STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING 00 B. WING	12/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHATEAU REHABILITATION AND HEALTHCARE CENTER	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for Investigation of Complaint IN00367883, IN00368346 and IN00368782. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00367883 - Substantiated. Federal/State deficiencies related to the allegations are cited at F0602. Complaint IN00368346 - Substantiated. Federal/State deficiencies related to the allegations are cited at F0561. Complaint IN00368782 - Substantiated. Federal/State deficiencies related to the allegations are cited at F0689 and F0573. Survey dates: December 16, 17, and 20, 2021 Facility number: 000153 Provider number: 155249 AIM number: 100266910 Census Bed Type: SNF/NF: 84 Total: 84 Census Payor Type: Medicare: 4 Medicaid: 64 Other: 16 Total: 84 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed December 22, 2021	F 0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on observation, interview, and record review, the facility failed to ensure residents had the opportunity to make their own meal choices for 5 of 7 observations affecting 3 of 5 residents. (Resident J, Resident M and Resident S). Findings include	F 0561	***F 561D SELF DETERMINATION*** ***The facility requests paper compliance for this citation.*** *This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or*	01/07/2022

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	During record review on 12/16/21 at 4:20 PM, the menu for the dinner meals indicated the regular diet included french onion soup, deluxe potato ham back, five way mixed vegetables, pumpkin bar, cornbread with margarine, and milk/beverage. During interview on 12/16/21 at 4:24 PM, Dietary Manager 1 indicated the french onion soup was placed on every hall tray but the soup was optional for residents in the dining room. During observation on 12/16/21 from 4:24 PM to 5:30 PM the plating of meal trays included hall trays and the main dining room. Drinks were not served on the trays, as they were placed on top of the hall tray carts. The drinks were lemonade, in pitchers or packets of hot cocoa. The hall tray carts did not include milk for drinks. During observation of meals being served in the main dining room, the delivery of meal trays was random. The first meal delivered was across the dining room to a resident over by the windows, the second tray was delivered to a resident closest to the kitchen, then some to the back of the dining room, and continued randomly serving trays to persons not together at a table. Resident S told Resident P he was going to reach over and take some of her food if his tray did not come out soon. The passing of drinks in the dining room began at the tables closest to the kitchen and did not follow the order of the trays coming out of the kitchen, leaving residents to eat food without drinks. As trays were being delivered, 2 residents needed assistance with eating; 2 staff sat down to assist those 2 residents, but 1 did not have any drink at that time. No soup or milk was observed to be offered to any residents in the dining room when their trays were delivered. During interview on 12/16/21 at 5:34 PM, Resident		*agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* ***1) Immediate actions taken for those residents identified:*** *Resident #J, #, #M, and #S were interviewed to determine they have had the opportunity to make their own meal choices. Care plans were reviewed and revised.* ***2) How the facility identified other residents:*** *Any resident residing in the facility had the potential to be affected. Facility audit was conducted by Social Services/Nursing and Dietary manager to determine the opportunity has been given to choose their own meal. Any identified concerns were immediately addressed.* ***3) Measures put into place/ System changes:*** *Education provided to facility staff with a focus on nursing and dietary staff in supporting and promoting the residents right of choice, which includes meal choice. Meal trays will be checked prior to leaving the kitchen per dietary staff and prior to serving per dining room staff. Alternate meal choices will be provided. Interviews will be conducted 3 times weekly with 3 residents to determine resident*	

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	P indicated the food was served usually served randomly and she was not offered soup. During interview on 12/16/21 at 5:36 PM, Dietary Manager 1 indicated they got meal tickets from the CNAs (Certified Nursing Assistants) as they brought residents into the dining room, so that was the order they sent the dining room trays out. Cook 1 indicated they did not have a seating chart. During interview on 12/17/21 at 9:45 AM, Resident G indicated she got eggs for breakfast despite not asking for eggs. She indicated nobody came around to ask what they want for lunch or dinner, they just got whatever is being served. Resident G indicated she had never been offered a snack. During interview on 12/17/21 at 9:55 AM, Resident M indicated she was not offered choices at mealtimes, that she just had to wait until the food came out to see if she wanted what was served or not. During interview on 12/17/21 at 10:40 AM, Resident S indicated he ate in the dining room the prior evening for dinner and was not aware french onion soup was available as nobody offered it to him. Resident S indicated he would have gotten soup, as French Onion soup was a favorite. The admissions booklet attachment 4 indicated "Statement of Residents' Rights ... Each resident shall have the right to exercise his or her rights as a resident of the facility ... Each resident shall have the right to exercise his or her individual rights or have his or her rights exercised by a person authorized by State law. ... Each resident shall have the right to exercise his or her civil and religious liberties, including he right to		*meal choice has been provided which will include all three meals. Identified concerns will be immediately addressed. Bimonthly resident council meetings for two months to determine satisfaction with self-determination and meal choice.* ***4) How the corrective actions will be monitored:*** *The responsible party for this plan of correction is the Executive Director and Director of Nursing and Dietary Manager.* *The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.* *5) Date of compliance: 1/7/22*	

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	independent personal decisions and knowledge of available choice, which shall not be infringed...." This Federal Citation is related to Complaint IN00368346 3.1-(u)(3)			
F 0573 SS=D Bldg. 00	483.10(g)(2)(i)(ii)(3) Right to Access/Purchase Copies of Records §483.10(g)(2) The resident has the right to access personal and medical records pertaining to him or herself. (i) The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays); and (ii) The facility must allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of: (A) Labor for copying the records requested by the individual, whether in paper or electronic form; (B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable			

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	media; and (C)Postage, when the individual has requested the copy be mailed. §483.10(g)(3) With the exception of information described in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand. Summaries that translate information described in paragraph (g)(2) of this section may be made available to the patient at their request and expense in accordance with applicable law. Based on interview and record review, the facility failed to provide requested medical records to a family member for 1 of 1 deceased resident (Resident C). Findings include The record for Resident C was reviewed on 12/16/21. The record did not indicate a Power of Attorney (POA) had been appointed, only 2 emergency contacts which were adult children. Hospital notes indicated the resident passed away on 11/23/21 at 7:45 PM. During interview on 12/16/21 at 12:10 PM, the Administrator indicated Resident C did not have a POA. He indicated one of the Emergency Contacts had come into the facility to go through the resident's personal items and then had requested medical records. The administrator indicated they could not give any records until the Emergency Contact could prove she was POA or related to the resident. He indicated he did not ask the Emergency Contact for identification to	F 0573	F573 D Right to Access/Purchase Copies of Records **The facility respectively requests paper compliance for this citation.** **This Plan of Correction is the center's credible allegation of compliance.** **Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** 1.) /b> b>. /b> /p>	01/07/2022

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	verify who she was. The Administrator indicated the facility questioned the relationship to the resident because the Emergency Contact never came to visit and the resident had been disconnected from the family. During interview at the same time, the Regional Director of Operations indicated he would not release records without knowing who the daughter was first. The facility policy titled "Medical Records Policy," dated 11/1/2021, indicated "It is the policy of the facility to allow the resident/responsible party access to personal and medical records pertaining to the resident in such a manner to acknowledge and respect resident rights. Procedure: The resident has the right to access personal and medical records pertaining to him or herself. ... 2. The facility will allow the resident/or responsible party, to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. Proof required by responsible party to obtain information...." This Federal Citation is realted to IN00368782 3.1-50e(4)		/b> /p> /b b> Identified medical record requests will be immediately reported to Executive Director/designee. Contact will be made with requesting party within 24 hours and education provided regarding requirements to obtain records. Log of medical record request will be kept and reviewed monthly during QA meetings to determine provision of said records occurred. Reviews will continue for 6 months and or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5.) Date of Correction 1/7/22	
F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.			

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	Based on record review and interview, the facility failed to ensure resident personal items were safe from disposal for 1 of 2 discharged residents reviewed (Resident D). Findings include The record for Resident D was reviewed on 12/17/21. The resident was discharged on October 16, 2021. The record did not indicate anyone had attempted to contact the family to obtain resident belongings and did not indicate an inventory sheet had been completed. During interview on 12/17/21 at 12:44 PM, Social Worker 1 indicated Resident D had a bunch of items in his room that were infection control issues. She indicated she had thrown out items due to blood and other chemicals on some of the items. Social Worker 1 indicated she threw out canned goods and boxed foods that were open because they had blood and other chemicals over them. Social Worker 1 indicated the items disposed of were perishable items the facility could not keep for infection control reasons. Social Worker 1 indicated it was a while before the friend came to get Resident D's items. She indicated the friend had called and indicated the food could be replaced, asked about some books, tablets and cell phones. Social Worker 1 indicated she did not document Resident D's friend had called and had not documented the items thrown out. She indicated she had not received any reports indicating the friend had not gotten everything. During interview on 12/20/21 at 2:55 PM, the Administrator indicated the resident inventory sheets were completed on admission for clothing and items needing to be laundered. He indicated	F 0602	**F-602 D Free from Misappropriation/Exploitation** **The facility respectively requests a desk review for this citation** **Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.** /u> /b> /p> /b> /p> /b /p> /b b>. Identified areas of concern will be immediately reported and investigated per guidelines and additional education provided as required. Audits and investigation process/grievances will be reviewed during scheduled morning IDT meetings and monthly during Quality Assurance. Audits will continue for 6 months and or until 100% compliance is	01/07/2022

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	any new item was taken to the nurse desk to be documented and labeled, otherwise anything brought in should be placed on the list. The Administrator indicated the responsible party, Power of Attorney (POA) or spouse, depending on family dynamics, or request, and next of kin, would pick up the belongings. The Administrator indicated Resident D had a lot of trash, and food in his room and many items had been contaminated with blood. He indicated social services saved what was not contaminated. During interview on 12/20/21 at 11:00 AM, the Regional Director of Operations indicated they did not have the inventory sheets for Resident D. The facility admission booklet contained the "Notification of Policy Regarding Personal Property," and indicated "Discharge of Persona Property: The Resident and/or the Resident's family/authorized representative is required to remove all clothing and other personal property from the facility within 14 days after transfer or discharge. All clothing remaining in the facility after the 14 days will be considered abandon by the Resident, and the facility will take possession of the property and dispose of it without an accounting to the Resident and/or authorized representative...." This Federal Citation is related to IN00367883 3.1-28(a)		achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5.) Date of Correction 1/7/22 **/p>** **/p>**	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment			

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	remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure the suspension of driving duties for 1 of 1 employee involved in a motor vehicle incident involving a resident (Resident C). Findings include The record for Resident C was reviewed on 12/16/21. Resident C had been involved in a transportation accident on 11/22/21, sustained fractures which required surgical intervention. Hospital notes indicated the resident passed away on 11/23/21 at 7:45 PM. The incident reported to the Indiana Department of Health (IDOH) indicated an accident happened on 11/22/21 at 12:46 PM. The report indicated during the investigation, the driver was removed from transportation duties. During interview on 12/17/21 at 2:00 PM, Maintenance Director 1 indicated he would occasionally help transport residents to appointments in the facility van. He indicated he was transporting Resident C back from dialysis, he had strapped the wheel chair onto the bus appropraitely and put the seatbelt on the resident. When he had to brake suddenly to avoid running a yellow light, the residnet fell out of her wheelchair. Maintenance Director 1 indicated he had not transported any residents since. He indicated the facility did not tell him he could not transport residents anymore. He indicated he	F 0689	**F 689 D Free of Accidents/Hazards/Supervision/ Devices** **The facility respectively requests paper compliance for this citation.** This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. **1.) What corrective actions will be accomplished for those residents found to have been affected by the practice?** Resident C's information was taken from closed record review and no longer resides within the facility. **2.) How will other residents having the potential to be affected by the same practice and what corrective action will be taken:** Any resident that utilized the	01/07/2022

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	wasn't suspended from anything after that, he just took 2 personal days off afterwards. He indicated he would still transport residents in a pinch, if they needed him to. Maintenance Director 1 indicated he did drive the van to get it serviced on or about 12-8-21. During interview on 12/20/21 at 9:30 AM, the Administrator indicated he did not have any paperwork specifically for the suspension of the Maintenance Director from doing resident transportation, only what was documented in the investigation notes. The facility policy titled "Driver Safety Regulations," indicated "3. Traffic Laws: Drivers must abide by the federal, state and local motor vehicle regulations, laws and ordinances. ..." This Federal Citation is related to IN00368782 3.1-45(a)		facility bus for transportation on 11-22-21 and driven by Maintenance Director 1 had the potential to be affected, however no other residents were affected. **3.) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur.** Any staff members that have Bus Driver responsibilities will be trained on Bus Driver Operations and Driver Safety Regulations. Training will occur upon hire and at least annually. The Director of Nursing/designee will determine the need of an additional staff member for transportation. Arrangements will be made prior to transport. The facility bus will be inspected as required. **4.) How the corrective actions will be monitored to ensure the practice will not recur and what quality assurance program will be put into place.** Monitoring of this plan of correction will be the facilities Executive Director/ designee. Audits conducted weekly to determine individuals with bus driving responsibilities are trained as required. Results of these audits will be reviewed in Quality Assurance Meeting Monthly x6 months or until an 100% compliance or greater is achieved x3 consecutive months. The QA	

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			Committee will identify any trends or patterns and make recommendations to revise the plan of correction as needed. **5. Date of Correction 1/7/22**	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;			

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	155249	A. BUILDING 00 B. WING	12/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHATEAU REHABILITATION AND HEALTHCARE CENTER	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observations, interviews and record reviews, the facility failed to properly prevent	F 0880	**F880 D Infection Prevention and Control.**	01/07/2022

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	and/or contain COVID-19 related to Personal Protective Equipment (PPE) during 3 of 3 observations. These observations affected 3 of 3 randomly observed residents reviewed for infection control (Resident K, Resident L, and Resident M). Findings include: 1. During observation on 12/17/21 at 9:35 AM, Certified Nursing Assistant (CNA) 1 was observed in the room of Resident M. CNA 1 had her mask down under her nose. During observation at 9:52 AM, CNA 1 was observed a second time with her mask under nose, then pulled the mask down under her chin to talk to another staff in the hallway. During interview at the same time, CNA 1 pulled the mask down and indicated she pulled her mask down because she could not breathe and that nobody could hear her talk. During observation on 12/17/21 at 10:16 AM at the B unit nurses' station, Licensed Practical Nurse (LPN) 1 had her mask down under her nose. During interview at the same time, she pulled the mask up and then pulled it out to talk and indicated that she had been educated on how to wear a mask and that she had it undone because she could not breathe. She indicated she had her first dose of Covid-19 vaccination. During interview on 12/17/21 at 10:26 AM, the Assistant Director of Nursing (ADON) indicated the facility was constantly educating on wearing masks appropriately and that if there are any changes to any infection control issues, they post signs on the back door for in-servicing. The ADON indicated they have been monitoring and correcting with on the spot education. The		**The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** **1)Immediate actions taken for those residents identified:** Immediate Directed In-servicing initiated for facility staff per the Director of Nursing/Infection Preventionist on Infection Control and Prevention, Donning and Doffing of PPE with specific focus on mask use, and Isolation Procedure/Signage requirements of PPE for Green, Yellow and Red Zones. Resident #K, #L and #M were assessed, and plan of care reviewed. Those staff members identified in the 2567 received individual training per the Director of Nursing **2)How the facility identified other residents:** Any residents residing in the facility has the potential to be affected. Visual rounding was completed and identified issues with donning and doffing, mask use and isolation	

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	ADON indicated staff should not be wearing masks under their noses or pulling them down to talk. 2. During observation on 12/17/21 at 10:29 AM, the room for Resident K and Resident L had sign on it indicating droplet and contact precautions were in place. There was not a PPE cart in the hall beside the door. During interview at the same time, CNA 3 indicated she thought just the sign had not been removed, as Resident L had been admitted on 11/21 and Resident K moved over from C wing yesterday. The facility policy titled "Infection Control Standard Precautions," indicated "Mask, eye protections, face shield 1. Wear mask and eye protection or a face shield to protect mucous membranes of the eyes, nose and mouth during procedure and resident care activities that are likely to generate splashes or sprays of blood, bloody fluids, secretions, and excretions...." 3.1-18(b)(1)(4)		procedures resulted in immediate education. Audit was conducted to identify those residents that are in isolation and appropriate signage is present. Any concerns identified resulted in immediate 1-1 re-education. .**3) Measures put into place/ System changes:** Directed in servicing was provided per the Director of Nursing/IP/Designee to ensure staff are instructed on PPE usage with return demonstration. Daily visual rounding (to include all shifts) throughout the facility to ensure staff are practicing appropriate Infection Control Practices and complying with solutions. During daily rounding 2 staff members will be interviewed on isolation procedures. Identified issues will result in repeat education. Daily visual rounding will continue for 6 weeks and or until compliance in maintained. Review during scheduled morning meetings concerns related to Infection Control Practices. Identified concerns will be immediately addressed. **4)How the corrective actions will be monitored:** The responsible party for this plan of correction is the Director of Nursing /Infection Preventionist with Executive Director oversight**.** The results of audits will be reviewed in Quality Assurance Meeting monthly for 6 months or	

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			until 100% compliance is achieved x3 consecutive months (post daily 6-week visual rounding) The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5)Date of compliance: 1/7/22**	