STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045372	A. BUILDING _____ B. WING _____	**08/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE WATERS OF WHITE HALL, LLC	**9209 DOLLARWAY ROAD WHITE HALL, AR 71602**

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

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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, record review and interview, the facility failed to ensure resident's fingernails and toenails were cleaned and trimmed regularly to promote, grooming, good personal hygiene and to decrease the risk of infections or complications for 1 (Resident #51) of 23 (Residents #5, #51, #49, #18, #11, #42, #4, #20, #10, #53, #14, #12, #26, #55, #31, #48, #52, #28, #23, #62, #29, #46, and #65) sampled residents who were dependent on staff for nail care. This failed practice had the potential to affect 42 residents who were dependent on staff for nail care, as documented on a list provided by the Social Director on 08/27/2020 at 11:04 AM. The findings are: Resident #51 had [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/01/20 documented the resident scored a 14 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS), and required set up only of one person for Activities of daily living (ADL). a. The Care Plan revised on 6/2/20 documented, I require assistance with ADL functions . b. The August 2020 Physician order [REDACTED]. c. On 08/25/20 at 08:36 AM, Resident #51's fingernails on both hands had a dark substance under them with jagged edges. (Photo taken). The resident stated, The nurses are supposed to clean and cut my nails, but they don't, and my toenails really need to be trimmed. Resident took his socks off to show the surveyor his toenails. Toenails were approximately 1/4-inch-long on both feet with dry and scaly skin. (Photo taken at 08:43 AM). The resident stated, I get a shower or bath whenever I need one usually 2-3 times a week but if I'm not feeling too good, I may refuse to take a bath. I had a bath on Saturday, (8/22/20) and I am supposed to have a shower tomorrow. d. On 08/25/20 at 08:59 AM, Certified Nursing Assistant (CNA) #2 was asked, Who is responsible for trimming and cleaning residents' fingernails and toenails? She stated, Anyone of us can clean the resident's nails, but if the resident is a diabetic the nurses have to trim them. She was asked, When should the resident's nails be cleaned and trimmed? She stated, Whenever they are dirty and especially on shower days, they should be cleaned and trimmed if needed. e. On 08/25/20 at 09:05 AM, Licensed Practical Nurse (LPN) #2 was asked, Who is responsible for trimming and cleaning residents' fingernails and toenails? She stated, Me, the floor nurse, and the main treatment nurse trim nails and any of the staff can clean them. She was asked, When should the resident's nails be cleaned and trimmed? She stated, Whenever they are dirty and need trimming. f. On 08/25/20 at 09:47 AM, the Director of Nursing (DON) was asked, Who is responsible for trimming and cleaning residents' fingernails and toenails? She stated, The CNAs, the nurses and the treatment nurse trim residents' nails. She was asked, When should the resident's nails be cleaned and trimmed? She stated, Fingernails and toenails should be routinely trimmed and cleaned with care as needed, often time in the shower. The DON was asked to look at this resident's toenails, she was asked, How long would you say his toenails are? She responded, I would say about 1/4 inch. She was asked, Do you think his toenails and fingernails need trimming and cleaning? She stated, Yes they do, and I will get it done. g. The Policy and Procedure on NAIL CARE, received from the Assistant Director of Nursing (ADON) on 08/27/20 at 03:50 PM documented, It is the policy of the facility to provide personal hygiene needs and to promote health, safety and the prevention of infection. This includes clean, smooth nails at a well-groomed safe length acceptable to the resident. NOTE: Only a Licensed Nurse can trim the nails of a diabetic resident .
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure adaptive equipment was provided to prevent further decrease/decline in range of motion for 2 (Residents #11, and #29) of 3 (Resident #11, #19, and #29) sampled residents who had contractures and required adaptive devices. This failed practice had the potential to affect 8 residents who had contractures according to a list provided by the Director of Nursing (DON) on 8/27/20 at 11:05 AM. The findings are: 1. Resident #11 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/5/20 documented the resident was severely impaired in cognitive skills for daily decision making per the Staff Assessment for Mental status, was totally dependent on the assistance of 2 plus people for bed mobility, transfer, dressing, bathing, toilet use and personal hygiene and had functional limitations in the upper extremities on both side and functional limitation on one side of the lower extremity. a. The Physician orders [REDACTED]. b. The Care Plan dated 2/27/20 documented, .I have contractures to my right and left hands . Apply right and left resting hand splints daily for 6-8 hours, as tolerated, every day by Restorative, per MD (Medical Doctor) orders . c. On 8/26/20 at 8:37 AM, the resident had no hand splints in place. d. On 08/27/20 at 02:05 PM, the resident had no hand splints in place. Licensed Practical Nurse (LPN) #1, was asked, Is this resident supposed to have hand splints on? LPN #1 stated, Yes, but they may be in laundry. We take them out when he goes to [MEDICAL TREATMENT] also. She was asked, What do you do when they are in laundry? LPN stated, We usually fold up wash clothes and put them in his hands.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** Based on observation and interview, the facility failed to ensure 2 of 3 clothes dryers remained free of lint build-up to decrease the potential for fire and loss of laundry services in 1 of 1 facility. This failed practice had the potential to affect all 59 residents according to the Resident Census and Conditions of Residents form dated 8/24/2020. The findings are: On 8/26/2020 at 12:51 PM, during the Infection Control tour of the Laundry Department with the Housekeeping Supervisor, the following observations were made: a. There were 3 electric dryers in the clean area of the laundry room. Dryer #1 was out of order. The Supervisor opened the bottom drawer to Dryer #2. There was lint sitting on the back floor of the dryer and on the screen approximately 1/4 inch thick. A photo was taken. He opened the lint trap for Dryer #3. He was asked to pull the basket out. There was a thick pile of lint on the floor of the dryer and around the wires in the bottom of the dryer. The Laundry Aide was asked to sweep the lint out. The swept material was a 2 foot by 8 inches thick piece of lint and a photo was taken. The Supervisor was asked, Is the lint supposed to be on the floor of the dryer and around the wires? He stated, No. He was asked, What can happen if left there. He stated, It can catch a fire. b. On 8/26/2020 at 2:36 PM, the surveyor showed the Administrator the photo of the lint and asked, Should the lint be left in the bottom of the dryer? She stated, Oh . no. c. On 8/26/2020 at 2:42 PM, the Housekeeping Supervisor provided a copy of Laundry-Daily

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

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) Inspections policy that documented, . Dryers: 1 Laundry personnel should brush the lint from the lint screens and remove all accumulated lint compartment after every 2 loads .
F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure oxygen was administered only in the presence of a Physician's Order for 2 (Residents #28 and #46) of 2 residents, and failed to ensure the oxygen tubing and humidifier bottles were dated appropriately, and stored in a bag when not in use, for 3 (Residents #28, #46 and #51) of 3 case mix residents to prevent potential for infection and complications for residents who had oxygen in use. This failed practice had the potential to affect 3 residents who used oxygen, according to a list provided by the Director of Nursing on 08/27/2020 at 11:30 AM. The findings are: 1. Resident #28 had [DIAGNOSES REDACTED]. An MDS with an ARD of 06/21/20 documented the resident scored 13 (13-15 indicates cognitively intact) on a BIMS, required extensive assistance of one person for activities of daily living. a. As of 8/25/20 at 11:30 a.m., there was no order found in the current Physician orders for O2 therapy. There was no documentation in the resident's Care Plan related to oxygen therapy. b. On 08/24/20 at 11:00 AM, the resident was sitting in a wheelchair in his doorway with O2 in use at 2 liters via N/C. There was no date on the O2 tubing. c. On 08/25/20 at 09:12 PM, the resident was lying in bedwith O2 at 2 liters via N/C. There was no date on the oxygen tubing. The O2 was not humidified and there was no bag available to store the O2 tubing in when not in use. The resident removed the O2 tubing from her nares and placed it on the bed. She was asked, Do the staff ever give you a bag to put your oxygen tubing in when you are not using it? She stated, No, I don't think so, I don't remember ever having a bag to put this tubing in. 3. Resident #46 had [DIAGNOSES REDACTED]. An MDS with an ARD of 08/27/20 documented the resident scored 15 (13-15 indicates cognitively intact) on a BIMS, required extensive assistance of 2 persons for ADLs. a. The August 2020 Physician Orders had no documentation for oxygen therapy. b. On 08/24/20 at 12:14 PM, the resident was sitting in a wheelchair at the bedside. Oxygen was on at 4 liters/via nasal cannula. There was no date on the humidifier bottle, and the date on the oxygen tubing was 08/16/20. There was no bag/container to store the oxygen tubing in when not in use. The resident was asked, How often do the staff change your oxygen tubing? She stated, They are supposed to change it every week, but they don't. She was asked, Do you know how many liters of oxygen you should be receiving? She stated, Yes, it should be on 4 liters. c. On 08/24/20 at 01:30 PM, the DON was asked, Is there an order for [REDACTED]. The DON did not locate an order for [REDACTED]. The Policy and Procedure for Oxygen Therapy received from the Assistant Director of Nursing (ADON) on 08/27/20 at 03:50 PM documented, . POLICY: Oxygen therapy is administered by licensed staff only as ordered by a physician or as an emergency measure until an order can be obtained. The physician's order will specify the rate of flow of oxygen. 3. Resident #51 had [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set (MDS) with and Assessment Reference Date (ARD) of 08/01/20 documented the resident scored 14 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS) and received oxygen while a resident. a. The Care Plan dated 01/24/20 documented, I have Oxygen (O2) Therapy @ (at) 2L (liters) PRN (as needed) via N/C (nasal cannula) r/t (related to) ineffective gas exchange . b. The August 2020 Physician orders documented, O2 at 2 l/m (liters per minute) via n/c prn, humidified as needed for SOB (shortness of breath) . c. On 08/24/20 at 12:05 PM, the resident was sitting on the side of the bed. The resident had oxygen at 2 liters by nasal cannula. The oxygen tubing was dated 08/16/20 and the humidifier bottle was dated 08/22/20, (photo taken at 12:06 PM). There was no bag/container to store the oxygen tubing in when it was not in use. d. On 08/25/20 at 09:26 AM, the resident was lying on his bed awake and alert. Oxygen at 2 liters via N/C. The date on the humidifier bottle was 08/22/20 and the date on the tubing was 08/16/20. There was not a bag on the concentrator for resident to store oxygen tubing in when it was not in use. e. On 08/25/20 at 09:30 AM, Licensed Practical Nurse (LPN) #3 was asked, How often should the O2 tubing and the humidifier bottles be changed? She stated, Every Sunday Night. She was asked, Who is responsible for changing O2 tubing and humidifier bottles? She stated, The 11-7 Shift. She was asked, Should there be a bag/container on the concentrator to store the oxygen tubing in when not in use? She stated, Well I guess so. f. On 08/25/20 at 09:40 AM, the Director of Nursing (DON) was asked, How often should the O2 tubing and the humidifier bottles be changed? She stated, Weekly on Sunday night. She was asked, Who is responsible for changing O2 tubing and humidifier bottles? She stated, The night shift on Sunday night, or as needed. She was asked, Should there be a clean dated bag/container on the concentrator to store the oxygen tubing in when not in use? She stated, Not necessarily dated, or changed just the oxygen tubing and the humidifier bottle should be changed weekly. She was asked, Should there be an order for [REDACTED].
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, and interviews the facility failed to ensure medications were labeled and stored in accordance with manufacturer's instructions and accepted standards of pharmacy practice to facilitate accurate administration of medications from 1 ([DATE] Hall medication cart) of 3 (,[DATE]hall, ,[DATE] hall and [DATE]) medication carts; and from 1 ([DATE] medication rooms) of 3 medication rooms, to prevent potential administration of an expired medication to a resident. The failed practices had the potential to affect all 59 residents, according to the Resident lists provided by the Administrator on [DATE]. The findings are: 1. On [DATE] at 1:43 pm, the 500, 600, 700 hall medication carts were inspected with the assistance of Licensed Practical Nurse (LPN) #6. A photo was taken of the top drawer of the cart that contained all the over-the-counter medications, insulins, and [MEDICATION NAME]. The over-the-counter medications did not have an open date written on each bottle. Photos were taken of all the medications listed below: a. Resident #317 had an open bottle of [MEDICATION NAME] 100units/ml (milliliter) with a pharmacy label date of [DATE] which documented, Discard 28 days after open. There was no open date written on the label or the bottle. b. Resident #5 had a open bottle of [MEDICATION NAME] 10ml with a pharmacy label date of [DATE]. There was no open date written on the label or the bottle. c. Resident #57 had a open bottle of [MEDICATION NAME] ,[DATE] with a pharmacy label date of [DATE]. An opened date of [DATE] was written on the label. d. Resident #11 had a open bottle of [MEDICATION NAME] ,[DATE] with a pharmacy label date of [DATE] which documented, Discard 28 days after open. There was no open date written on the label or the bottle. f. Resident #60 had a open bottle of [MEDICATION NAME] with a pharmacy label date of [DATE]. There was no open date written on the label or the bottle. g. Resident #15 had a open bottle of [MEDICATION NAME] with a pharmacy label date of [DATE]. There was no open date written on the label or the bottle. h. On [DATE] at 9:56 am, the DON provided Insulin Expiration dates list: .[MEDICATION NAME], stable for 28 days once in use . [MEDICATION NAME] ,[DATE] .In use vial stable for 42 days . [MEDICATION NAME] ,[DATE] .In use vial stable for 28 days . and [MEDICATION NAME] R .stable for 28 days once in use at room temperature . 2. On [DATE] at 1:58 pm, the medication storage room for [DATE] Halls was inspected with the assistance of Licensed Practical Nurse (LPN) #6. The findings are: a. There were two cartons of [MEDICATION NAME] 1.5 with a use by date of [DATE]. 3. On [DATE] at 02:19 pm, the medication cart for the ,[DATE] hall was inspected with LPN #4 in attendance. In the bottom of the medication cart there was a card that documented, . (Resident #43) [MEDICATION NAME] 50 MG (milligram) . expire: ,[DATE] . a. On [DATE] at 02:42 pm, LPN #4 was asked, Was that medication discontinued that I took a photo of earlier? She said, I believe so. She was asked, Should it have been left in the medication cart? She said, No. She was asked, Could it have been given if it's in the medication cart? She said, Yes. 4. On [DATE] at 08:32 am, the DON was asked, What are the nurses supposed to do with medications that are discontinued? She said, They are to immediately remove from the cart and log in for destruction for the pharmacist to destroy. On [DATE] at 10:15 am, the DON was asked, How long is [MEDICATION NAME] good? The DON stated, It is good until the expiration date on the bottle. The bottles are for a set number of sprays. Once the number of sprays have been exhausted it must be discarded. She was asked, How long is insulin stable for once it has been opened? The DON stated, It should be discarded after 28 days. She was asked, Are staff supposed to date the insulin bottles when they open it? The DON stated, Yes, or we will have to discard it according to the filled by date.
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.**

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) Based on observation and interview, the facility failed to ensure dietary staff washed their hands between dirty and clean tasks and before handling clean equipment or food items to minimize the potential for food borne illness for residents who received meals from 1 of 1 kitchen. The failed practice had the potential to affect 57 residents who received meals from the kitchen (total census: 59), as documented on a list provided by Dietary Employee #1 on 8/25/2020. The findings are: 1. On 08/24/20 at 11:04 AM, Dietary Employee #1 turned on the hand washing sink faucet and washed her hands. After washing her hands, she used her bare hands to turn off the faucet, contaminating her hands in the process. She used her bare hand to push down on the paper towel dispenser handle to dispense paper towel for her to dry her hands. Without washing her hands, she picked up a clean blender blade and attached it to the base of the blender to be used in pureeing food for residents on pureed diets. 2. On 8/24/20 at 11:16 AM, Dietary Employee #2 turned on the 3-compartment sink faucet and washed the blender bowl to be used in pureeing food items for the residents on pureed diets. After washing her hands, she used her bare hands to turn off the faucet, contaminating her hands in the process. Without washing her hands, she picked up a clean blender blade and attached it to the base of the blender to be used in pureeing food for residents on pureed diets. 3. On 8/24/20 at 11:51 AM, Dietary Employee #1 prepared garlic potato to be served to the residents on regular diets. She used a dish towel to pick up a pot that contained garlic potato from the counter and poured some of the garlic potatoes into a pan. At 11:52 am, Dietary Employee #3 took the same dish towel that Dietary Employee #1 had used and transferred garlic mashed potatoes into a pan. As Dietary Employee #3 picked up a pot of garlic mashed potatoes, the dish towel brushed on the garlic potatoes. At 11:53 am, Dietary Employee #1 reached into a parsley container, removed a handful of parsley with her bare hand and sprinkled it on top of the garlic mashed potatoes to be served to the residents on regular diets. She picked up a piece of parsley and put it in her mouth. Dietary Employee #1 did not wash her hands before touching parsley. 4. On 8/24/20 at 12:17 PM, Dietary Employee #4 turned on the sink faucet and washed her hands. After washing her hands. She used her bare hand to push down on the paper towel dispenser handle to dispense paper towel to dry her hands. She went to the walk-in refrigerator and removed 5 pounds of cheese slices and placed it on the counter. Without washing her hands, she placed gloves on her hands, contaminating the gloves. She removed slices of cheese from the package and placed them on top of hamburger patty to be served to a resident who requested cheeseburger with her meal. At 1:29 pm, Dietary Employee #1 was asked, What should you have done after handling dirty objects before touching clean equipment or food? She stated, Washed my hands. 5. On 8/24/20 at 3:25 PM, Dietary Employee #2 turned on the hand washing sink faucet and washed her hands. After washing her hands, she used her bare hand to turn off the faucet, contaminating her hand in the process. She used her bare hand to push down on the paper towel dispenser handle to dispense paper towel to dry her hands. She then picked up paper cups by their rims and placed them on the cart to be used in serving beverages to the residents for the supper meal. 6. On 8/24/20 at 3:30 PM, Dietary Employee #4 was about to pour pureed cut green beans into a pan that had a piece of leftover wet brown matter in it. Surveyor showed the piece of wet leftover residue to Dietary Employee #4 who took the pan away and used another pan to pour the pureed cut green beans into. At 3:33 PM, Dietary Employee #4 used her bare hand to scrape pureed cut green beans and felt it with her fingers. She picked up a spatula from the counter and rinsed it at the sink, then used the spatula to scrape pureed cut green beans into a pan. Dietary Employee did not wash the spatula with soap or sanitize it before using it to scrape the pureed green beans.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 318) was substantiated, all or in part with these findings. Based on observations, record review and interviews, the facility failed to ensure proper infection prevention and control practices were maintained to prevent the development and transmission of COVID-19 and other communicable diseases and infections by wearing a face mask to cover the mouth and the nose and failed to ensure resident drainage bags were not in direct contact with the floor in 1 of 1 facility. These failed practices had the potential to affect 1 resident with drainage bags and 59 residents who resided in the facility according to the Resident Census and Conditions of Residents form dated 8/24/2020. The findings are: 1. Resident #317 had [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/27/20, documented the resident scored 15 (13-15 indicates cognitively intact) on the Brief Interview for Mental Status (BIMS), required supervision only with bed mobility, transfer, dressing, toilet use and personal hygiene. a. On 08/24/20 at 3:20 PM, Resident #317 was lying in bed. There were two drain tubes coming from the resident and the tubing and bags were lying in the floor. Resident #317 stated, I have a drain coming from my stomach and I have a drain coming from my pancreas. He was asked, Do your drainage bags always lay in the floor? Resident #317 stated, Yes. b. On 8/25/20 at 8:32 AM, Resident #317 was lying in bed. The two drain tubes and drainage bags continued to lie in the floor. Photos were taken. c. On 8/26/20 at 9:22 AM, Resident #317 was lying in bed. There was only one drainage bag on the floor. Resident #317 stated, I went to the doctor today and he removed the drain that was in my pancreas. d. On 08/27/20 at 2:33 PM, Resident #317 had one drainage bag that was on the floor in a pillowcase. e. On 08/27/20 at 2:35 PM, Licensed Practical Nurse (LPN) #1 was asked, Should the resident's drainage bag be on the floor? She stated, No, he gets himself up and down, so he takes it off on his own. She was asked, What could happen with it on the floor? LPN #1 stated, It is not sanitary, and he could trip over it. She was asked, Is that a potential for an infection control issue? LPN #1 stated, Absolutely, it would be. f. On 08/27/20 at 2:43 PM, The Director of Nursing (DON) was asked, Should the Resident's drainage bag be on the floor? The DON stated, Not ideally, no. She was asked, What could happen with it on the floor? The DON stated, He could trip over them, potential for infection control and it would be preferred to keep it off the floor. She was asked, Is that a potential for an infection control issue? DON stated, Certainly a concern. 2. On 08/24/20 at 11:08 AM, Certified Nursing Assistant (CNA) #4 was walking down the 500 hallway, carrying a bag of trash. Her mask was down under her nose. She was asked, How are you supposed to wear your mask? CNA #4 stated, It was over my nose, but it slipped down. She was asked again, How are you supposed to wear your mask? CNA #4 stated, Cover my nose and my mouth. 3. On 8/25/20 at 8:23 AM, CNA #5 place her notebook in the clean linen cart on the 400 Hall. She was asked, The notebook you put into the clean linen cart, has it been cleaned and sanitized? CNA #5, No. She was asked, By placing a dirty notebook into the clean linen cart, is that potential to spread infection? CNA #5 stated, Yes. 4. On 08/25/20 at 12:57 PM, Licensed Practical Nurse (LPN) #2 had a mask on that was not covering her mouth or nose. She looked up at the surveyor and pulled her mask up to cover her nose. She was asked, How are you supposed to wear your mask? She said, Cover nose mouth and under goggles. She was asked, How did you have it when we walked up? She said, I had it down under nose and mouth. 5. On 08/25/20 at 12:58 PM, LPN #1 was talking with a resident who was sitting in her wheelchair. Her mask was down under her chin. She looked up at the surveyor and pulled her mask up to cover her nose. She was asked, How are you supposed to wear your mask? She said, Cover your nose, and this one won't stay up. 6. On 08/25/20 at 01:14 PM, CNA #1 was talking with a resident. The CNA's mask was down below her nose. When she saw the surveyor, she pulled her mask up to cover her nose. She was asked, How are you supposed to wear your mask? She said, Over my nose and my mouth. 7. On 8/26/20 at 12:57 PM, CNA #6 exited a resident's room. Her mask was down below her nose as she stood in the doorway. She was asked, How are you supposed to wear your mask? CNA #6 stated, Above your nose and cover your mouth. It just slid down. When you work and sweat, it just slides down.