STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(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		F 0000		

This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00352236, Complaint IN00354248, and Complaint IN00355329.

This visit was done in conjunction with Complaint IN00355484.

Complaint IN00352236 - Substantiated.
Federal/State deficiencies related to the allegations are cited at F677.
Complaint IN00354248 - Substantiated.
Federal/State deficiencies related to the allegations are cited at F684 and F686.
Complaint IN00355329 - Unsubstantiated due to lack of evidence.
Complaint IN00355484 - Substantiated.
Federal/State deficiencies related to the allegations are cited at F677.

Survey dates: June 7, 8, 9, 10, and 11, 2021

Facility number: 000316
Provider number: 155491
AIM number: 100286370

Census Bed Type:
SNF/NF: 71
Total: 71

Census Payor Type:
Medicare: 3
Medicaid: 55
Other: 13
Total: 71

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

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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 21, 2021			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review, the facility failed to ensure residents who were dependent on nursing staff for activities of daily living (ADLs) received incontinent care timely and feeding assistance for 3 of 4 residents reviewed for ADLs. (Resident C, Resident P, and Resident R) Findings include: 1. The clinical record for Resident C was reviewed on 6/10/21 at 6:06 p.m. The diagnoses included, but were not limited to, respiratory failure, obesity and congestive heart failure. An Admission Minimum Data Set (MDS) assessment, dated 5/26/21, noted Resident C to be cognitively intact with extensive staff assistance of two people for bed mobility, toilet use and personal hygiene. Resident C was marked occasionally incontinent of bowel and the use of an indwelling catheter. A progress note, dated 5/26/21, indicated the indwelling catheter was discontinued for Resident C.	F 0677	F677 ADL Care Provided to Dependent Residents 1. Residents C, P and R provided care as needed upon awareness of need. 2. Audit completed to ensure residents received a timely response for ADL needs with no negative findings. 3. Staff re-educated on timely answering of call lights and importance of providing timely ADL care within their scope. 4. DNS or designee to QA audit weekly x 4 weeks then monthly x 4 months to ensure resident ADL needs are met in a timely manner. 5. Date of completion 7.1.21	07/01/2021

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	A care plan for ADLs, revised 6/8/21, indicated the following, "...[name of Resident C] needs assistance with activities of daily living...Interventions...Toileting - staff assist of 2 to assist resident to toilet, ensuring that resident is clean and dry after every toileting episode...BED MOBILITY: Staff assistance of two to assist resident to turn and reposition in bed...." An interview conducted with Resident C, on 6/8/21 at 10:38 a.m., indicated the staff could be quicker at answering call lights. He has to wait over 30 minutes at times for staff to answer his call light. This had resulted in incontinence and he was continent. An interview conducted with Registered Nurse (RN) 6, on 6/11/21 at 12:00 p.m., indicated Resident C did have an indwelling catheter upon admission but it was discontinued. Resident C is continent of bowel and bladder but needs staff assistance to ensure proper placement of either the urinal or bedpan that was utilized. She has not observed Resident C being incontinent while she has cared for him. 2. An observation was conducted of Resident P's call light being on starting on 6/8/21 at 8:56 a.m. Nurse 20 indicated that Resident P was incontinent and needed incontinent care. Nurse 20 was unsure where the Certified Nursing Assistant (CNA) was at that time. Nurse 20 continued to prepare and administer medications to other residents while Resident P's call light was on. Other staff members, Director of Nursing and MDS Coordinator, were observed asking Resident P what he needed, and Nurse 20 responded that he needed incontinent care. Nurse 20 proceeded to prepare and administer medications for the roommate of Resident P on 6/8/21 at 9:02 a.m.,			

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	while reassuring Resident P someone would be in to assist him shortly. There were 2 CNAs, CNA 24 and CNA 26, observed coming from the 800/900 hallway and taking a mechanical lift into another resident's room. After CNA 24 and 26 assisted the resident in the other room they both entered Resident P's room to assist him at 9:26 a.m. Interview conducted with CNA 24 and she indicated herself and CNA 26 were busy on another hallway assisting other residents that needed 2 person staff assistance. The clinical record for Resident P was reviewed on 6/10/21 at 6:01 p.m. The diagnoses included, but was not limited to, cerebral infarction, urinary incontinence, muscle weakness and age-related physical debility. An Annual MDS assessment, dated 5/29/21, indicated Resident P had moderate cognitive impairment and the need for extensive assistance of one staff person for bed mobility, dressing, toilet use and personal hygiene. A care plan for ADLs, revised 8/10/20, indicated the following, "...[name of Resident P] needs assistance with activities of daily living...Interventions...Toileting - staff of one to assist with incontinent care/Toileting, ensuring that resident is clean and dry after every toileting episode...." 3. An observation was conducted of Resident R's room on 6/10/21 at 5:13 p.m. There appeared to be a food tray on the bedside table on the right side of Resident R's bed but not in reach. The silverware was wrapped with a napkin and the lids were still present on the food as well as the 2 beverages located on the food tray. CNA 24 was in the process of passing out dinner trays and			

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	approached Resident R's room. She indicated Resident R needs constant cueing to continue to eat from staff during meals, but she did not feed Resident R lunch. The speech therapy staff fed Resident R his lunch that was still present on his bedside table. An interview conducted with Therapy Staff 11, on 6/11/21 at 12:07 p.m., indicated speech therapy evaluated Resident R on 6/1/21 but no further speech therapy notes were found in Resident R's clinical record. Therapy Staff 11 indicated he conducted physical therapy for Resident R on 6/10/21 but it was in the morning time. He wasn't in Resident R's room during lunch time. The clinical record for Resident R was reviewed on 6/11/21 at 12:25 p.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance, conduct disorder and repeated falls. An Admission MDS assessment, in progress, indicated Resident R needed extensive assistance of 1 staff person for eating and had severe cognitive impairment. A care plan for ADLs, revised 5/28/21, indicted Resident R needed one staff person assistance at mealtimes by setting up tray, opening cartons and packages, cutting meats, encouraging resident to eat and hydrate, and to assist resident with feeding if and when necessary. A document titled "Response History", dated 6/11/21, was indicative of meal consumptions documented for Resident R. There was no documentation of Resident R consuming lunch on 6/10/21. There were no progress notes, dated 6/10/21, that			

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	indicated Resident R refused any meals. A policy titled "Activities of Daily Living", revised March of 2018, was provided by the Director of Nursing on 6/10/21 at 6:30 p.m. The policy indicated the following, "...Residents will provided [sic] with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living [ADLs]. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene...2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident in accordance with the plan of care, including appropriate support and assistance with...a. Hygiene [bathing, dressing, grooming, and oral care]...c. Elimination [toileting]...d. Dining [meals and snacks]...." This Federal tag relates to Complaint lN00352236 and Complaint IN00355484. 3.1-38(a)(3)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility	F 0684	F684 Quality of Care 1. Resident D assessed with	07/01/2021

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	failed to ensure a treatment was initiated after an open area was identified that resulted in a delay in treatment for 1 of 6 residents reviewed for skin integrity. (Resident D) Findings include: The clinical record for Resident D was reviewed on 6/9/21 at 12:06 p.m. The diagnoses included, but were not limited to, diabetes mellitus, acquired absence of other left toe(s), mild cognitive impairment, osteomyelitis, peripheral vascular disease and muscle weakness. A Quarterly Minimum Data Set (MDS) assessment, dated 4/9/21, indicated moderate cognitive impairment and diabetic ulcer was present. A Quarterly MDS assessment, dated 5/12/21, indicated a diabetic ulcer was still present and Resident D required extensive assistance with bed mobility, dressing, toileting and personal hygiene. A "Skilled Care Nursing Documentation" document, dated 3/16/21, indicated an open area was identified to Resident D's left medial plantar measuring 4 centimeters x 2.8 centimeters x 0.1 centimeters in depth. The area was cleansed with normal saline and covered with a foam dressing. A "Non Pressure Ulcer - Weekly Observation" document, dated 3/18/21, indicated a diabetic ulcer was present to Resident D's left foot plantar. Area was assessed and new treatment order obtained from the Nurse Practitioner. The current treatment plan was skin prep to peri wound and application of medihoney to wound bed and cover with a dry dressing daily and as needed.		no negative findings related to the status of her wound. 2. Audit of current residents with wounds completed to ensure treatment are in place and initiated. 3. Nursing staff re-educated on new order process and timeliness of initiation of orders. 4. DNS or designee to QA audit weekly x 4 weeks then monthly x 4 months to ensure new orders are processed and initiated timely. 5. Dater of completion 7.1.21	

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	A physician order, start date of 3/19/21, indicated the following, "...Cleanse left foot plantar with NS [normal saline]. Skin prep peri wound and apply medi honey [sic] to wound bed, cover with dry dressing and secure with tape. Change daily and prn [as needed]. every day shift for diabetic foot ulcer...." The electronic treatment administration record, dated March of 2021, indicated the following: 3/19/21- blank and indicative of not being completed, 3/20/21- blank and indicative of not being completed, 3/21/21- blank and indicative of not being completed & 3/22/21- signed off as completed. There was no indication a treatment was initiated for the diabetic ulcer initially found on Resident D, on 3/16/21, until 3/19/21 but not completed until 3/22/21. A care plan for skin integrity, revised 6/7/21, indicated the following, "...[name of Resident D] has impaired skin integrity - old amputation of 2 toes of L [left] foot and new amputation of 2 more toes on L foot...Interventions...wound treatment as ordered...." An interview conducted with the Assistant Director of Nursing on 6/11/21 at 2:38 p.m., indicated when an alteration in skin integrity is identified a treatment should be initiated that was appropriate for the skin concern identified. A policy titled "Skin Management", dated October of 2019, was provided by the Director of Nursing on 6/10/21 at 8:40 a.m. The policy			

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	indicated the following, "...Guidelines...8. Any skin alterations noted by direct care givers during daily care and/or shower days must be reported to the licensed nurse for further assessment, to include but not limited to bruises, open areas, redness, skin tears, blisters, and rashes...PROCEDURE FOR ALTERATIONS IN SKIN INTEGRITY...1. Alterations in skin integrity will be reported to the physician/NP [Nurse Practitioner]...2. Treatment order will be obtained...." This Federal tag relates to Complaint IN00354248. 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to include a description of the skin assessment on the wound assessment for 2 of 4 residents reviewed for pressure ulcers. (Residents F and S)	F 0686	F686 Treatment to Prevent/Heal Pressure Ulcers 1. Resident F and Resident S received a comprehensive skin assessment with no negative findings.	07/01/2021

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	Findings included: 1. Resident F's record was reviewed on 6/08/21 at 3:16 p.m. The record indicated Resident F had diagnoses that included, but were not limited to, chronic obstructive pulmonary disease, chronic kidney disease stage 3, dementia with behavioral disturbance, sleep disorders, depression, anxiety, Alzheimer's disease with late onset, diabetes mellitus due to underlying condition with diabetic neuropathy, low back pain, and generalized muscle weakness. A Quarterly Minimum Data Set assessment, 3/29/21, indicated Resident F was severely cognitively impaired, required assistance with all activities of daily living, used a wheelchair, was at risk for developing pressure ulcers, and did not have any pressure ulcers, wounds or skin problems, had moisture associated skin damage, had a pressure reducing device for chair and bed, and had applications of ointments/medications other than to feet. Resident F had a care plan for at risk for skin breakdown with risk factors that included diabetes, impaired mobility, and incontinence. On 6/07/21 at 11:03 a.m., Resident F was observed in bed, the head of his bed was 25 degrees elevated, and his feet were offloaded on pillows. A "Bathtime Skin Anatomy Diagram", dated 6/8/21, indicated Resident F had a full bed bath, and he had "skin areas on buttocks". On 6/10/21 at 11:30 a.m., with CNA 12, Resident F's skin was observed. His heels were clear, and he had reddened, broken skin on his left and right		2. Audit completed on residents with current altered skin integrity to ensure wound evaluations include a description of the wound. 3. Nursing staff re-educated on wound evaluation completion including documentation of a description of the wound. 4. DNS or designee to QA audit weekly x 4 weeks and monthly x 4 months to ensure wound evaluation include a description of the wound. 5. Date of completion 7.1.21	

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	buttocks. CNA 12 indicated he is turned every 2 hours, his heels are kept elevated off the bed, and the nurse applies something to his buttocks. Current physician's orders indicated an order for "Barrier cream to buttocks and peri area every shift and prn (as needed) for prevention", dated 4/13/21. Resident F had weekly skin evaluations that included his heels, but no evaluation was in the clinical record that indicated he had moisture associated skin damage on his buttocks. On 6/11/21 at 1:07 p.m., the Director of Nursing indicated she couldn't find any evaluations for the buttocks, and said he is getting a treatment to his buttocks. 2. Resident S's record was reviewed on 6/09/21 at 9:43 a.m. The record indicated Resident S was admitted on 4/20/21 and discharged on 5/16/21. Resident S had diagnoses that included, but were not limited to, acute and chronic respiratory failure with hypoxia, dysphagia, had a tracheostomy, atrial fibrillation, type 2 diabetes mellitus without complications, congestive heart failure, chronic kidney disease stage 3, high blood pressure, gastro-esophageal reflux disorder, high blood fats, limitation of activities due to disability, anemia, urinary retention, chronic pain syndrome, foot drop, acute myocardial infarction, history of peptic ulcer disease, and gastrointestinal hemorrhage. An Admission Minimum Data Set (MDS) assessment, dated 4/21/21, indicated her cognitive status was not assessed, she required total assist for bed mobility, she was not transferred from bed,			

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	she did not walk, she was one person assist for dressing, totally dependent on 2 for bathing, no impairment in range of motion, had a catheter and was always incontinent of bowels, had a feeding tube, did not have a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device. She was at risk for pressure injuries, has no unhealed pressure ulcers/injuries, had no venous or arterial ulcers, no infections on feet, no diabetic foot ulcers, no open lesions on the foot, and no skin tears, but did have a surgical wound. A Medicare 5 day MDS dated 5/16/21, indicated short and long term memory was ok, she was moderately impaired in cognitive skills for daily decision making, bed mobility was extensive assist of 2 persons, did not walk, had no impairment in range of motion, used a wheelchair, had an indwelling catheter and was always incontinent of bowel, was at risk for pressure ulcers/injuries, had no unhealed pressure ulcers/injuries, and no other wounds. A care plan, dated 4/28/21, indicated: "[Resident S] has episodes of incontinence of bowels. [Resident S] will be free from complications of incontinence Interventions: Assist with routine toileting and as needed. Check routinely for incontinence and provide incontinence care as needed. Observe for signs of urinary tract infection such as foul smelling or discolored urine, painful urination, abdominal or flank pain. Change in mental status or fever. Observe skin during care for redness, irritation or open areas, notify nurse of abnormal findings. Skin check weekly and as needed." A care plan initiated on 4/20/21 and revised on 5/6/21 indicated: "[Resident S] has been admitted			

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	with impaired skin integrity-a reddened bottom, and dry tops of feet, as well as a gastrostomy tube and a tracheostomy tube/ readmitted with open areas on bilateral buttocks. Goals: Tissue injury will heal and be free from complications. Interventions: Assess and document skin condition, notify MD of signs of infection (redness, drainage, pain, fever). Assist with bed mobility to turn and reposition routinely. Assist with toileting. Check for incontinence and provide incontinent care as needed. Notify nurse of any redness or irritation. GTube site care as ordered. Pressure reducing/redistributing mattress on bed. Wound treatment as ordered." A care plan dated 4/20/21 and 4/28/21 indicated: "[Resident S] is at Risk for skin breakdown d/t (due to) multiple serious health conditions, mobility deficits, communication deficits, incontinence of bowel, and hx (history) of osteomyelitis (bone infection) of R foot. Resident will be free from skin breakdown. Interventions: Assist with bed mobility to turn and reposition routinely. Assist with routine toileting. Check for incontinence and provide incontinent care as needed. Notify nurse of any redness or irritation. Preventative skin care as ordered/indicated. Skin inspection weekly and as needed, document and notify MD of abnormal findings." An admission evaluation, dated 4/20/21 indicated she had no identified skin conditions or wounds. A re-admission evaluation dated 4/27/21 indicated she had redness to her buttocks. A Braden scale for predicting pressure sore risk, dated 4/27/21, was 8 which indicated a very high risk.			

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	155491	A. BUILDING 00 B. WING	06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

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	A re-admission evaluation dated 5/5/21 indicated she had right and left buttock excoriation. A Braden scale for predicting pressure risk dated 5/5/21 was 9 which indicated a very high risk. A skin assessment dated 5/14/21 indicated Resident S had wounds on the right and left heel, and right and left buttock with no wound descriptions. A skin assessment dated 5/16/21 indicated resident was alert, unable to determine orientation, she had a wound site on the right and left heel, and on the right and left buttock. The sizes of the wounds were documented, but there was no description of the wounds documented. On 6/11/21 at 1:07 p.m., the Director of Nursing indicated she couldn't find any descriptions for the skin assessments but the resident had been getting a treatment. A policy and procedure for "Skin Management" was provided by the Director of Nursing on 6/10/21 at 8:40 a.m. The policy included, but was not limited to, "Policy: It is the policy of Majestic Care to assess each resident to determine the risk of potential skin integrity impairment. Residents will have a skin assessment completed upon admission and no less than weekly by the licensed nurse in an effort to assess overall skin condition, skin integrity, and skin impairment. Guidelines: Prevention...3. A head to toe assessment will be completed by a licensed nurse upon admission/re-admission and no less weekly...8. Any skin alterations noted by direct care givers during daily care and/or shower days must be reported to the licensed nurse for further assessment, to include but not limited to bruises,			

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	open areas, redness, skin tears, blisters, and rashes. a) The licensed nurse is responsible for assessing any and all skin alterations as reported by the direct caregivers on the shift reported...Procedure for alterations in skin integrity...3. All alterations in skin integrity will be documented in the medical record...4. The wound nurse (licensed nurse assigned responsibility for wounds for the building) will be notified of alterations in skin integrity. a) The facility assigned wound nurse will complete further evaluation of the wounds identified and complete the appropriate skin evaluation on the next business day...." This Federal tag relates to Complaint IN00354248. 3.1-40(a)(1) 3.2-40(b)(2)			
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 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 observation, interview and record review, the facility failed to maintain observation and documentation for 1 of 5 residents reviewed for accidents, following a resident to resident altercation. (Resident 217 and Resident 28) Findings include:	F 0689	F689 Free of Accident Hazards/Supervision/Devices 1. Resident 217 continued to be monitored 1:1 for resident safety. 2. No other residents could be audited as no other residents are requiring 1:1 supervision at this	07/01/2021

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	The clinical record of Resident 217 was reviewed on 6-8-21 at 12:23 p.m. His diagnoses included, but were not limited to, dementia with behavioral disturbance, unspecified psychosis not due to a substance or known physiological condition and insomnia. It indicated Resident 217 had been admitted to the facility less than one week prior and resided on the secured dementia care unit. The Admission Nursing Evaluation for Resident 217, dated 6-4-21, indicated he was alert with memory problems, was unable to communicate his wants and needs, was unable to understand others, had behaviors of wandering, being physically abusive, was resistive to care, takes medications of antidepressants, antipsychotics, hypnotics and mood stabilizers, had no identified skin conditions or wounds, requires physical assistance with ambulation, toileting and bathing, was independent with eating, was incontinent of bowel and bladder, wears incontinence briefs, has a shuffling gait and unsteady balance and had no history of falls prior to admission. Review of a hospitalization initial psychiatric history and physical, dated 5-11-21, indicated, Resident 217 had been diagnosed approximately 10 years ago with dementia and had remained at home with family until "had been getting increasingly aggressive, urinating on himself and has verbalized wanting to harm her [spouse]...She can no longer care for patient at home and is requesting ECF [extended care facility or nursing home] placement after stabilization. Patient was agitated and combative at the ED and had to be medicated with Geodon [a anti-psychotic medication] 10 mg [milligrams] with sub optimal effect...He remained irritable, agitated, unable to follow verbal prompting or command and combative with care on admission to the unit. He		time. 3. Nursing staff re-educated on proper documentation for residents requiring 1:1 monitoring. 4. DNS or designee to QA audit weekly x 4 weeks and monthly x 4 months to ensure any residents requiring 1:1 or other routine monitoring will have completed monitoring documented correctly. 5. Date of completion 7.1.21	

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	is not redirectable and had to be medicated with p.r.n. [as needed] Zyprexa [a anti-psychotic medication] 2.5 mg and Benadryl [a antihistamine medication] 25 mg with good effect..." An ISDH (Indiana State Department of Health) incident report was submitted to ISDH on 6-5-21 of an incident occurring on the same date at 7:40 p.m. in which Resident 217 was alleged to have entered the room of Resident 28 and touched Resident 28 in the vaginal area. The report indicated the family, physician, Director of Nursing (DON) and Administrator were notified of the incident. Orders were received for as needed (prn) anti-anxietymedication and every 15 minute visual observations for Resident 217. A follow-up report, dated 6-10-21, indicated Resident 217 had no further behaviors and Resident 28 had denied the initial allegation of the touching of her vaginal area in a follow-up interview. In an interview with Resident 28 on 6-10-21 at 9:45 a.m., she indicated there had been an incident in the past week in which a male resident entered her room uninvited and grabbed her arms above the wrist. She denied any injury and was scared at the time, but not since. She denied any physical contact between she and the male peer beyond him grabbing her arms and the staff immediately separated them. She indicated she has not seen the male peer since. Review of Resident 217's progress notes indicated the following: -6/5/2021 at 2:30 a.m.: out of bed multiple times this shift, stripping all clothing off, wandering into others rooms naked. Very difficult to redirect. -6/5/2021 at 2:16 p.m.: "Res [resident] has been inappropriate with staff this shift, touching a staff member's breast, wandering in an out of other res			

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	rooms. Res was also observed playing with his privates, in front of a female resident. Res has been difficult to redirect." -6/5/2021 7:38 p.m.: "I was attending with another res when a female res screamed help help. Res was reported to this writer that res had grabbed another female residents private area. This was not visualized by this writer." -6/5/2021 9:12 p.m.: "This writer assured all res and staff was safe and separated from female residents room." -6/6/2021 1:43 p.m.: "Was reported by CNA that res. was on the floor. Found res. in his room setting by his trash can with legs sprawled out and trash can tipped over. Res. was found setting on the trash can earlier in this shift. V/S [vital signs], neuros [neurochecks] wnl. No injuries noted. DON NP [nurse practitioner], [name of spouse] POA [power of attorney] aware." -6/6/2021 4:27 p.m. "Res. remains on 15 min [minute] visuals r/t [related to] previous incident. Res. has been removing his clothing right after staff dresses him numerous times this shift. Unable to re-direct res. from going into other res. rooms naked. Res. has become aggressive hitting staf when re-directing. S.S. [social services] aware and [name of psychiatric services company] to eval [evaluation] on 6/7/21." -6/7/2021 2:48 a.m.: "Resident alert but confused, stripping off clothing, wandering into peers' rooms naked, staff attempted dressing resident but will immediately take them off, including briefs. Resident urinates on the floor both in his room and hallway. Very difficult to redirect, and aggressive when redirected." -6/7/2021 11:07 a.m. "Resident found in recliner in room without clothing on and dried blood on face coming from a laceration to mid forehead. This nurse asked resident how wound happened. Resident could not clearly state how the wound			

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	occurred. cleansed wound with NS [normal saline] and applied steri strips. Neuro check initiated. VS - 148/74, 82hr, 96% ra, 18 resp, 97.7 temp. NP [name of NP] notified. DON [name of DON] notified. POA [name of spouse] notified." -6/7/2021 5:01 p.m.: IDT [Interdisciplinary Team] reviewed and discussed recent behaviors, referral to [name of psychiatric services company] made, resident encouraged to participated [sic] in activities of interest, and to be assessed for ADL needa [sic]." -6/8/2021 5:27 a.m.: "...Resident is currently resting and that staff was still present doing 1:1 [one staff person to one resident observation continuously]." -6/10/2021 10:08 a.m.: "IDT reviewed and discussed N.O's [new orders] for Trazodone 100mg QHS [at each bedtime] for depression and Zyprexa 5mg BID [twice daily] for agitation. Resident has been having physical aggression with care. Resident to be followed by [name of psychiatric services company] 6/10/2021." During an interview with LPN 1 on 6-8-21 at 9:20 a.m., LPN 1 was queried as to if Resident 217 remained on every 15 minute checks and she responded, "I didn't get that information in report, only that he was on neurochecks from a fall over the weekend." In an interview on 6-8-21 at 9:52 a.m., with the Assistanat Director of Nursing, she indicated she was unsure if Resident 217 had an incident over the weekend that was reported to the State of an allegation of sexual abuse towards a female resident. "He was placed on 1:1 at that time. I'm not sure if he is on 1:1 still or 15 minute checks." In an interview on the same date at 10:40 a.m., the ADON confirmed Resident 217 remained on 1:1 observations.			

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Review of the transition from every 15 minute observation to 1:1 observation was identified on the observation documentation form as occurring on 6-7-21 at 8:30 p.m. The transition from every 15 minute observations to 1:1 observation was not documented until a late entry into the clinical record of Resident 217 on 6-11-21.

In an interview with the DON on 6-11-21 at 8:40 a.m., she indicated, "I didn't realize the IDT notes didn't address the every 15 minute or 1:1 monitoring or the reason for it. We made the change to 1:1 due to the fact there had been the sexual abuse allegation and a recent fall and he was still wandering around and we wanted to be cautious [during the IDT meeting on 6-7-21]."

Review of the documentation for the every 15 minute observation documentation and the 1:1 observation documentation indicated the following time frames had no documentation identified:
-6-6-21 from 10:45 p.m. until 6-7-21 at 7:00 a.m., for 8 hours and 15 minutes.
-6-7-21 from 10:45 p.m. until 6-8-21 at 7:00 a.m., for 8 hours and 15 minutes.

In an interview with the DON on 6-11-21 at 8:40 a.m., she indicated, "We did have agency staff that was available to be with him. I have no idea why they didn't write it down."

On 6-11-21 at 1:07 p.m., the DON provided a copy of a policy entitled, "Safety and Supervision of Residents, with a revision date of July, 2017. This policy indicated, " Our facility strives to make the environment as free from accident hazard as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide

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	155491	A. BUILDING 00 B. WING	06/11/2021

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	priorities...The interdisciplinary care team shall analyze information obtained from assessments and observations to identity any specific hazards or risks for individual residents. Implementing interventions to reduce risks and hazards shall include the following: Communicating specific interventions to all relevant staff; Assigning responsibility for carrying out interventions; Providing training, as necessary; Ensuring that interventions are implemented; and; Documenting interventions...The facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment (such as construction) of if there is a change in the resident's condition..." 3.1-45(a)(1) 3.1-45(a)(2)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and			

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	preferences. Based on interview and record review, the facility failed to ensure complete documentation of pre/post dialysis evaluations for 1 of 1 resident reviewed for dialysis. (Resident 33) Findings include: The clinical record for Resident 33 was reviewed on 6/9/21 at 8:42 a.m. The diagnoses included, but were not limited to, hypertensive chronic kidney disease, diabetes mellitus and anemia. A Quarterly Minimum Data Set (MDS) assessment, dated 4/16/21, indicated Resident 33 was cognitively intact and received dialysis. An interview conducted with Resident 33 on 6/7/21 at 11:33 a.m., indicated she goes to dialysis on Monday, Wednesday and Fridays. An interview conducted with Registered Nurse (RN) 6 on 6/10/21 at 4:52 p.m., indicated Resident 33 leaves for dialysis prior to the day shift coming in. The nursing staff are to conduct a pre/post dialysis evaluation that was found on the computer charting. Evaluations titled "Dialysis PRE/POST Communication Record" were reviewed and noted the following assessments with incomplete documentation: 5/28/21- no weight obtained pre dialysis, 5/31/21- no weight obtained pre dialysis, 6/2/21- no weight obtained and/or complete vital signs pre dialysis, 6/4/21- no weight obtained pre dialysis, 6/7/21- no pre/post dialysis evaluation completed	F 0698	F698 Dialysis 1. Resident #33 dialysis Pre/Post forms reviewed for accuracy. 2. Audit completed to ensure that residents who receive dialysis have a complete and accurate Pre and Post dialysis form completed with each Dialysis session completed. 3. Nursing staff re-educated on the accurate completion of Pre and Post Dialysis evaluations. 4. DNS or designee to QA audit weekly x 4 weeks then monthly x 4 to ensure Pre/Post Dialysis forms completed accurately. 5. Date of completion 7.1.21	07/01/2021

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	& 6/9/21- no weight obtained pre dialysis. A nutritional risk care plan, revised 4/15/21, indicated the following, "...potential for nutritional risk related to dx [diagnoses] including ESRD [end stage renal disease] receiving HD [hemodialysis]...Interventions...weights as ordered/indicated...." A dialysis care plan, revised 1/26/21, indicated the following, "...Interventions...Dialysis Days: Monday Wednesday and Friday...observe for symptoms of fluid volume deficit such as...weight loss...observe for symptoms of fluid volume excess such as...weight gain...VITAL SIGNS as ordered/indicated...." An interview conducted with the Assistant Director of Nursing, on 6/11/21 at 2:38 p.m., indicated dialysis residents have a binder and a pre/post evaluation was to be fully completed before and after dialysis. A policy titled "Dialysis Care, revised July of 2020, was provided by the Director of Nursing on 6/9/21 at 2:05 p.m. The policy indicated the following, "...The facility will assure that each resident that requires dialysis services, receives such services that are consistent with the professional standards. Including...Continued assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at an off-site dialysis center...Assessment of resident before, during, and after dialysis treatments...2. For resident's receiving treatment at an off-site facility that following will be completed...Assess and document vital signs upon return...."			

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	155491	A. BUILDING 00 B. WING	06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	3.1-37(a)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure medication carts and medication rooms were free from expired insulin and purified protein derivative (PPD) solution for 1 of 3 medication carts and 1 of 2 medication refrigerators observed. Findings include:	F 0761	F761 Label/Store Drugs and Biologicals 1. Expired insulin pens and expired PPD solution discarded and reordered at the time of awareness. 2. Audit of med carts completed to ensure no other medications or solutions are	07/01/2021

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	155491	A. BUILDING 00 B. WING	06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	1a. An observation conducted of the 600-hallway medication cart with Licensed Practical Nurse 8, on 6/8/21 at 1:45 p.m., noted a Humalog insulin pen with an open date of 4/26/21 for Resident 62 and a Novolog insulin pen with an open date of 4/26/21 for Resident 16. LPN 8 indicated the pharmacy was moving towards utilizing insulin vials instead of insulin pens for the residents. The clinical record for Resident 62 was reviewed on 6/8/21 at 2:00 p.m. The diagnoses included, but were not limited to, diabetes mellitus, vascular dementia and muscle weakness. A physician order, dated 3/20/21, indicated the following, "...Humalog Solution...Inject as per sliding scale...subcutaneously before meals and at bedtime related to TYPE 2 DIABETES MELLITUS...." The electronic medication administration record (EMAR), dated May of 2021, indicated the sliding scale Humalog was administered 5 times after the expiration date of 5/24/21. The EMAR, dated June of 2021, indicated the sliding scale Humalog was administered 13 times from 6/1/21 to 6/7/21. 1b. The clinical record for Resident 16 was reviewed on 6/8/21 at 2:05 p.m. The diagnoses included, but were not limited to, diabetes mellitus, dementia and weakness. A physician order, dated 10/27/20, indicated the following, "...Novolog Solution...Inject as per sliding scale...subcutaneously with meals related to TYPE 2 DIABETES MELLITUS...."		expired. 3. Nursing staff re-educated on insulin expiration dates and PPD solution/ medication vial expiration dates. 4. DNS or designee to QA audit weekly x 4 weeks and monthly x 4 months to ensure facility is free of expired medications/ solutions 5. Date of completion 7.1.21	

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	155491	A. BUILDING 00 B. WING	06/11/2021

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	The EMAR, dated May of 2021, indicated the sliding scale Novolog was administered 9 times after the expiration date of 5/24/21. The EMAR, dated June of 2021, indicated the sliding scale Novolog was administered 3 times from 6/1/21 to 6/7/21. 2. An observation of the medication room off of the 800/900 hallway noted an open vial of Aplisol solution dated 2/28/21. A policy titled "Drug Expiration Dating", revised 1/23/18, was provided by the Director of Nursing on 6/10/21 at 3:18 p.m. The policy indicated the following, "...Aplisol/Tubersol...Expiration Date...28 days from date opened...Insulin - Opened...Default to Manufacturer recommendations...." The manufacture recommendations were for insulin pens to be thrown away 28 days after first use, even if they still contain insulin. 3.1-25(o)			
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 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			

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	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 ensure appropriate hair coverings were worn by 1 of 1 dietary staff with facial hair while working in the kitchen area. Findings include: In an observation on 6-7-21 at 10:12 a.m., Dietary Staff 4 was observed actively running the dishwasher while wearing a surgical mask under his chin, exposing his nose, mouth and full facial beard. Dietary Staff 4 was observed at 10:17 a.m. to place his surgical mask over his nose, mouth and beard. In an observation on 6-7-21 at 3:10 p.m., Dietary Staff 4 was observed to be actively running the dishwasher while wearing a surgical mask under his chin, exposing his nose, mouth and full facial beard. Dietary Staff 4 was observed at 3:16 pm. to place his surgical mask over his nose, mouth and beard. In an observation on 6-10-21 at 2:03 p.m., Dietary Aide 4 was observed actively unloading the dishwasher while wearing a surgical mask under his chin, exposing his nose, mouth and full facial beard. Dietary Staff 4 was observed at 2:11 p.m. to place his surgical mask over his nose, mouth and	F 0812	F812 Food Procurement, Storage/Prepare/Serve-Sanitary 1. Staff #4 re-educated on proper use of PPE and beard coverings. 2. Audit completed of dietary staff to ensure proper use of PPE/ beard coverings in place. 3. Dietary staff re-educated on proper usage of PPE and beard coverings when applicable. 4. DNS or designee to QA audit weekly x 4 weeks then monthly x monthly x 4 months to ensure PPE and beard coverings present and used appropriately. 5. Date of completion 7.1.21	07/01/2021

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	beard. In interview with Dietary Staff 4 at 2:17 p.m., he indicated he was unfamiliar with facial hair requirements for kitchen staff. On 6-11-21 at 1:45 p.m., the Director of Nursing provided an undated copy of a policy entitled, "Preventing Foodborne Illness." This policy indicated, "Culinary Services employees shall follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. All employees who handle, prepare or serve food will be trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents...Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens." 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:			

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	§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; (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.			

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	§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 observation, interview and record review, the facility failed to (A) prevent and/or contain the spread of COVID-19 by failure to wear personal protective equipment (PPE) upon entrance into a room on transmission-based precautions (TBP) for 2 observations, Resident D, and wearing a surgical mask that covered ones' nose and mouth, and (B) failed to ensure facility staff follows current Covid-19 protocols related to correctly wearing facial coverings within the facility. Findings include: 1a. An observation conducted of Resident D's room, on 6/7/21 at 10:56 a.m., noted Therapy Staff 10 entering the room wearing a surgical mask and eye protection. He proceeded to sit down next to Resident D's bed with an electronic device and started conversing with Resident D. There was signage to Resident D's room that was indicative of being on TBP, or in "yellow zone". Therapy Staff 10 didn't don a gown prior to entry into the room.	F 0880	F880 INFECTION PREVENTION AND CONTROL 1. Staff #10, LPN #9 and Dietary Manager re-educated on proper use and placement of PPE and proper PPE usage per zones . Dietary staff #4 re-educated on proper use of PPE and beard coverings. LPN #1 is no longer employed with the facility. 2. Audit of random staff completed to ensure proper usage of and proper placement of PPE and beard coverings. 3. Staff re-educated on proper usage of and proper placement of PPE, proper usage for zones and use of beard coverings as warranted. 4. DNS or designee to QA audit weekly x 4 weeks then monthly x 4 months to ensure staff are wearing PPE appropriately for placement and	07/01/2021

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	1b. Another observation conducted of Resident D's room, on 6/8/21 at 1:58 p.m., noted Licensed Practical Nurse (LPN) 9 donning a gown prior to entering Resident D's room. She was wearing a surgical mask and eye protection but didn't apply an N95 respirator mask and/or approved KN95 mask prior to entering Resident D's room. LPN 9 indicated she was conducting wound rounds at that time. The clinical record of Resident D was reviewed on 6/9/21 at 12:06 p.m. The diagnoses included, but were not limited to, diabetes mellitus, acute osteomyelitis and muscle weakness. She was discharged to the hospital on 5/25/21 and returned to the facility on 5/31/21 after a surgical procedure. Resident D was not fully vaccinated for COVID-19. An interview conducted with the Assistant Director of Nursing, on 6/11/21 at 2:38 p.m., indicated the expectations are for staff to don PPE prior to entering a room on TBP or deemed "yellow". That includes gown, eye protection and the use of an N95 mask. A document titled "COVID-19 LTC [long term care] Facility Infection Control Guidance Standard Operating Procedure", revised 6/1/21, indicated the following, "...Unknown COVID-19 status [Yellow]: All residents in this category warrant transmission-based precautions [droplet and contact]. HCP [healthcare personnel] will wear single gown per resident, glove, N95 mask and eye protection...." B1. In an observation on 6-7-21 at 10:12 a.m., Dietary Staff 4 was observed actively running the dishwasher while wearing a surgical mask under his chin, exposing his nose, mouth and full facial		zone and to ensure beard coverings are in place as warranted.	

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	beard. Dietary Staff 4 was observed at 10:17 a.m. to place his surgical mask over his nose, mouth and beard. B2. In an observation on 6-7-21 at 3:10 p.m., Dietary Staff 4 was observed to be actively running the dishwasher while wearing a surgical mask under his chin, exposing his nose, mouth and full facial beard. Dietary Staff 4 was observed at 3:16 pm. to place his surgical mask over his nose, mouth and beard. B3. In an observation on 6-10-21 at 2:03 p.m., Dietary Aide 4 was observed actively unloading the dishwasher while wearing a surgical mask under his chin, exposing his nose, mouth and full facial beard. Dietary Staff 4 was observed at 2:11 p.m. to place his surgical mask over his nose, mouth and beard. In interview with Dietary Staff 4 at 2:17 p.m., he indicated he was unfamiliar with facial hair requirements for kitchen staff. B4. In an observation of the Dietary Manager on 6-7-21 at 10:17 a.m., she was observed with her surgical mask below nose, but promptly positioned the surgical mask above her nose. B5. In an observation of LPN 1 on 6-8-21 at 9:20 a.m., she was located at the medication cart in the 300 hallway with her face shield in place and her surgical mask below nose. She was observed to promptly positron her surgical mask above her nose. On 6-11-21 at 2:15 p.m., the Assistant Director of Nursing provided a copy of a policy entitled, "Covid-19 PPE Guidance," with a revision date of October, 2020. This policy indicated, "All PPE [personal protective equipment] will be used in accordance with the current CDC guidelines for			

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	PPE preservation." It indicated, "Purpose: To ensure proper PPE usage during the Covid-19 pandemic...Green Zone [area of facility without any residents with a current Covid-19 diagnoses]: Universal Surgical mask - may use entire shift if not visibly soiled or wet. Universal eye protection for all direct care within 6 feet. (May use goggles or face shields..." The COVID-19 LTC Facility Infection Control Guidance Standard Operating Procedure (SOP), updated on 6-1-21 indicates, For "COVID-19 Negative (Green)...Direct care providers should wear a surgical mask for the duration of their shifts. Indirect care providers should wear a mask during their shifts...All LTC facilities should require those [staff members] involved in direct resident care and indirect resident care to wear a facemask during their entire shift. 3.1-18(b)(1) 3.1-18(b)(2)			