STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SETTLERS PLACE	3304 MONROE ST LA PORTE, IN 46350

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey date: March 4, 2019. Facility number: 004458 Residential Census: 38 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 3/8/19.	R 0000	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	
R 0044 Bldg. 00	410 IAC 16.2-5-1.2(r)(1-5) Residents' Right - Deficiency (r) The transfer and discharge rights of residents of a facility are as follows: (1) As used in this section, " interfacility transfer and discharge " means the movement of a resident to a bed outside of the licensed facility. (2) As used in this section, " intrafacility transfer " means the movement of a resident			

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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	to a bed within the same licensed facility. (3) When a transfer or discharge of a resident is proposed, whether intrafacility or interfacility, provision for continuity of care shall be provided by the facility. (4) Health facilities must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless: (A) the transfer or discharge is necessary for the resident ' s welfare and the resident ' s needs cannot be met in the facility; (B) the transfer or discharge is appropriate because the resident ' s health has improved sufficiently so that the resident no longer needs the services provided by the facility; (C) the safety of individuals in the facility is endangered; (D) the health of individuals in the facility would otherwise be endangered; (E) the resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility; or (F) the facility ceases to operate. (5) When the facility proposes to transfer or discharge a resident under any of the circumstances specified in subdivision (4)(A), (4)(B), (4)(C), (4)(D), or (4)(E), the resident ' s clinical records must be documented. The documentation must be made by the following: (A) The resident ' s physician when transfer or discharge is necessary under subdivision (4)(A) or (4)(B). (B) Any physician when transfer or discharge is necessary under subdivision (4)(D). Based on record review and interview, the facility failed to ensure discharge instructions were provided at the time of discharge to provide continuity of care for 1 of 1 closed records	R 0044	1.Record for resident 4 was closed 2/24/2019 and no further changes can be made to it. 2.Current residents have the	04/18/2019

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	reviewed. (Resident 4) Finding includes: The closed record for Resident 4 was reviewed on 3/4/19 at 1:27 p.m. Diagnoses included, but were not limited to, diabetes type 2, hypothyroidism, asthma, glaucoma, and atrial fibrillation. The resident was discharged home on 2/24/19. There were no discharge instructions available for review. Interview with the Care Services Manager on 3/4/18 at 2:40 p.m., indicated there was no copy of the resident's discharge instructions available for review.		potential to be affected by this alleged deficient practice. Indiana State Notice of Discharge/Transfer in place and community specific transfer form being initiated for discharges to provide continuity of care. 3.Care staff in-serviced on 3/5/2019 and 3/21/2019 by CSM on the use of transfer form for residents being discharged. CSM or designee will audit charts after discharge. 4.CSM is responsible for sustained compliance. CSM or designee will audit resident records who have been discharged weekly for 4 weeks then monthly for 3 months and then after each individual discharge ongoing. Discharge reports to be reviewed at monthly QI meetings for 6 months. On-going QI review will be based on 6 months of sustained compliance. 5.Completion date : April 18 2019	
R 0045 Bldg. 00	410 IAC 16.2-5-1.2(r)(6-9) Residents' Rights - Deficiency (6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a			

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	copy to the following: (i) The resident. (ii) A family member of the resident if known. (iii) The resident ' s legal representative if known. (iv) The local long term care ombudsman program (for involuntary relocations or discharges only). (v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility. (vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions. (vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F). (B) Record the reasons in the resident ' s clinical record. (C) Include in the notice the items described in subdivision (9). (7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged. (8) Notice may be made as soon as practicable before transfer or discharge when: (A) the safety of individuals in the facility would be endangered; (B) the health of individuals in the facility would be endangered; (C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge; (D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or			

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	(E) a resident has not resided in the facility for thirty (30) days. (9) For health facilities, the written notice specified in subdivision (7) must include the following: (A) The reason for transfer or discharge. (B) The effective date of transfer or discharge. (C) The location to which the resident is transferred or discharged. (D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " . (E) The name of the director and the address, telephone number, and hours of operation of the division. (F) A hearing request form prescribed by the department. (G) The name, address, and telephone number of the state and local long term care ombudsman. (H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and			

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	telephone number of the protection and advocacy services commission. Based on record review and interview, the facility failed to ensure each resident who was transferred and/ or discharged from the facility received, in writing, the reason for the transfer and information regarding the Ombudsman, State agency, and appeal process for 1 of 2 closed records reviewed. (Resident 4) Finding includes: The closed record for Resident 4 was reviewed on 3/4/19 at 1:27 p.m. Diagnoses included, but were not limited to, diabetes type 2, hypothyroidism, asthma, glaucoma, and atrial fibrillation. Nurse's notes, dated 12/22/18 at 10:00 a.m., indicated the resident was complaining of seeing colors and painted flowers on the wall. The resident refused to eat breakfast and became agitated. The resident's daughter was notified of the change in condition. At 11:00 a.m., the resident continued to see the objects on the wall and the different colors. The nurse informed the daughter, who was in the facility, her mother would be transferred to the hospital. There was lack of documentation of a completed transfer form with the reason of the transfer, the rights of the resident, and information for the local Ombudsman, State Agency, and the appeal process. Nurse's notes, dated 1/29/19 at 8:30 p.m., indicated the resident was confused, called the police and sent them to her daughter's house. The resident's blood pressure was 176/93 at that time. She was sent to the hospital.	R 0045	1.Record for resident 4 was closed 2/24/2019 and no further changes can be made to it. 2. Current residents have the potential to be affected by this alleged deficient practice. Indiana State Notice of Discharge/Transfer in place and community specific transfer form being initiated for discharges to provide continuity of care. 3.Care staff in-serviced on 3/5/2019 and 3/21/2019 by CSM on the use of transfer form for residents being discharged. CSM or designee will audit charts after discharge. 4.CSM is responsible for sustained compliance. CSM or designee will audit resident records who have been discharged weekly for 4 weeks then monthly for 3 months and then after each individual discharge ongoing. Discharge audits to be reviewed at monthly QI meetings for 6 months. On-going QI review will be based on 6 months of sustained compliance. 5.Completion date : April 18 2019	04/18/2019

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	A facility transfer form was completed with an attached state form which provided the information of where the resident was being transferred to and the reason. There was lack of documentation the state transfer form was provided in writing to the resident's daughter. Interview with the Care Services Manager on 3/4/19 at 2:40 p.m., indicated she was unaware they had to send the state transfer form to the resident's family.			
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to keep the residents' environment clean and in good repair related to marred, scuffed, and gouged walls, doors and door frames, dirty and stained carpet, a dirty ceiling vent and a discolored sink bowl for 1 of 1 libraries and 1 of 1 floors. (The Library and the First Floor.) Findings include: During the Environmental tour with the Maintenance Technician (MT) on 3/4/19 at 2:45 p.m., the following was observed: 1. The Library a. The carpet was dirty and stained. b. The ceiling vent above the sofa had an accumulation of dust and debris. 2. The First Floor	R 0144	1.Maintenance Tech was in-serviced on 3/14/2019 by the Executive Director on making rounds to insure the environment is clean and in good repair 2.Current residents have the potential to be affected by this alleged deficient practice. 3.Maintenance Tech to make weekly rounds and designate a minimum of one day a week to touch up walls, doors and door frames, stained carpet and to clean vents. Rounding check list created and areas in need of cleaning or repair reviewed with ED to ensure compliance. 4.ED is responsible for sustained compliance. Maintenance technician or designee to round and monitor weekly for 3 months, then	04/18/2019

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	a. Room 104, the bathroom door frame was gouged and marred. One resident resided in the room. b. Room 108, the carpet was dirty and stained. The bathroom sink bowl was discolored and the door frame was gouged and marred. One resident resided in the room and used the bathroom. c. Room 124, the apartment door was marred and scuffed. One resident resided in the room. d. Room 130, the apartment door was marred and scuffed. One resident resided in the room. e. Room 137, the bathroom door frame was gouged and marred. Two residents shared the room. f. The carpet at the entryway and in the resident common area was dirty and stained. Interview at the time with the MT indicated the above was in need of cleaning and/or repair.		bi-weekly for 3 months then monthly thereafter. Audits will be reviewed for compliance at monthly Safety Committee meeting for 6 months. On-going review will be based on 6 months of sustained compliance. 5.Completion date : April 18 2019	
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation and interview, the facility failed to ensure kitchen areas were clean related to dirty pipes, drains, walls, and the dish machine for 1 of 1 kitchens. (The Main Kitchen) Findings include:	R 0154	1.Dietary Manager was in-serviced on 3/5/2019 by ED Safe Food Handling Policy and utilizing cleaning schedule on a regular basis, and storing food properly. Deep cleaning of the kitchen was initiated on 3/6/2019.	04/18/2019

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	1. On 3/4/19 at 9:05 a.m., during the Full Kitchen Tour with the Dietary Manager (DM), the following was observed: a. There was a heavy accumulation of dried food spillage on the back splash behind the dish machine. b. The white pvc pipes and floor drain under the dish machine and 3 compartment sink were dirty. c. There was a heavy accumulation of grease and dust balls on top of the dish machine. d. There was a large amount of grease and dirt noted on the exhaust fan above the dish machine. e. There was a large amount of dirt, food crumbs, and plastic wrappers along the baseboard behind the ice machine. Interview at that time with the DM indicated all of the above was in need of cleaning.		2.Current residents have the potential to be affected by this alleged deficient practice. 3.In-service provided dietary staff on 3/7/2019 by Sheree Ledwell, Consultant Dietician, on proper glove and utensil usage when serving food and usage and following/sign off on cleaning schedule. Ecolab has been contacted to provide best practices and in-servicing on cleaning chemical usage and processes. 4.Dietary manager responsible for sustained compliance. Executive Director or designee to audit cleaning checklist signed offs and spot check kitchen 5 out of 7 days for 3 weeks then twice a week for 6 weeks then bi-weekly for 4 weeks. Audits will be reviewed for compliance at monthly Safety Committee meeting for 6 months. On-going review will be based on 6 months of sustained compliance. 5.Completion date : April 18 2019	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.			

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	Based on observation, record review, and interview, the facility failed to ensure medications were given as ordered for 1 of 5 residents observed during medication administration. (Resident 11) Finding includes: On 3/4/19 at 8:22 a.m., LPN 1 was observed preparing medications for Resident 11. The LPN placed a 25 milligram (mg) tablet of Atenolol (a medication used to treat high blood pressure and chest pain) into the medication cup. The label on the medication bottle indicated the resident was to receive a half tablet of Atenolol. The LPN proceeded to add six other pills to the medication cup. She then locked the medication cart and started to leave the medication room. At that time, the LPN was asked to check the Physician's order for the Atenolol. The LPN looked at the Medication Administration Record (MAR) and indicated the resident should have received a half tablet of the Atenolol. The LPN proceeded to remove the Atenolol from the medication cup and cut it in half. The record for Resident 11 was reviewed on 3/4/19 at 12:28 p.m. Diagnoses included, but were not limited to, memory impaired, falls, hearing loss, hypertension and pacemaker. A Physician's order, dated 9/30/18, indicated the resident was to receive Atenolol 25 mg, give 1/2 tablet daily. Interview with the Care Services Manager on 3/4/19 at 9:00 a.m., indicated the resident should receive a half tablet of Atenolol rather than a whole tablet.	R 0241	1.Resident 11's medications and MAR audited on 3/4/2019 CSM to make ensure pills were scored and that appropriate milligram dosage was in the bottle and that medication matched the order. 2.Current residents have the potential to be affected by this alleged deficient practice. Audit was completed on 3/5/2019, audit results indicated no other residents were effected. 3.MAR/cart audit completed on 3/5/2019 by CSM to insure accuracy of medications and orders. LPN's and QMA's in-serviced on 3/5/2019 by CSM on appropriate medication pass. 4.CSM is responsible for sustained compliance. MAR/cart audits to be completed by CSM or designee weekly on-going. Medication pass audits to be completed on LPNs and QMA quarterly on-going. Audit outcomes to be reviewed monthly at QI meeting for 6 months. Continued review will be based on 6 months of sustained compliance. 5.Completion date : April 18 2019	04/18/2019

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R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure food was served under sanitary conditions related to using gloves to touch food, greasy/dirty oven hood, stove, oven, and griddle, accumulation of food crumbs on freezer shelves, dirty cupboard shelves, transportation carts and ceiling vents, and stored cases of juice on the floor in the pantry for 1 of 1 kitchens. (The Main Kitchen) Findings include: On 3/4/19 at 9:05 a.m., during the Full Kitchen Tour with the Dietary Manager (DM), the following was observed: a. There was a large amount of dried food and dirt on 2 food transportation carts. b. There was no lid on the garbage can in the dish room. c. The shelves which housed the spices and the clean pans were dirty and sticky to the touch. d. The microwave oven was dirty with dried food noted on the inside. e. The oven hood slats were dirty and greasy. f. There was a heavy accumulation of grease and dried food on the griddle and the stove grates.	R 0273	1.Dietary Manager was in-serviced on 3/5/2019 by ED Safe Food Handling Policy and utilizing cleaning schedule on a regular basis, and storing food properly. Items stored on the floor were removed from the floor. Deep cleaning of the kitchen was initiated on 3/6/2019. 2.Current residents have the potential to be affected by this alleged deficient practice. 3.In-service provided dietary staff on 3/7/2019 by Sheree Ledwell, Consultant Dietician, on proper glove and utensil usage when serving food and usage and following/sign off on cleaning schedule. Ecolab has been contacted to provide best practices and in-servicing on cleaning chemical usage and processes. 4.Dietary manager responsible for sustained compliance. Executive Director or designee to audit cleaning checklist signed offs and spot check kitchen 5 out of 7 days for 3 weeks then twice a week for 6 weeks then bi-weekly for 4 weeks. Audits will be reviewed for compliance at monthly Safety Committee	04/18/2019

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	g. There was a heavy accumulation of burned food on the bottom of the oven. h. There was uncontained frozen food noted on the shelves in both freezers. i. The outside of the cooler and freezer doors were dirty and sticky to the touch. j. There was a heavy accumulation of dust and dirt on 2 ceiling vents located directly above the stove. k. There were 5 cases of juice, 2 roaster pans, and 5 boxes of glassware on the floor in the pantry. l. There was a heavy accumulation of food crumbs on the floor and behind the shelves in the pantry. Interview with the DM at that time, indicated all of the above was in need of cleaning. 2. On 3/4/19 at 12:07 p.m., the Dietary Manager (DM) was observed pouring soup into bowls. At that time, she was wearing clean gloves to both hands. After she had finished with the soup, she removed the gloves and threw them away. She put on oven mitts and removed the pans of roast beef, red potatoes, and the pork chops from the oven. She removed the mitts and donned clean gloves to both hands without performing any type of hand hygiene. The DM began to plate the food for the residents' lunch. She had touched the utensils, plates, pans and trays with the gloved hands. Using the same gloved hands, she picked up the dinner rolls and placed them on the residents' plates. Interview with the DM at that time, indicated she		meeting for 6 months. On-going review will be based on 6 months of sustained compliance. 5.Completion date : April 18 2019	

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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
	was unaware she could not touch the rolls with same pair of gloves she had used to touch everything else. The current 7/1/2014 "Safe Food Handling" policy, provided by the Administrator on 3/4/19 at 1:40 p.m., indicated "During food preparation, food items that will not be cooked before being served to a resident should be handled with utensils or gloved hands."			
R 0274 Bldg. 00	410 IAC 16.2-5-5.1(g)(1-3) Food and Nutritional Services - Noncompliance (g) There shall be an organized food service department directed by a supervisor competent in food service management and knowledgeable in sanitation standards, food handling, food preparation, and meal service. (1) The supervisor must be one (1) of the following: (A) A dietitian. (B) A graduate or student enrolled in and within one (1) year from completing a division approved, minimum ninety (90) hour classroom instruction course that provides classroom instruction in food service supervision who has a minimum of one (1) year of experience in some aspect of institutional food service management. (C) A graduate of a dietetic technician program approved by the American Dietetic Association. (D) A graduate of an accredited college or university or within one (1) year of graduating from an accredited college or university with a degree in foods and nutrition or food administration with a minimum of one (1) year of experience in some aspect of food service management.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/04/2019

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	(E) An individual with training and experience in food service supervision and management. (2) If the supervisor is not a dietitian, a dietitian shall provide consultant services on the premises at peak periods of operation on a regularly scheduled basis. (3) Food service staff shall be on duty to ensure proper food preparation, serving, and sanitation. Based on observation, record review, and interview, the facility failed to use a recipe to prepare a pureed meal for 1 of 1 residents receiving a pureed diet. (Resident 5) Finding includes: 1. On 3/4/19 at 12:29 p.m., the Dietary Manager (DM) was observed preparing pureed red potatoes. She placed a serving and a half of the cooked red potatoes into the food processor and added an unmeasured amount of liquid from the pan in which the red potatoes had cooked. The DM turned on the food processor and blended until smooth. The resident was served the pureed meal. Interview with the DM at that time, indicated she had no recipes for pureed food. She was unaware of the Registered Dietitian's name and how to obtain recipes. The record for Resident 5 was reviewed on 3/4/19 at 10:00 a.m. Diagnoses included, but were not limited, esophageal cancer. A Physician's order, dated 2/22/19, indicated pureed diet. Interview with the Care Services Manager on 3/4/19 at 1:30 p.m., indicated the Administrator	R 0274	1.Dietary Manager was provided with copies of Modified Diet recipes and policy on Altered Consitency of Food and Liquids Policy to be utilized for meal preparation for Resident 5 on 3/5/2019 by Executive Director. 2.Resident's diet orders were audited on 3/14/2019 and no other residents orders for modified diets. 3.Inservice provided to dietary staff on 3/7/2019 by Sheree Ledwell, Consultant Dietician on modified consistency diets 4.Dietary Manager responsible for sustained compliance. Executive Director or designee to observe puree meal is prepared properly at 7 meals a week days for 3 weeks then 3 meals a week for 6 weeks then bi-weekly for 4 weeks. Audits will be reviewed at monthly QI meeting for 6 months. On-going monitoring will be based on 6 months of sustained compliance. 5.Completion date : April 18 2019	04/18/2019

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	had computer access to obtain the pureed recipes.			
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, record review, and interview, the facility failed to ensure handwashing was completed after resident contact for 2 of 5 residents observed for medication administration. (Residents 12 and 13) Finding includes: On 3/4/19 at 8:38 a.m., LPN 1 was observed preparing medications for Resident 12. The LPN placed 3 pills in the medication cup and proceeded to hand them to the resident. The LPN did not wash her hands or use an alcohol based hand gel prior to preparing the medications or after giving them. After giving the resident his medications, the LPN went back to the Medication Room and stared to prepare medications for Resident 13. The LPN placed 2 pills in the medication cup and proceeded to give the resident her medications. Again, the LPN did not wash her hands or use an alcohol based hand gel prior to preparing the medications. Interview with the Care Services Manager (CSM) on 3/4/19 at 9:00 a.m., indicated the LPN should have washed her hands or used an alcohol based hand gel in between each resident contact. The facility policy titled, "Handwashing" was reviewed on 3/4/19 at 2:43 p.m. The policy was provided by the CSM and identified as current.	R 0414	1.LPN was immediately inserviced on 3/4/2019 by CSM on appropriate handwashing techniques. 2.Current residents have the potential to be affected by this alleged deficient practice. 3.Inservice provided by CSM on 3/6/2019 to staff on handwashing policy. 4.ED is responsible for sustained compliance. CSM or designee to conduct weekly observation of medication pass to observe proper handwashing technique for 4 weeks. CSM or designee will do random staff observations during resident care to ensure proper handwashing is being completed. Audits will be reviewed at monthly QI meeting for 6 months. On-going monitoring will be based on 6 months of sustained compliance. 5.Completion date : April 18 2019	04/18/2019

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	The policy indicated, "staff should always thoroughly wash their hands in the following situations: before and after the handling of any medications and/or treatment."			