the DON (Director of Nursing) on 06/10/2016 at 8:49 A.M. and was reviewed at that time. The policy indicated, "...This facility will establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment</p>			

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	<p>and to help prevent the development and transmission of diseases and infection...Staff will wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.</p> <p>The current facility policy, titled "Handwashing/Alcohol-Based Hand Rub/Hand Hygiene" and dated 1/16, was provided by the DON on 06/10/2016 at 8:49 A.M. and was reviewed at that time. The policy indicated, "...When to Use Handwashing...after contact with blood, bodily fluids, secretions, excretions...After gloves are removed...After touching inanimate sources that are likely to be contaminated with virulent or epidemiologically important microorganisms...After touching your hair, face...Before and after touching a resident or handling his/her belongings..." and "...The duration of the entire procedure should take 40-60 seconds..."</p> <p>3.1-18(1)</p>			