STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075368	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GARDNER HEIGHTS HEALTH CARE CENTER, INC	172 ROCKY REST ROAD SHELTON, CT 06484

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 0557 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documentation, review of facility policy, and interviews, for the only sampled residents (Resident #1) reviewed for an allegation of abuse, the facility ensure the resident was treated in a dignified manner. The findings include: Resident #1's [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was moderately cognitively impaired and required extensive assistance with transfers, ambulation, dressing, and toilet use. Additionally, Resident #1 was occasionally incontinent of urine and always incontinent of bowel. The Resident Care Plan (RCP) dated 5/7/20 identified Activity of Daily Living (ADL) and cognition problems and chronic pain with decreased mobility. Resident #1 required assistance with my ADL's. Resident #1 was non-compliant with calling for assistance, was sometimes confused and forgetful, however could make his/her needs known and understand what is being said to hi/her. Interventions included assist with washing, dressing, bed and wheelchair mobility, personal hygiene, and toileting, allow time for Resident #1 to respond when speaking to him/her, and call Resident #1 by his/her first name. If Resident #1 is confused or forgetful, offer gentle reminders, offer one step at a time directions, and offer support and reassurance if Resident #1 appears anxious. A physician's orders [REDACTED].#1 with the assistance of one, gait with rollator walker and assist of one, and may use wheelchair for mobility. Review of the Reportable Event dated 6/2/20 at 8:30 AM identified that Resident #1 reported to Nurse Aide (NA) #2 that a nurse who gives him/her pills on the 11-7 shift snatched her brief from him/her while sitting on the toilet and used abusive language. The Resident was noted to be alert and oriented and upset. The Reportable Event indicated that the allegation was witnessed by NA #1. Interview and review of the facility Reportable Event dated 6/2/20 with RN #1 on 8/6/20 at 12:18 PM and her statements dated 6/2/20 and 6/4/20 identified that he/she vaguely remembered the details. Registered Nurse (RN) #1 identified Resident #1 had dementia, that it took one half hour to provide care and that he/she did not have time to go back because he/she was both the supervisor and the medication nurse. RN #1 stated he/she had given medications to Resident #1 around 6:00 AM while the resident was sitting on the toilet. RN #1 further stated that the DNS had told him/her that he/she should not have administered medications to a resident in the bathroom. During an interview and review of facility Reportable Event and investigation on 8/6/20 at 2:35 PM the Director of Nurses (DNS) identified that it was inappropriate for RN #1 to give pills while Resident #1 was sitting on the toilet. The facility failed to ensure that Resident #1 was treated in a dignified manner when RN #1 gave Resident #1 his/her medications while sitting on the toilet. Review of facility Bill of Rights Policy identified, in part, that you have the right to be treated with consideration, respect and full recognition of your dignity and individuality.
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 clinical record review, review of facility documentation, review of facility policy, and interviews for the only sampled residents (Resident #1) reviewed for an allegation of abuse, the facility failed to protect a resident from verbal mistreatment. The findings include: Resident #1's [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was moderately cognitively impaired and required extensive assistance with transfers, ambulation, dressing, and toilet use. Additionally, Resident #1 was occasionally incontinent of urine and always incontinent of bowel. The Resident Care Plan (RCP) dated 5/7/20 identified Activity of Daily Living (ADL) and cognition problems and chronic pain with decreased mobility. Resident #1 required assistance with my ADL's. Resident #1 was non-compliant with calling for assistance, was sometimes confused and forgetful, however could make his/her needs known and understand what is being said to hi/her. Interventions included assist with washing, dressing, bed and wheelchair mobility, personal hygiene, and toileting, allow time for Resident #1 to respond when speaking to him/her, and call Resident #1 by his/her first name. If Resident #1 is confused or forgetful, offer gentle reminders, offer one step at a time directions, and offer support and reassurance if Resident #1 appears anxious. A physician's orders [REDACTED].#1 with the assistance of one, gait with rollator walker and assist of one, and may use wheelchair for mobility. Review of the Reportable Event dated 6/2/20 at 8:30 AM identified that Resident #1 reported to Nurse Aide (NA) #2 that a nurse who gives him/her pills on the 11-7 shift snatched her brief from him/her while sitting on the toilet and used abusive language. The Resident was noted to be alert and oriented and upset. The Reportable Event indicated that the allegation was witnessed by NA #1. Review of NA #1's statement dated 5/2/20, (incorrectly dated per the Director of Nurses (DNS)) identified that Resident #1's light was on and NA #1 assisted the resident into the bathroom. NA #1's statement identified that Resident #1's underwear was dirty, and NA #1 offered to change him/her, but that Resident #1 refused. According to NA #1's statement, Registered Nurse (RN) #1 went into the bathroom, saw the dirty underwear and called NA #1 to come change him/her. NA #1's statement identified that he/she told RN #1 that Resident #1 refused, and then RN #1 told him/her to get Resident #1 another pair of underwear. NA #1 identified that when he/she came back, he/she (the resident) was shaking and crying with no underwear, no socks and no pants on. NA #1's statement identified that he/she helped Resident #1 get dressed and that RN #1 told NA #1 to go and that he/she would take over. Review of Social Worker #2's interview statement with Resident #1, dated 6/2/20 identified that the girl who gives me meds, shoved me down onto the toilet seat when I was trying to standup. She told me to get my a** down there because they had other people, they had to take care of; she yanked my pants and panties off and threw them because he/she got angry. I felt scared. There was another person in the room who never said a word. Review of Social Worker #2's interview statement dated 6/2/20 with Resident #2 identified the girl yanked his/her diaper and yelled at Resident #1 and told him/her they have other people to take care of. Resident #2 identified that around 6:30 AM Resident #1 must have been trying to stand up and that the nurse told her to sit her a** down. Additionally, the NA that takes care of him/her was in the room too, but didn't say anything. The Social Service's note in Resident #1's clinical record dated 6/2/20 at 3:39 PM identified that a staff member, early this morning yelled at him/her and made him/her feel uncomfortable. The Social Worker followed up with nursing staff regarding the interaction. Resident #1 had no signs or symptoms of distress. The Social Service's note dated 6/2/20 at 3:47 PM identified Resident #1 had a BIMS score of 11 (indicating moderate cognitive impairment). Review of the typed Director of Nurses (DNS) telephone clarification statement dated 6/4/20 with NA #1, identified that NA #1 assisted Resident #1 onto the toilet and that Resident #1's underwear was stained. RN #1 came into the bathroom and stated that Resident #1's underwear was dirty and had NA #1 go get a clean pair. According to the statement, NA #1 heard RN #1 state what the f*** (expletive) is that, he/she has to take them off. When the DNS questioned

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) NA #1 about the abusive language, she said that RN #1 had said it to Resident #1. The written clarification statement further identified that the DNS repeatedly asked NA #1 what exactly was said, and to who it was said, and that NA #1 answered that she said it to the resident. The facility summary dated 6/9/20 identified that abuse could not be substantiated as the investigation did not identify that the nurse directed the inappropriate language toward the resident. The Resident's roommate said the nurse was trying to help. The licensed nurse was attempting to help Resident #1 by explaining the risks of keeping on soiled underwear. The Resident sometimes refused help with ADL's that placed him/her at risk. The corrective action was to update the care plan and care card and educate the licensed nurse on acceptable professional behavior and dignity. Interview and review of the facility Reportable Event and statement with Licensed Practical Nurse (LPN) #1 on 8/5/20 at 12:22 PM identified that he/she had been passing medications around 8:30 AM when NA #2 came to her and identified that Resident #1 had complained that something had happened on the 11:00 PM to 7:00 AM shift. LPN #1 identified that when he/she went to see Resident #1, Resident #1 stated I'm so upset, I'm going to cry, but didn't want to say what had happened. Resident #1 kept saying that there was a girl there watching and she just stood there. LPN #1 identified that he/she immediately went to get Social Worker #1 and that Social Worker #1 immediately went to see the resident. Interview and review of the Reportable Event and facility statement with NA #2 on 8/5/20 at 12:35 PM identified that Resident #1 had called him/her into the room stating I have to tell you something. NA #2 identified that when he/she went into the room, Resident #1 alleged that the nurse, RN #1, last night, had picked him/her up out of the chair and threw him/her onto the toilet, took his/her clothes off and put them in his/her face. NA #2 identified that Resident #1 informed her that RN #1, screamed at him/her, called him/her something like dirty and disgusting and that there was another person in the room that was watching and was probably too scared to say anything. NA #2 identified that while he/she was in the room, Resident #1's roommate, Resident #2 had offered that RN #1 screamed at Resident #1. Additionally, according to NA #2, Resident #2 had identified that he/she could not see Resident #1 in the bathroom, but that NA #1 just stood there and didn't say anything. Interview with Resident #2 on 8/6/20 at 12:05 PM identified that he/she remembered the incident back in June when Resident #1 was in the bathroom and that the nurse, RN #1, had yelled at Resident #1. Resident #2 identified that although he/she did not remember what RN #1 said, it was yelling. Interview with Resident #1 on 8/6/20 at 12:10 PM failed to identify that he/she remembered the event. Interview and review of the facility Reportable Event dated 6/2/20 with RN #1 on 8/6/20 at 12:18 PM and her statements dated 6/2/20 and 6/4/20 identified that he/she vaguely remembered the details. RN #1 identified Resident #1 had dementia, that it took one half hour to provide care and that he/she did not have time to go back because he/she was both the supervisor and the medication nurse. RN #1 identified he/she was aware Resident #1 reported RN #1 had yelled at him/her but that he/she had a loud voice. RN #1 stated he/she had given medications to Resident #1 around 6:00 AM while the resident was sitting on the toilet. RN #1 further stated that the DNS had told him/her that he/she should not have administered medications to a resident in the bathroom. RN #1 indicated that he/she had removed Resident #1's underwear due to soiling. RN #1 identified that Resident #1 refused the removal of her underwear, that they went back and forth, and despite the resident's refusal he/she slipped them off and showed the underwear to Resident #1, bringing the garment up close to the resident's face. RN #1 identified that he/she and the DNS had come to an understanding that since no one's statement identified that Resident #1 was ever standing, he/she could not have stated to Resident #1 sit your a** down. RN #1 identified that rather than remove the underwear, he/she should have re-approached Resident #1 later or notified the oncoming staff of Resident #1's refusal. RN #1 identified that he/she was not aware of saying F*** (expletive) to Resident #1. RN #1 identified that he/she has not had any contact with Resident #1 since the incident. Interview and review of the facility Reportable Event dated 6/2/20 with Social Worker #1 on 8/6/20 at 12:56 PM and review of statements he/she obtained, identified that he/she had interviewed Resident #1 on 6/2/20. Social Worker #1 identified that Resident #2 focused on RN #1 yelling, and had stated that RN #1 had told Resident #1 to sit your a** down. Social Worker #1 indicated that Resident #1 had stated that RN #1 had said F*** (expletive) and described RN #1. Social Worker #1 identified that he/she had never before or since heard Resident #1 make up stories or use the F*** (expletive). Social Worker #1 identified that he/she had left out of her statement that Resident #1 reported RN #1 as having said F*** (expletive) but should have written it down. Social Worker #1 identified that using that expletive with Resident #1 would constitute verbal abuse. Social Worker #1's statement identified that Resident #1 felt scared and that he/she described the accused staff as the one who gives me my pills, threw me in the chair and threw me onto the toilet and yelled sit your a** down there, I have other people to take of. Additionally, she threw my panties in my face and left the bathroom. Social Worker #1 identified in his/her interview statement with Resident #2 that the identified staff was my aide and the nurse. Social Worker #1 identified that Resident #1's roommate, Resident #2, had stated he/she heard I can't take care of you, this is impossible, sit your a** down, there are other people to take care of. Interview and review of facility Reportable Event and investigation on 8/6/20 at 2:35 PM with the DNS identified that in his/her conclusion he/she had written that inappropriate language was used but had not identified the inappropriate language. The DNS identified that the inappropriate language was F*** (expletive). The DNS identified that NA #1 insisted RN #1 had directed F*** (expletive) toward Resident #1. The DNS identified that when he/she interviewed Resident #1, he/she had never specifically stated an expletive was used and that it was not in Social Worker #1's interview statement. Additionally, Resident #1 and Resident #2 had never directly told her that RN #1 had stated sit your a** down and that it was only in Social Worker #1's interview statements. The DNS identified that he/she never questioned the content of Social Worker #1's statement on either the expletive or that both Resident statements identified RN #1 had directed Resident #1 to sit your a** down. The DNS identified that no staff could corroborate Resident #1 had ever tried to stand up, that Resident #2 could not see into the bathroom, and therefore he/she could not come to an absolute conclusion. The DNS identified that he/she had read the entire investigation and that he/she negated the fact that both Resident #1 and Resident #2 had described the same account of the incident. The DNS identified that she thought it was RN #1's intention to get Resident #1 cleaned and that he/she went about it in the wrong way. Additionally, the DNS identified that if NA #1 had heard RN #1 use the F*** (expletive) the incident should have been reported immediately as an allegation of mistreatment according to the facility policy and that was why he/she questioned if the expletive was actually used. The DNS identified that RN #1 should not have removed the resident's underwear when he/she refused, and that Resident #1 should have been re-approached later or the on-coming shift notified to assist Resident #1. The DNS also identified that it was inappropriate for RN #1 to give pills while Resident #1 was sitting on the toilet. Three attempts to reach NA #1 were unsuccessful. The facility failed to ensure Resident #1 was free from verbal abuse. Review of facility abuse Policy identified, in part, abuse means the willful infliction or injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include but are not limited to threats of harm and saying things to frighten a resident/patient.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documentation, review of facility policy, and interviews for the only sampled residents (Resident #1) reviewed for an allegation of abuse, the facility failed to ensure a staff member reported an allegation of mistreatment in a timely manner. The findings include: Resident #1's [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was moderately cognitively impaired and required extensive assistance with transfers, ambulation, dressing, and toilet use. Additionally, Resident #1 was occasionally incontinent of urine and always incontinent of bowel. The Resident Care Plan (RCP) dated 5/7/20 identified Activity of Daily Living (ADL) and cognition problems and chronic pain with decreased mobility. Resident #1 required assistance with my ADL's. Resident #1 was non-compliant with calling for assistance, was sometimes confused and forgetful, however could make his/her needs known and understand what is being said to hi/her. Interventions included assist with washing, dressing, bed and wheelchair mobility, personal hygiene, and toileting, allow time for Resident #1 to respond when speaking to him/her, and call Resident #1 by his/her first name. If Resident #1 is confused or forgetful, offer gentle reminders, offer one step at a time directions, and offer support and reassurance if Resident #1 appears anxious. A physician's orders [REDACTED].#1 with the assistance of one, gait with rollator walker and assist of one, and may use wheelchair for mobility. Review of the Reportable Event dated 6/2/20 at 8:30 AM identified that Resident #1 reported to NUrse Aide (NA) #2 that a nurse who gives him/her pills on the 11-7 shift snatched his/her brief from him/her while sitting on the toilet and used abusive language. The Resident was noted to be alert and oriented and upset. The Reportable Event indicated that the allegation was witnessed by NA #1. Review of NA #1's statement dated 5/2/20, (incorrectly dated per the DNS) identified that Resident #1's light was

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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) on and he/she assisted Resident #1 into the bathroom. NA #1's statement identified that Resident #1's underwear was dirty, and NA #1 offered to change him/her, but that Resident #1 refused. According to NA #1's statement, Registered Nurse (RN) #1 went into the bathroom, saw the dirty underwear and called NA #1 to come change him/her. NA #1's statement identified that he/she told RN #1 that Resident #1 refused, and then RN #1 told him/her to get Resident #1 another pair of underwear. NA #1 identified that when he/she came back, Resident #1 was shaking and crying with no underwear, no socks, and no pants on. NA #1's statement identified that he/she helped Resident #1 get dressed and that RN #1 told her to go and that he/she would take over. The Social Service's note dated 6/2/20 at 3:47 PM identified Resident #1 had a BIMS score of 11 (indicating moderate cognitive impairment). Review of the typed Director of Nurses (DNS) telephone clarification statement dated 6/4/20 with NA #1, identified that NA #1 assisted Resident #1 onto the toilet and that Resident #1's underwear was stained. RN #1 came into the bathroom and stated that Resident #1's underwear was dirty and had NA #1 go get a clean pair. According to the statement, NA #1 heard RN #1 state what the f*** (expletive) is that, he/she has to take them off. When the DNS questioned NA #1 about the abusive language, he/she said that RN #1 had said it to Resident #1. The written clarification statement further identified that the DNS repeatedly asked NA #1 what exactly was said, and to who it was said, and that NA #1 answered that he/she said it to the resident. Interview and review of the Reportable Event and facility statement with NA #2 on 8/5/20 at 12:35 PM identified that Resident #1 had called him/her into the room stating I have to tell you something. NA #2 identified that when he/she went into the room, Resident #1 alleged that the nurse, RN #1, last night, had picked him/her up out of the chair and threw him/her onto the toilet, took his/her clothes off and put them in his/her face. NA #2 identified that Resident #1 informed him/her that RN #1, screamed at him/her, called him/her something like dirty and disgusting and that there was another person in the room that was watching and was probably too scared to say anything. NA #2 identified that while he/she was in the room, Resident #1's roommate, Resident #2 had offered that RN #1 screamed at Resident #1. Additionally, according to NA #2, Resident #2 had identified that he/she could not see Resident #1 in the bathroom, but that NA #1 just stood there and didn't say anything. Interview with Resident #1 on 8/6/20 at 12:10 PM failed to identify that he/she remembered the event. Interview and review of facility Reportable Event and investigation on 8/6/20 at 2:35 PM with the DNS identified that if NA #1 had heard RN #1 use the F*** (expletive), the incident should have been reported immediately as an allegation of mistreatment according to the facility policy Three attempts to reach NA #1 were unsuccessful. Review of facility abuse Policy identified, in part, that anyone witnessing, and/or having knowledge of the abuse or mistreatment of [REDACTED]. Review of the clinical record and facility documentation failed to reflect that NA #1 reported the incident in a timely manner.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, review of facility documentation, review of facility policy, and interviews, for the only sampled residents (Resident #1) reviewed for an allegation of abuse and for one of three newly admitted residents (Resident #5) who were under observation for COVID-19, the facility failed to update the resident care plans to meet the needs of the resident. The findings include: a. Resident #1's [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was moderately cognitively impaired and required extensive assistance with transfers, ambulation, dressing, and toilet use. Additionally, Resident #1 was occasionally incontinent of urine and always incontinent of bowel. The Resident Care Plan (RCP) dated 5/7/20 identified Activity of Daily Living (ADL) and cognition problems. Resident #1 had chronic pain with decreased mobility and required assistance with ADL's. Resident #1 was noted to be non-compliant with calling for assistance, was sometimes confused and forgetful however could make needs known and understand what is being said to him/her. Interventions directed assist Resident #1 with washing, dressing, bed and wheelchair mobility, personal hygiene, and toileting, to allow time for resident to respond when speaking to him/her, and call Resident #1 by his/her first name. If Resident #1 is confused or forgetful, offer gentle reminders, offer one step at a time directions, and offer support and reassurance if he/she appears anxious. A physician's orders [REDACTED].#1 with the assistance of one, gait with rollator walker and assist of one, and may use wheelchair for mobility. Review of the Reportable Event dated 6/2/20 at 8:30 AM identified that Resident #1 reported to Nurse Aide (NA) #1 that a nurse who gives him/her pills on the 11-7 shift snatched his/her brief from him/her while sitting on the toilet and used abusive language. Resident #1 was noted to be alert and oriented and upset. The Reportable Event indicated that the allegation was witnessed by NA #1. Review of the facility conclusion to the allegation identified that the corrective action plan to prevent reoccurrence included that Resident #1's care plan and care card would be updated and staff provided education on professional behavior and dignity. Review of the clinical record failed to reflect Resident #1's care plan was revised to reflect the allegation of abuse and/or interventions addressing such. Interview with the Director of Nurses (DNS) on 8/5/20 at 11:25 AM identified that the MDS Coordinator was the staff responsible to initiate a care plan when there is an allegation. The DNS identified that the incident was never care planned but should have been. The DNS identified that the MDS Coordinator attended the morning meeting following the allegation and should have reviewed and updated the care plan to include the allegation of mistreatment. The DNS identified that he/she assumed the care plan had been updated but had never reviewed the care plan to ensure it had been. b. Resident #5 was admitted on [DATE] with [DIAGNOSES REDACTED]. The undated admission Resident Care Plan (RCP) identified contact/droplet precautions for 14 days and that Resident #5 was non-compliant with wearing a face mask. During a tour of the facility on 8/5/20 at 2:00 PM with Registered Nurse (RN) #2, Resident #5 was observed ambulating in the hall without the benefit of a mask and among five other residents who were not wearing a mask. Interview with RN #2 identified that the unit was a memory care unit and the only way to ensure that Resident #5 kept his/her mask in place and maintained transmission based precautions, would be to place Resident #5 on a one to one status with another staff member. Review of the clinical record failed to reflect a revision of the care plan and interventions to address Resident #5's continued non-compliance with wearing a mask. Interview and review of Resident #5's care plan with the DNS on 8/6/20 at 2:35 PM identified that there had previously been no additions or changes to the plan of care to ensure Resident #5 was maintained transmission based precautions, social distanced and kept a mask in place. Subsequent to surveyor inquiry, the facility had updated the resident care plan with new interventions.