STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155076	A. BUILDING _____ B. WING _____	**08/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVING CENTER-BROOKVIEW	**7145 E 21ST STREET INDIANAPOLIS, IN 46219**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0554 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Allow residents to self-administer drugs if determined clinically appropriate.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to assure a resident was able to self-administer medications for 1 of 1 randomly observed residents. (Resident N) Findings include: The clinical record of Resident N was reviewed on 8/10/20 at 12:30 p.m. The resident's [DIAGNOSES REDACTED]. The Admission MDS (Minimum Data Set) Assessment, completed 6/19/2020, indicating the resident cognition was severely impaired. On 8/10/2020 at 11:55 a.m., Resident N was observed sitting in a wheelchair in her room. A plastic medication cup with crushed medications in applesauce and a spoon resting in the cup was present on the dresser in her room. There was no staff present in her room. RN 7 walked up the hallway and entered her room. He picked up the plastic medication cup off of the dresser and approached her. During an interview on 8/10/2020 at 11:56 a.m., RN 7 indicated the plastic medication cup contained Resident N's morning medications. He had left the medications on her dresser so that he could give them to her over the course of the morning, because she had difficulty taking them all at once. The clinical record for Resident N did not contain a Self-Administration of Medications Assessment. During an interview on 8/10/2020 at 3:04 p.m., the DNS (Director of Nursing Services) indicated that Resident N's medications should not have been left in her room unattended. This Federal Tag relates to complaint IN 957. 3.1-11
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident was free of verbal abuse for 1 of 3 abuse investigations reviewed. (Resident F) Findings include: The clinical record for Resident F was reviewed on 8/10/20 at 9:00 a.m. The resident's [DIAGNOSES REDACTED]. The incident report, dated 6/25/20, indicated .Incident Date 6/25/20 and time: 10:01 a.m .Brief Description of Incident .6/25/20 Resident (F) was asking about a fitted sheet for her bed. (Certified Nursing Assistant (CNA) 20) offered to assist resident. Resident was upset and words were exchanged. Allegation made by other staff that (CNA 20) cursed at (Resident F) during interaction with resident .Follow up: 6/30/20 After a complete investigation, the allegation was found to be substantiated. The incident was observed by multiple witnesses and the observation included that Resident (F) was upset and speaking inappropriately to the staff member. As a result, the staff member lost her composure while Resident (F) was speaking inappropriately to her and the staff member engaged with poor conduct. Staff member's employment was terminated due to misconduct . The investigation file was provided by the Executive Director on 8/10/20 at 2:00 p.m. It included the following: A statement by Resident F conducted with Social Services Director (SSD) dated 6/25/20, indicated .This writer (SSD) met with resident to discuss the incident that took place with a staff member (CNA 20). Resident (F) states she spoke to staff member early this morning and she didn't speak back. Resident (F) states she thought staff member was just having a bad day. Resident states she later asked the resident (sic) for a sheet to make up her bed. Resident states, staff member (CNA 20) stated to her that she would return with the sheets. Resident states after approx. (approximately) 20-30 minutes, she asked another staff member (35) if she could get her some sheets. (staff member 35) stated she would. Resident states, at this point, staff member (CNA 20) stated to her, I was going to get the sheets, resident admits she stated to staff member (CNA 20) 'I'm trying to get my bed made before [MEDICAL TREATMENT], I don't have time for this s***'. Resident states the staff member (CNA 20) stated at that time, 'well s*** I was trying to help you'. Resident states she then stated to staff member (CNA 20) 'I don't need your help b****', resident states the staff member's response was 'your momma is a b****.' Resident states staff member was walking away she then turned around and began walking toward resident taking off her jacket in a fighting manor, resident states that's when she stood up and stated I'm not scared of you . A written statement by Qualified Nursing Assistant (QMA) 40 dated 6/25/20, indicated I witnessed the verbal altercation between the CNA (Certified Nursing Assistant) (20) and the resident (Resident F). I was in the hall by room (number) and it was after breakfast and (Resident F) was in the hall talking to another resident stating that no one picked up her tray or the dirty sheets on the floor. CNA (20) was coming down the hall an offered to get clean sheets for her. The CNA (20) checked in laundry for the sheets but come out and stated there were no sheets. This made resident (20) mad and she started to cuss. CNA (20) tried to explain to resident about the sheets and it turned into a heated verbal altercation between the two. Myself and the physical therapist (32) proceeded to break-up the altercation between the two of them. We separated the CNA (20) and the resident (F) but they both continued to exchange foul words between the two of them until the CNA (20) went out of the building. The resident (F) called (CNA 20) a,,, b**** and the CNA (20) said your mama is a b**** . A written statement by Physical Therapist (32) on 6/25/20, indicated On June 25, 2020, I was walking through the hallway with CNA (20) I stopped in scheduler office and CNA (20) kept going. CNA (20) encountered resident (F) in hallway. PT (patient) was asking for sheet (sic). CNA (20) went into laundry room which she informed (Resident F) there was no sheets. Pt became upset stating she's sick of you b****es around here not doing nothing. CNA (20) stated I was trying to help you, you don't have to cuss @ (at) me. Me and QMA (40) attempted to separate CNA (20) and patient (F). Patient (F) continued to verbally cuss @ CNA (20) calling her b****es. (CNA 20) stated I'm not a b**** you momma's a b****. Writer (Physical Therapist 32) and QMA (40) continued to attempt to separate the 2 (to) until (CNA 20) just left the building. A statement by CNA 20 conducted with the Director of Nursing Services (DNS) on 6/25/20, indicated .(CNA 20) immediately stated when she called 'I just can't take it anymore. They (residents) can't just talk to us any old way. They can't just call us out our names and b****es. I just couldn't take it anymore.' I (DNS) asked (CNA 20) what happened? She stated that (Resident F) was in the hallway asking to have her sheets changed. (CNA 20) offered to go get sheets to make (Resident F)'s bed. (CNA 20) stated when she went to walk way, (Resident F) started saying 'you just a lazy b****'. And I (CNA 20) said 'you mama'. I (CNA 20) just couldn't take it anymore. Then I just walked out of the building and left. I (DNS) advised her that she was suspended pending investigation and we would be in touch with her once the investigation was completed An interview was conducted with QMA 40 on 8/11/20 at 11:00 a.m. She indicated she had been administrating medications, and CNA 20 was walking down the hallway. Resident F was upset that her room tray was not picked up and her sheets were not changed. The verbal altercation between CNA 20 and Resident F were back and forth. CNA 20 did not remove her jacket or charge after Resident F. She did call Resident F a b****. Resident F was upset about the sheets not available and started cussing at CNA 20 calling her a b****. Resident F stood up and appeared to want to fight CNA 20. Physical Therapist 32 and QMA 40 stood in between the two trying to calm Resident F down. An interview was conducted with Physical Therapist 32 on 8/11/20 at 11:15 a.m. She indicated the whole altercation between CNA 20 and Resident F was over a food tray and sheets. CNA 20 had offered to help Resident F with getting some sheets for her bed. Resident F started cussing at CNA 20. CNA 20 walked away from Resident F, but then turned around and came back down the hall toward Resident F. Physical Therapist 32 had later told CNA 20 if we were all in the streets I would have gotten the impression you were

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

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

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) coming back to fight, so I imagine the resident did as well. The altercation was only verbal not physical. An interview was conducted with Resident F on 8/12/20 at 10:17 a.m. Resident F indicated CNA 20 and herself did get in a verbal argument. Resident F wanted her sheets change, and CNA 20 had offered to get her some. Resident F had gotten upset when CNA 20 told her there was none available. Resident F called CNA 20 a b**** then CNA 20 called her and her mama a b****. An interview was conducted with Executive Director (ED) on 8/11/20 at 10:42 a.m. ED indicated after the investigation was completed for the verbal altercation involving CNA 20 and Resident F; it was found to be substantiated. The incident was witnessed, and after interviews from all parties involved were conducted the statements of what happened were the same. The abuse policy was provided by the Area Vice President on 8/11/20 at 11:47 a.m. It indicated .Policy It is the policy of the Company to take appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown origin and misappropriation of resident property are reported immediately to the Executive Director (hereinafter ED) of the center and the Director of Rehabilitation (DOR) .Procedure. The Company shall take the following steps to prevent, detect, and report abuse, neglect, injuries of unknown origin and the misappropriation of resident property .Prevention .The Executive Director, Director of Rehabilitation, Director of Nursing Services shall engage in efforts to identify, intervene and correct situations in which abuse, neglect, or misappropriation of resident property are more likely to occur This Federal Tag relates to Complaint # IN 896. 3.1-27(a)(1) 3.1-27(b)
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide nail care for 1 of 4 residents reviewed for ADL (Activities of Daily Living) care. (Resident N) Findings include: The clinical record of Resident N was reviewed on 8/10/20 at 12:30 p.m. The resident's [DIAGNOSES REDACTED]. The Admission MDS (Minimum Data Set) Assessment, completed 6/19/2020, indicating the resident needed extensive assistance of one physical staff member for personal hygiene and total assistance of one physical staff member for bathing. The resident cognition was severely impaired. On 8/10/2020 at 11:55 a.m., Resident N was observed sitting in a wheel chair in her room. Her fingernails on both of her hands were long, with jagged edges. On 8/11/2020 at 2:14 p.m., Resident N was observed sitting in the common area. She had her right hand on her head and nails on her right hand continued to be long. The nails on her left hand were also long, extending at least a 1/2 an inch over the end of her finger tips, with a brown substance under them. During an interview on 8/11/2020 at 2:18 p.m., QMA (Qualified Medication Aide) 15 indicated that Resident N's nails needed to be trimmed. She then asked her if she could trim her nails and Resident N indicated yes. On 8/12/2020 at 2:30 p.m., the ED (Executive Director) provided the Bed Bath Procedure which read .Procedures Purpose: To cleanse, refresh and soothe the resident . Procedure .14. Care of fingernails and toenails is part of the bath. Be certain nails are clean . This Federal Tag relates to complaint IN 953. 3.1-38 (a)(3)
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor a vascular wound and to address a hospice recommendation for a wound treatment for 1 of 6 residents reviewed for wounds (Resident L) Findings include: The clinical record of Resident L was reviewed on 8/10/2020 at 11:35 a.m. The resident's [DIAGNOSES REDACTED]. During an interview on 8/10/2020 at 3:11 p.m., FM (Family Member) 22 indicated she had been informed, by the hospice company at the end of June 2020 that her family member had developed an infection in his left leg. She did not think the facility had treated his infected wounds timely. The Admission Clinical Health Status, dated 4/28/2020, indicated the resident had hard eschar (black dead tissue) present on the left outer foot, measuring 2.5 cm (centimeters) x 1.5 cm., the left heel, measuring 7 cm. x 4 cm. The front of the left lower leg had 2 vascular wounds present, both covered with hard eschar, the 1st measuring 32 cm. x 10 cm, and the 2nd measuring 1.5cm x 1 cm x 0.3 cm. A physician's orders [REDACTED]. The left lower leg and foot were to be left open to air. This was the only treatment order present in the clinical record for the left lower leg and foot. The Weekly Skin Review Assessment, dated 5/12/2020, indicated . 1. Skin Condition: If skin alteration identified, validated that the Wound Evaluation Flow Sheet is in place .9. Other Vascular ulcer to LLE (Left Lower Extremity). Right heel mushy. Skin dry . During an interview on 8/12/2020 at 2:55 p.m., the DNS (Director of Nursing Services) indicated that there were no Wound Evaluation Flow Sheets for Resident L. The entire LLE was black and necrotic upon his admission to the facility. He was receiving hospice services during the length of his stay due to [MEDICAL CONDITION]. During an interview on 8/11/2020 at 11:36 a.m., HN (Hospice Nurse) 1 indicated that she had visited Resident L, in the last week of June 2020, after not having seen him for a couple of weeks. She noted a strong odor upon entering the room. She and the facility nurse had looked at his wound, which was necrotic and had foul smelling drainage. She had contacted the hospice physician about the change in his LLE and received an order for [REDACTED]. During an interview on 8/11/2020 at 3:55 p.m., HN (Hospice Nurse) 2 indicated the hospice records contained a physician's orders [REDACTED]. 2 times daily for 7 days. The Nursing Progress noted, dated 6/26/2020 at 6:03 a.m., indicated the hospice nurse had visited Resident L. His left leg was dark, necrotic, and draining with a foul odor. His legs were cleansed with wound cleanser, and an ABD (type of bandage) was applied and secured with Kerlix (type of bandage). The hospice nurse stated that she would call the facility with new wound orders from the physician, and a return call had not been received yet. During an interview on 8/11/2020 at 12:03 p.m., Pharmacy Technician 3 indicated that the pharmacy had delivered Keflex 500 mg, [MEDICATION NAME] 500 mg and Dakin's Solution to the facility for Resident L on 6/28/2020. The order for these medications had been received by the pharmacy on 6/27/20. The MAR (Medication Administration Record) and TAR (Treatment Administration Record) for June 2020 were reviewed. They did not contain documentation that the [MEDICATION NAME] 500 mg, Keflex 500 mg, or Dakin's Solution had been administered during the Month of June. During an interview on 8/13/2020 at 2:25 p.m., the DNS indicated the hospice orders for the [MEDICATION NAME], Keflex, and Dakin's Solution should have been entered into the facilities physicians' orders. The hospice nurse and the facility nurses usually communicated when hospice is in the building. On 8/12/2020 at 2:30 p.m., the ED (Executive Director) provided the Skin Integrity Guidelines Policy which read . Purpose: To provide a comprehensive approach for monitoring skin conditions .To promote healing of wounds of any etiology, whether admitted or acquired .General Guidelines .Wound status is monitored on a weekly basis .Documentation of Weekly Skin Evaluation/ Observations .Licensed nurse to document weekly on identified wounds using the 'Wound Evaluation Flow Sheet' . This Federal Tag relates to complaint IN 567 and IN 033. 3.1-37
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide weekly monitoring of a pressure ulcer for 1 of 6 residents reviewed for wounds (Resident M) Findings include: The clinical record of Resident M was reviewed on 8/11/2020 at 9:20 a.m. The Resident's [DIAGNOSES REDACTED]. She was admitted to the facility on [DATE] and discharged from the facility on 7/31/2020. The clinical record contained an Admission MDS (Minimum Data Set) Assessment, completed 6/11/2020, which indicated she was cognitively intact and had an unstageable pressure ulcer upon admission to the facility. During an interview on 8/10/2020 at 3:10 p.m., FM (Family Member) 32 indicated her sister had a pressure wound on her foot when she admitted to the facility. The left heel wound was still open when she discharged from the facility. She did not think the facility had treated or monitored the pressure wound appropriately. The admission assessment, dated 6/3/2020, indicated that there was pressure ulcer present on Resident M's left heel. The admission assessment did not contain measurements for the left heel pressure ulcer. The clinical record contained a care plan, with an initiation date of 4/28/2020, which indicated Resident M had a pressure ulcer present to her left heel. The goal was for the pressure ulcer to heal without complications and the interventions included to conduct weekly skin inspections and to complete skin assessments per facility policy. A Wound Evaluation Flow Sheet, dated 6/9/20, indicated a left heel wound, identified 6/3/2020, measured 3.4 x 6.7 cm and was unstageable. The wound bed had 90% slough, 10% necrotic. There are no further assessments present in the medical record addressing the measurements or appearance of the Left heel wound. During an interview on 8/13/2020 at 2:25 p.m., the DNS (Director of Nursing Services) indicated there was no further documentation or measurements available for the left heel wound. On 8/12/2020 at 2:30 p.m., the ED (Executive Director) provided the Skin Integrity Guidelines

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Policy which read . Purpose: To provide a comprehensive approach for monitoring skin conditions .To promote healing of wounds of any etiology, whether admitted or acquired .General Guidelines .Wound status is monitored on a weekly basis .Documentation of Weekly Skin Evaluation/ Observations .Licensed nurse to document weekly on identified wounds using the 'Wound Evaluation Flow Sheet' . This Federal Tag relates to complaint IN 953 and IN 341. 3.1-40
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a new admitted resident's medication was available timely for 1 of 3 residents medications reviewed. (Resident K) Findings include: The clinical record for Resident K was reviewed on 8/10/20 at 2:00 p.m. The resident's [DIAGNOSES REDACTED]. The discharge hospital records indicated Resident K was currently on 50 milligrams of [MEDICATION NAME] by mouth every 6 hours as needed for pain. A physician's orders [REDACTED]. A progress note, dated 7/3/20, indicated the resident arrived to facility and was alert, oriented and was able to voice needs. A faxed cover sheet for the physician, dated 7/5/20, indicated the pharmacy needed a written prescription for Resident K's [MEDICATION NAME]. A progress note, dated 7/6/20, indicated the pharmacy had not received the written prescription for Resident K's [MEDICATION NAME]. A nursing note, dated 7/6/20, indicated the resident had complaints of pain, but a prescription was needed for [MEDICATION NAME]. An interview was conducted with Pharmacy Tech 16 on 8/13/20 at 10:06 a.m. She indicated the facility had provided a prescription for [MEDICATION NAME] on 7/7/20, and it was available that day. The [MEDICATION NAME] was stored in the medication dispensing machine in the facility. The [MEDICATION NAME] does not come in a medication card. After the pharmacy receives the request, and written prescription of the [MEDICATION NAME]; it would be available at that time and would be pulled from the dispensing machine in the facility. An interview was conducted with Resident K on 8/13/20 at 11:29 a.m. She indicated there was a few days when she first arrived to the facility she could not get her [MEDICATION NAME] for pain. The staff would give her Tylenol, but it was not helping her. An interview was conducted with RN 17 on 8/13/20 at 11:45 a.m. He indicated there was a delay in getting Resident K's medications on admission. The facility received a new provider on July 1st, and they do things a little differently. The pharmacy was needing a hard script for Resident K's [MEDICATION NAME]. A Medication Orders policy was provided by the Executive Director on 8/14/20 at 8:30 a.m. It indicated .Policy. Before a controlled drug can be dispensed, the pharmacy must be in receipt of a clear, complete, and signed written prescription from a person lawfully authorized to prescribe .The written prescription may be faxed to the pharmacy for long-term care facility residents .E. New Prescriptions .2.) New orders for controlled substances communicated to the nurse on duty verbally or orally by the prescriber, including emergency medications: [REDACTED]. b. New orders for controlled substances communicated to the nurse verbally or orally by the prescriber via telephone are entered onto the physician order [REDACTED].To ensure the pharmacy has a complete, valid prescription from which to dispense the medication, the facility requests that: 1. The prescriber or prescriber's employee prepares a written prescription and faxes or electronically submits the complete prescription (containing all required elements) to the pharmacist directly This Federal Tag relates to Complaint IN 057. 3.1-25(g)(3)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** Based on observation and interview, the facility failed to maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections by staff members not wearing face masks correctly. This deficient practice had the potential to affect 76 of 76 residents that reside in the facility. Findings include: 1. An observation was made of the front lobby on 8/10/20 at 10:00 a.m. Receptionist 14 was observed sitting behind a desk with a resident in a wheelchair sitting on the other side of the desk. The resident had a mask on his face covering his nose and mouth. Receptionist 14 had her mask pulled down to her top lip covering her mouth, but her nose was entirely exposed. 2. An observation was made of CNA (certified nursing assistant) 8 using a wall computer in the dining room on 8/11/20 at 11:34 a.m. CNA 8 had her face mask pulled down below her nose which left her nose uncovered. She then placed the face mask over her mouth and nose by grabbing the outside of the mask and pulling it up and after touching the outside of her mask, she continued to use the wall computer. CNA 8 did not perform hand hygiene after touching the outside of her mask. 3. An observation was made of CNA 9 walking down the 200 hallway along with two coworkers on 8/11/20 at 11:35 a.m. CNA 9 had her face mask pulled down below her nose which left her nose uncovered as she walked beside her coworkers. 4. An observation was made of the 200 hallway nursing station on 8/11/20 at 11:36 a.m. CNA 10 was standing in the nursing station speaking with a coworker with her face mask pulled down below her nose leaving her nose uncovered while standing next to her coworker. She then pulled up her face mask to cover her nose by touching the outside of the mask then touched the desk of the nursing station. CNA 10 did not perform any hand hygiene after touching the outside of her face mask. 5. An observation was made of Housekeeper 11 on 8/11/20 at 11:37 a.m. Housekeeper 11 was on the 300 hallway cleaning with her face mask pulled down below her nose which left her nose uncovered. 6. An observation was made on 8/14/20 at 12:50 p.m. of CNA 12 walking down the 300 hallway with her face mask pulled down below her nose which left her nose uncovered. 7. An observation was made on 8/14/20 at 12:51 p.m. of CNA 13 walking down the 300 hallway with his face mask hanging around his neck. An interview conducted on 8/11/20 at 11:38 a.m. with Executive Director (ED) indicated face masks are required to be worn within the facility at all times except when eating on breaks and face masks should be worn to cover the nose and mouth. On the Centers for Disease and Control (CDC) website, it stated HCP (sic, Health Care Providers) should wear a facemask at all times while they are in the healthcare facility, including in breakrooms or other spaces where they might encounter co-workers. When available, facemasks are preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. Cloth face coverings should NOT be worn instead of a respirator or facemask if more than source control is needed. To reduce the number of times HCP must touch their face and potential risk for self-contamination, HCP should consider continuing to wear the same respirator or facemask (extended use) throughout their entire work shift, instead of intermittently switching back to their cloth face covering. Respirators with an exhalation valve are not recommended for source control, as they allow unfiltered exhaled breath to escape. HCP should remove their respirator or facemask, perform hand hygiene, and put on their cloth face covering when leaving the facility at the end of their shift. Educate patients, visitors, and HCP about the importance of performing hand hygiene immediately before and after any contact with their facemask or cloth face covering. This Federal tag relates to complaints IN 646, IN 957, and IN 057. 3.1-18
F 0943 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.** Based on interview and record review, the facility failed to ensure abuse and dementia yearly in-service training was conducted for 2 of 5 staff training reviewed. (Unit Manager UM 6 and License Practical Nurse 15) Findings include: The employee records were provided by the Executive Director on 8/14/20 at 9:00 a.m. The records indicated Unit Manager (UM) 6 and License Practical Nurse (LPN) 15 was full time working status employees. LPN 15's file indicated she had completed abuse and dementia in-service training on 8/4/19. There was no current abuse or dementia training in her file. UM 6's file indicated she had completed dementia in-service training on 6/25/19. There was no current dementia training in her file. An interview was conducted with the Executive Director on 8/14/20 at 1:00 p.m. He indicated the annual in-service training was behind. It should be done yearly. The In-Service Training was provided by the Executive Director on 8/14/20 at 1:30 p.m. It indicated .Policy Employees will receive training (in-services) according to the Company's requirements, and state and federal requirements .Training Appropriate training will be developed and provide for all positions as required by company standards and/or by state or federal regulations. Proper documentation of training will be maintained, including an agenda, minutes and an employee attendance list . The abuse policy was provided by the Area Vice President on 8/11/20 at 11:47 a.m. It indicated .Policy It is the policy of the Company to take appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown origin and misappropriation of resident property are reported immediately to the Executive Director (hereinafter ED) of the center and the Director of Rehabilitation (DOR) .Training .Each employee shall receive annual training on the requirements of the center/location's policies and procedures regarding alleged violations and the

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F 0943 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) requirements of state and federal law .