STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155651	A. BUILDING 00 B. WING	01/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOMEVIEW CENTER OF FRANKLIN	651 SOUTH STATE STREET FRANKLIN, IN 46131

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: January 23, 24, 25, 26, and 27, 2023 Facility number: 000353 Provider number: 155651 AIM number: 100291330 Census Bed Type: SNF/NF: 110 Total: 110 Census Payor Type: Medicare: 4 Medicaid: 64 Other: 42 Total: 110 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 1, 2023.	F 0000	**The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. The plan of correction is provided as evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk review for compliance.**	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or			

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

Mark Gavorski | Administrator | 02/14/2023

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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	enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed ensure residents were treated with dignity for 1 of 32 residents reviewed. Staff failed to acknowledge a resident while providing care and failed to inform the resident of the placement of the call light. (Resident 165) Finding includes:	F 0550	The facility will ensure this requirement is met through the following corrective measures: 1. Resident 165 was unharmed. Once informed, the facility ensured her call light was in reach and that she understands where it is. 2. All residents have the potential to be affected. Rounds were	02/17/2023

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	On 1/24/23 at 9:05 a.m., Resident 165 was observed in her room. Resident 165 was sitting in her wheel chair that was in between the bed and the wall. Resident 165's call light was observed attached to the bed and behind the resident and out of the residents view. During an interview at that time, Resident 165 indicated she was not sure where her call light was. Resident 165 was observed to look for the call light. The call light was observed to be out of the residents reach. During an interview on 1/24/23 at 9:11 a.m., Nurses Aide (NA) 3 indicated Resident 165 should have had her call light in reach. Observed NA 3 provide the call light to the resident. NA 3 placed the call light on the bed on the right side of the wheel chair. No interaction by NA 3 to the resident was observed. NA 3 was not observed to communicate to the resident where the call light was placed. During an interview on 1/24/23, at 9:20 a.m., Resident 165 indicated she did not know where NA 3 had placed the call light. Resident 165 was observed looking for the call light on the left side of the wheel chair. The clinical record for Resident 165 was reviewed on 1/24/23 at 10:00 a.m. The diagnoses included, but were not limited to, unsteadiness on feet and cognitive communication deficit. An Admission Minimum Data Set (MDS) assessment, dated 1/20/23, indicated Resident 165 was cognitively intact. A Plan of Care History, dated January 2023, indicated Resident 165 required one person physical assist for all Activities of Daily Living.		made to ensure all residents' call lights were within reach and, if able to understand, that they were told where it is located. NA 3 was re-educated on resident rights and the call light use policy. 3. The policies on Resident Rights and Call Light Use were reviewed and no changes are indicated. Facility staff will be re-educated on these policies. The DON or her designee will make rounds twice daily, 7 days a week at varying times, to ensure call lights are within reach and observe staff interactions to ensure residents are acknowledged. These rounds will continue for 6 weeks and until 100% compliance is achieved, then be conducted 3 times a week for 6 months and until 100% compliance is maintained. 4. The findings for these audits will be presented during the facility's monthly QAPI meetings and the plan of action will be adjusted accordingly.	

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	During an interview on 1/27/23 at 8:45 a.m., the Director of Nursing (DON) indicated the call light should have been in reach. The DON also indicated NA 3 should have addressed the resident by name and communicated the placement of the call light. On 1/27/23 at 9:17 a.m., the DON provided a policy titled Resident Rights, undated, and indicated it was the current policy being used by the facility. A review of the policy indicated, "Basic rights: You have the right to be treated with respect and dignity in recognition of your individuality and preferences." 3.1-3(a)			
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, record review, and interview, the facility failed to ensure a call light was in the reach of a resident for 1 of 32 residents reviewed. (Resident 165) Finding includes: On 1/24/23 at 9:05 a.m., Resident 165 was observed in her room. Resident 165 was in her wheel chair watching television. The wheel chair was in between the bed and the wall. Resident 165's call light was observed attached to the bed and behind the resident and out of the residents view. During an interview at that time, Resident	F 0558	The facility will ensure this requirement is met through the following corrective measures: 1. Resident 165 was unharmed. Once informed, the facility ensured her call light was in reach and that she understands where it is. 2. All residents have the potential to be affected. Rounds were made to ensure all residents' call lights were within reach and, if able to understand, that they were told where it is located. NA 3 was	02/17/2023

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	165 indicated she was not sure where her call light was. Resident 165 was observed to look for the call light. The call light was observed to be out of the residents reach. During an interview on 1/24/23 at 9:11 a.m., Nurses Aide (NA) 3 indicated Resident 165 should have had her call light in reach. Observed NA 3 provide the call light to the resident. NA 3 placed the call light on the bed on the right side of the wheel chair. No interaction by the NA to the resident was observed. NA 3 was not observed to communicate to the resident where the call light was placed. During an interview, on 1/24/23 at 9:20 a.m., Resident 165 indicated she did not know where NA 3 had placed the call light. At that time, Resident 165 was observed looking for the call light on the left side of the wheel chair. The clinical record for Resident 165 was reviewed on 1/24/23 at 10:00 a.m. The diagnoses included, but were not limited to, unsteadiness on feet and cognitive communication deficit. An Admission Minimum Data Set (MDS) assessment, dated 1/20/23, indicated Resident 165 was cognitively intact. A Plan of Care History, dated January 2023, indicated Resident 165 required one person physical assist for all Activities of Daily Living. During an interview, on 1/27/23 at 8:45 a.m., the Director of Nursing (DON) indicated the call light should have been in reach for Resident 165. The DON also indicated NA 3 should have communicated the placement of the call light.		re-educated on resident rights and the call light use policy. 3. The policies on Resident Rights and Call Light Use were reviewed and no changes are indicated. Facility staff will be re-educated on these policies. The DON or her designee will make rounds twice daily, 7 days a week at varying times, to ensure call lights are within reach and observe staff interactions to ensure residents are acknowledged. These rounds will continue for 6 weeks and until 100% compliance is achieved, then be conducted 3 times a week for 6 months and until 100% compliance is maintained. 4. The findings for these audits will be presented during the facility's monthly QAPI meetings and the plan of action will be adjusted accordingly.	

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	On 1/27/23 at 9:17 a.m., the DON provided a policy titled Resident Call System, dated October 2022, and indicated it was the current policy being used by the facility. A review of the policy indicated, "All residents will be instructed in the use of the call light system...The call light should be within reach of the resident." 3.1-3(v)(1)			
F 0801 SS=F Bldg. 00	483.60(a)(1)(2) Qualified Dietary Staff §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or			

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	nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1,			

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	2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. Based on observation, interview, and record review, the facility failed to ensure a staff member working as the Director of Dining and Nutrition Services (Dietary Manager) had a valid and active CDM (Certified Dietary Manager) certification. This had the potential to affect 110 of 110 residents residing in the facility who received food from the kitchen. Finding includes: On 1/27/23 at 8:30 a.m., the personnel file for the Director of Dining and Nutrition Services (Dietary Manager) was reviewed. The following documents were reviewed: -The Director of Dining and Nutrition Services job description indicated, "...has the authority and responsibility for assuring that established policies are carried out...regulatory compliant...the Department shall be directed on a full time basis by an individual who, by education or specialized training and experience...assuring that State/Federal regulations, specific to dining and nutrition, are met...managing food production and service, using safe, sanitary and efficient principles...managing and directing all employees	F 0801	The facility will ensure this requirement is met through the following corrective measures: 1. No residents were harmed. 2. All residents have the potential to be affected. See below for corrective actions. 3. A policy was written on the Director of Dining Services-qualifications. The HFA was educated on this policy. The current Dietary Manager is enrolled in the CDM course currently and will be completed in 12 months. The Assistant Dietary Manager has several years experience as a manager in SNF kitchens and has her Safe Serve Certificate. She currently manages the kitchen while the Manager completes the required paperwork and ordering and will continue to do so. The Dietician will visit the facility at least once a week and more frequently, if needed. She or her designee will also be available at all times as needed. The HFA or his designee	02/17/2023

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	of the Dining and Nutrition Services department, including hiring, training, and evaluation...must meet...criteria as defined by federal regulation...a certified dietary manager or certified food service manager..." The document was signed by the staff member on 9/5/21. -The Job Description Performance Management System (JDPMS) Signature Sheet indicated, "Director of Dining and Nutrition Services...I have read and received a copy of the Job Description and Performance Management System for the position..." The document was signed by the staff member on 9/5/21. The record lacked supporting documentation that the Director of Dining and Nutrition Services had successfully completed and received the required Certified Dietary Manager certification. The record also lacked supporting documentation that at least two years of working experience as a Dietary Manager had been fulfilled. During an interview on 1/27/23 at 8:42 a.m., the Administrator (ADM) indicated the Director of Dining and Nutrition Services was hired in 2016 as a cook. In September of 2021, the staff member was promoted to the Director of Dining and Nutrition Services position. On 1/27/23, the staff member enrolled and had not yet begun the "Become a Certified Dietary Manager" online course. The ADM indicated the Registered Dietician visited the facility weekly on Mondays. During an interview on 1/27/23 at 1:48 p.m., the Director of Dining and Nutrition Services indicated he was hired at the facility in 2016 as a cook and was promoted on 9/5/21 to the Director of Dining and Nutrition Services position. He enrolled into the Certified Dietary Manager online		will meet with the Dietary Manager weekly to discuss and review progress towards completion of his CDM and any issues which may require dietician oversight or review. These meetings will continue weekly until completion of the course. 4. The findings of these reviews will be presented during the facility's monthly QAPI meetings and the plan of action adjusted as indicated.	

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	course "today" (1/27/23). He indicated, "previously the staff member just hadn't had time to enroll in the course." The Director of Dining and Nutrition Service job responsibilities included all aspects of the kitchen, food service, and staff supervision to ensure all regulations were met. During an interview on 1/27/23 at 1:52 p.m., the ADM indicated the facility lacked a policy regarding the Director of Dining and Nutrition Services job specific education or certification requirements. The lack of a Certified Dietary Manager resulted in a lack of direct dietary staff supervision. Cross reference F812. On 1/25/23 at 3:30 p.m., a review of the Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24, effective November 13, 2004, indicated, "...the person-in-charge shall demonstrate this knowledge...having a certified food employee who has shown proficiency of required information through passing a test that is of an accredited program...food employees shall wear hair restraints such as...hair coverings or nets...that are designed and worn to wear effectively keep their hair from contacting...exposed food..." 3.1-20(c)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by			

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	federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to serve food in a sanitary manner during 4 of 4 observations where staff's hair was uncovered potentially affecting 110 of 110 residents residing in the facility who received food from the kitchen. (Cook 2, Cook 6) Findings includes: 1. During the initial kitchen tour, on 1/23/23 from 9:00 a.m. to 9:25 a.m., observed Cook 2 walking through out the kitchen area where the noon meal was being prepared. Cook 2 was observed labeling food containers for the noon meal. Cook 2 had multiple loose hairs, approximately 4 inches in length, hanging below the neckline that were observed to not be covered. 2. During a follow-up kitchen tour, on 1/23/23 from 11:10 a.m. to 11:30 a.m., observed Cook 2 walking through out the kitchen area where the noon meal was being prepared and observed walking near	F 0812	The facility will ensure this requirement is met through the following corrective measures: 1. No residents were harmed. Cook 2 and Cook 6 were both re-educated on the policy related to hair coverings. 2. All residents have the potential to be affected. See below for corrective measures: 3. The policy related to Hair Coverings were reviewed and no changes were indicated. Dietary staff will be re-educated on this policy. The HFA or his designee will observe one meal, varying times and days 4 times weekly for 6 weeks to ensure hair is secured and covered accordingly and until 100% compliance is achieved, then weekly for 6 months and until 100% compliance is maintained. 4. The findings of these audits will	02/17/2023

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	the steamtable where the noon meal foods were being held. Cook 2 was observed making a lettuce and tomato sandwich for a resident. Cook 2 had multiple loose hairs, approximately 4 inches in length, hanging below the neckline that were observed to not be covered. 3. During a follow-up kitchen tour, on 1/23/23 from 12:35 p.m. to 12:49 p.m., observed Cook 2 standing at the steamtable plating the resident's noon meal. Cook 2 had multiple loose hairs, approximately 4 inches in length, hanging below the neckline that were observed to not be covered. 4. During a follow-up kitchen tour, on 1/27/23 from 1:30 p.m. to 1:40 p.m., observed Cook 6 at the food preparation table preparing stuffing for the evening meal. Cook 6 was wearing a white hair net that covered the hair located above the ears to the top of her head. The hair located from the ears to the neckline was observed to not be covered. Cook 6 had multiple loose hairs, approximately 4 inches in length, that hung below the neckline that were observed to not be covered. During an interview on 1/23/23 at 9:15 a.m., the Administrator indicated the current facility census was 110. During an interview on 1/23/23 at 12:55 p.m., the Assistant Dietary Manager indicated all staff hair was to be covered while in the kitchen. All residents residing in the facility received food from the kitchen. On 1/26/23 at 8:55 a.m., the Administrator provided a copy of the Personal Hygiene and Jewelry policy, dated June 2021, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...employees of		be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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(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
	the Dining and Nutrition Services Department will be expected to maintain proper personal hygiene, in compliance with the state sanitation code and follow the facility uniform policy when on duty...all employees...must wear hair restraints (hairnet, hat...) when they are in the department to prevent hair from contacting exposed food..." On 1/25/23 at 3:30 p.m., a review of the Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24, effective November 13, 2004, indicated, "...food employees shall wear hair restraints such as...hair coverings or nets...that are designed and worn to wear effectively keep their hair from contacting...exposed food..." 3.1-21(i)(2) 3.1-21(i)(3)			
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,			

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	155651	A. BUILDING 00 B. WING	01/27/2023

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	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; (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			

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	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 observation, record review, and interview, the facility failed implement infection control practices to prevent the spread of infections for 2 of 4 observations of resident care. Handwashing was not complete. (LPN 5, CNA 4) Findings include: 1. During an observation of wound care on 1/24/23 at 10:00 a.m., Licensed Practical Nurse (LPN) 5 was observed to perform hand hygiene for 10 seconds before completing a treatment order for Resident 165's pressure ulcer. Licensed Practical Nurse (LPN) 5 was observed to perform hand hygiene for 10 seconds after completing the treatment. During an interview on 1/26/23 at 9:55 a.m., the Infection Preventionist (IP) indicated LPN 5 should have washed her hands for at least 20 seconds before and after wound care. 2. During a catheter care observation, on 1/25/23 at 11:20 a.m., observed Certified Nursing Assistant (CNA) 4 perform hand hygiene for 10 seconds prior to providing catheter care for Resident 107. Observed CNA 4 perform hand hygiene for 10 seconds after the providing catheter care for Resident 107.	F 0880	DIRECTED PLAN OF CORRECTION CAN BE VIEWED FOLLOWING THE REQUIRED PLAN OF CORRECTION BELOW: The facility will ensure this requirement will be met through the following corrective measures: 1. Residents 165 and 107 were not harmed. LPN 5 and CNA 4 were re-educated on handwashing. 2. All residents have the potential to be affected. See below for corrective actions. 3. The Hand Hygiene policy was reviewed and no changes are indicated. Facility staff will be re-educated on this policy, to include return demonstrations. The IP or her designee will observe a minimum of 2 staff members daily, on varying shifts, 7 days a week. These handwashing observations will continue for 6 weeks and until 100% compliance is achieved, then 5 per week for six months and until 100% compliance is maintained. 4. The findings of these observations will be presented	02/17/2023

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	During an interview on 1/26/23 at 9:55 a.m., the IP indicated CNA 4 should have washed her hands for a at least 20 seconds before and after catheter care. The IP provided a document, titled Hand Hygiene: and indicated it was the current procedure used by the facility. The procedure indicated, "Why, How and When, dated June 2021, indicated "Duration of the entire procedure: 20-30 seconds." On 1/26/23 at 12:15 p.m., the IP provided a policy titled, Catheter Use and Care, dated July, 2018, and indicated it was the current policy being used by the facility. A review of the policy indicated "Procedure: Perform hand hygiene and put on clean gloves." On 1/26/23 at 12:15 p.m., the IP provided a policy titled, Hand Washing, revised 6/2021, and indicated it was the current policy being used by the facility. A review of the policy indicated "Policy: to ensure proper hand washing before and after procedures and/or resident care to prevent the spread of infection. Procedure: Refer to who "Hand Hygiene: why, how and when of the patient safety packet." 3.1-18(b)(1)		during the facility's monthly QAPI meetings and the plan of action adjusted accordingly. **DIRECTED PLAN OF CORRECTION & ROOT CAUSE ANALYSIS** Homeview Health and Rehabilitation 651 S. State St Franklin, IN 46131 Survey Date January 27, 2023 Survey Event ID IEKH11 Deficiency F 880 The facility failed to properly prevent and/or contain the potential spread of infection by 2 staff members during the provision of direct care. **ROOT CAUSE ANALYSIS** Finding: 2 staff not performing hand hygiene for at least 20 seconds after completing direct resident care. What: A nurse was observed washing hands prior to completion of a wound treatment and was observed washing for less than 20 seconds. A CNA was observed washing her hands prior to providing catheter care and did not was for 20 seconds. Why: Both felt confident they had performed hand hygiene for at least the required 20 seconds. Immediate corrective action: CNA's were re-educated on the appropriate length of time to perform hand hygiene with return	

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			demonstration. **Corrective measures** Reeducation and inservices with staff including: Hand hygiene Summary: Root cause analysis determined the need for daily observations and continual re-education by the IP and facility administration. Continued non-compliance will result in disciplinary action and possible termination to protect residents and staff. Competencies on hand hygiene to be completed with nursing staff which include return demonstrations. Daily rounding, varying shifts and with at least 2 staff members observed, will be conducted by the IP or designee using the Hand Hygiene Monitoring tool to continue for a period of six weeks and until 100% compliance is achieved then two times weekly for a period of at least 6 months and 100% compliance is maintained to be determined by the QAPI Committee. The Facility LTC infection control self-assessment was reviewed with the regional IP it was agreed that it is an accurate assessment of the facility. Survey findings, root cause analysis reviewed with regional IP, Medical Director, Administrator, facility IP, and Director of Clinical Services. The plan of action was	

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			agreed upon.	