

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 345342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/22/2020
NAME OF PROVIDER OF SUPPLIER BIG ELM RETIREMENT AND NURSING CENTERS		STREET ADDRESS, CITY, STATE, ZIP 1285 WEST A STREET KANNAPOLIS, NC 28081	
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 0684 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on interviews with nursing staff, physicians, and a Paramedic, and review of hospital records and medical records, the facility failed to leave a cognitively impaired resident in place, for a full assessment to rule out significant injury, after a fall with a head injury. Resident #1 was found face down on the floor after an unwitnessed fall that resulted in a 4 centimeter (cm) laceration to the mid forehead. The staff failed to stabilize the head/neck of Resident #1 before she was turned to her back and mechanically transferred to her bed. The Resident was transferred to the hospital for an evaluation of sutures to the laceration. This affected 1 of 3 sampled residents reviewed for assessing quality of care. The findings included:Resident #1 was admitted to the facility on [DATE] and readmitted from the hospital on [DATE] to the facility under Hospice care. Resident #1 was discharged to the Emergency Department (ED) on 5/1/20 for suture evaluation after a fall in the facility. She did not return to the facility. [DIAGNOSES REDACTED]. A Significant Change Minimum Data Set (MDS), dated [DATE], assessed Resident #1 with unclear speech, sometimes understood/understands, highly impaired vision, impaired short/long-term memory, moderately impaired cognitive skills for daily decision-making, impaired mood, impaired range of motion (ROM) to her lower extremities, total dependence on staff for bed mobility/transfers, frequent use of antipsychotic/antidepressant/opioids and Hospice care. Review of a quarterly MDS dated [DATE], assessed Resident #1 with unclear speech, sometimes understood/understands, highly impaired vision, short/long-term memory loss, moderately impaired cognitive skills for daily decision-making skills, impaired mood, impaired ROM to her lower extremities, total dependence on staff for bed mobility/transfers, daily use of antipsychotic/antidepressant medications and Hospice care. The MDS documented that since readmission to the facility, she had 1 fall without injury and 1 fall with injury that was not major. A care plan, last reviewed 4/7/20, documented Resident #1 was at risk for falls and fall related injuries. Her fall risk factors were related to a [DIAGNOSES REDACTED]. Interventions included, in part, to initiate neuro checks (neurological assessment) if a head injury was suspected or occurred, advise the physician of any changes in level of consciousness and follow up per physician recommendations. Review of the facility's policy, Assessing Falls and their Causes, revised March 2018, documented in part, that if a resident was found on the floor without a witness to the event, staff should evaluate for possible injuries to the head, neck, spine and extremities. If there was evidence of injury, staff should provide appropriate first aide and/or refer for medical treatment immediately. If the assessment ruled out significant injury, the resident should be assisted to a comfortable sitting, lying or standing position. A nurse progress note, dated 5/1/20 written at 11:53 AM, was completed by Nurse #1. The note documented that on 5/1/20, at 9:00 AM, Resident #1 was found on the floor face down with blood puddled underneath her face. The Resident was turned to rest on her back, a gash was noted to her forehead, blood was on her lips and under the tongue. All her teeth that were visible were observed intact. She was able to move her upper and lower extremities. The Hospice nurse, her family and her physician were contacted. Resident #1 left the facility at 9:34 AM for a hospital evaluation. An incident report (IR) completed by Nurse #1, recorded that Resident #1 had an unwitnessed fall from her bed on 5/1/20. The IR documented that the Resident was found by NA #1 face down on the floor in a puddle of blood under her face at approximately 9:00 AM. Nurse #1 was notified. Nurse #1 observed Resident #1 face down on the floor at bedside in a puddle of blood under her face. Resident #1 was positioned onto her back and observed with a 4 cm deep laceration to her forehead. She was put in bed, steri strips (bandage) applied and the physician and family were notified. Resident #1 was transferred to the ER for evaluation. A SBAR (Situation, Background, Appearance and Review) dated 5/1/20, completed by Nurse #2 (Unit Manager) documented that Resident #1 sustained a laceration to her forehead from a fall on 5/1/20. Vital signs were assessed as blood pressure, 130/74; pulse 80; respirations, 20; temperature 98.2 and oxygen saturations 98% on room air. Steri strips were applied with pressure and the Resident was given [MEDICATION NAME] SL (sublingual/under the tongue) for generalized pain as evidenced by facial grimacing and non-verbal signs of pain. She was transferred to the hospital via a stretcher for evaluation of sutures to the laceration. A telephone interview occurred on 5/13/20 at 12:15 PM with Nurse Aide #1 (NA #1). The interview revealed, she was the assigned NA on 5/1/20 when Resident #1 fell. NA #1 stated she provided morning care to Resident #1 between 7:30 - 8:00 AM the morning of 5/1/20. NA #1 described Resident #1 as combative during care, fighting/screaming, and trying to get out of her bed. NA #1 stated redirection was not successful, so she advised Medication Aide #1 (MA #1) who provided Resident #1 with her morning medications and [MEDICATION NAME] (medication for anxiety). Resident #1 then received her morning care and had breakfast. NA #1 further stated that after breakfast, around 8:30 AM, she was asked by Nurse #2 to place Resident #1 back to bed for a wound consult. Around 9:00 AM, NA #1 found Resident #1 on the floor, next to her bed, face down, laughing, moaning and bleeding. NA #1 further stated that Nurse #1 and Nurse #2 turned Resident #1 onto her back and Nurse #1 and Nurse #2 assessed the Resident. After Resident #1 was assessed, NA #1 received instruction to move Resident #1 from the floor to her bed. NA #1 stated she used a mechanical (Hoyer) lift to move Resident #1 from the floor to her bed. NA #1 also stated that nothing was used to support Resident #1's head/neck during the transfer because she was not told to do that. NA #1 described that Resident #1 began to yell out when NA #1 moved Resident #1 with a Hoyer lift off the floor to her bed. When emergency medical services (EMS) arrived, Resident #1 was in her bed on her back yelling/screaming off/on. An interview with Nurse #1 occurred on 5/12/20 at 12:20 PM. Nurse #1 stated she was the assigned Nurse for Resident #1 on 5/1/20 the day she fell. The Resident was found by NA #1 around 9:00 AM and Nurse #1 was called to the room. Nurse #1 said she found the Resident lying face down on the floor, with her arms extended out, in a pool of blood around her head. Nurse #1 said, I turned her over to see where the blood was coming from and to get her cleaned up. Nurse #1 said she found a deep gash (laceration) to Resident #1's mid forehead. Nurse #1 also said she did not stabilize the head/neck of Resident #1 before the Resident was turned to her back or moved off the floor because Nurse #1 did not notice anything unusual about the position of the Resident's head. Nurse #1 further stated she touched and looked everywhere, assessed Resident #1's vital signs within normal limits, completed a full head to toe assessment and range of motion (ROM). Resident #1 had full ROM to all extremities with no other injuries noted and neuro checks were initiated. Nurse #1 described that Resident #1 was confused, laughing/moaning and unable to provide an explanation of the events surrounding the unwitnessed fall or if she was in pain. After Resident #1 was assessed she was moved off the floor with a Hoyer lift by NA #1 and placed in bed on her back. The Resident was medicated with [MEDICATION NAME] for generalized pain as evidenced by moaning and remained in bed until EMS arrived. An interview with Nurse #2 occurred on 5/12/20 at 12:56 PM. Nurse #2 stated Resident #1 had an in-house appointment for a wound consult on 5/1/20, so she asked NA #1 to put Resident #1 back to bed after breakfast. Around 9:00 AM, Nurse #2 was advised that Resident #1 had fallen in her room. Nurse #2 went to the room and saw NA #1 and Nurse #1 in the room with Resident #1 face down on the floor in a pool of blood. Nurse #2 further stated, she and Nurse #1 turned Resident #1 onto her back to assess the Resident and to see where the blood was</p>		

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 0684 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>(continued... from page 1)</p> <p>coming from. Nurse #2 stated that staff did not wait for EMS to arrive and they did not use anything to stabilize the head/neck of Resident #1 because her head was not in an odd position. Nurse #2 stated Nurse #1 completed a head to toe assessment, took vital signs and that pressure, ice and steri strips were applied to the laceration on her forehead to stop the bleeding. Nurse #2 described Resident #1 was moaning/laughing when she found on the floor and screamed, yelled, moaned and grimaced when she was turned to her back, when she was assessed and when she was moved off the floor back to her bed. Nurse #2 also stated that Resident #1 could not state whether or not she was in pain, but that the Resident was medicated for generalized pain because the moaning and grimacing were not baseline responses for this Resident. Nurse #2 stated that the Physician, family, and Hospice Nurse were notified. EMS was called for a hospital transfer to evaluate the need for sutures because the steri strips did not hold the laceration intact. Nurse #2 stated after Resident #1 was assessed, she was transferred off the floor to her bed with a Hoyer lift and remained in bed until EMS arrived. An interview with Medication Aide #1 (MA #1) occurred on 5/12/20 at 1:13 PM. MA #1 stated that on 5/1/20 around 7:30 AM, NA #1 advised her that Resident #1 was fighting/screaming during morning care, and after trying everything Resident #1 could not be redirected. MA #1 stated she medicated Resident #1 with [MEDICATION NAME] which was effective. MA #1 further stated that around 9:00 AM she saw Resident #1 on the floor in her room lying on her back, moaning, grimacing and agitated. Staff were present and the Resident had a gash to her forehead that was bleeding. MA #1 also stated that once staff got Resident #1 cleaned up, MA #1 gave her [MEDICATION NAME] in a syringe due to moaning/agitation. Review of ED records dated 5/1/20, revealed Resident #1 received 8 sutures to close the laceration she sustained to her mid forehead after the fall. A computed tomography (CT) scan dated 5/1/20 revealed prior cervical spine surgery, [MEDICAL CONDITION] cervical vertebra and small [MEDICAL CONDITION] of the 5th cervical vertebra. The physician did not document that the CT scan identified any acute findings or the age of the fractures. The CT scan of the head showed no acute intracranial pathology. Additionally, an orthopedic consult recommended the application of a cervical collar due to fractures of the 4th cervical vertebra and a small [MEDICAL CONDITION] of the 5th cervical vertebra. Review of the EMS report dated 05/01/20 revealed EMS was dispatched at 9:18 AM, arrived at the Resident's bedside at 9:29 AM and placed a cervical collar to Resident #1 at 9:44 AM. A telephone interview occurred on 5/21/20 at 10:28 PM with Paramedic #1. During the interview, Paramedic #1 stated EMS received a phone call from the facility on 5/1/20 at 9:15 AM requesting a transport to the ED. Paramedic #1 stated when she arrived at the facility, Resident #1 was in her bed on her back, bleeding from her forehead and 2 staff were present. Paramedic #1 stated staff advised that Resident #1 had an unwitnessed fall from her bed and was found on the floor face down in a pool of blood. Staff advised that the Resident had progressive dementia and cognitive impairment and could not explain the events that led to her fall. Staff also advised that they moved Resident #1 off the floor to her bed using a Hoyer lift after assessing her and treating her wound. Paramedic #1 further stated that paramedics worked under the direction of county protocols from the Medical Examiner which required assessing the head/neck and stabilizing the head/neck for spine clearance prior to moving a patient who had an unwitnessed fall with head injury and the patient could not describe the events of the fall. Paramedic #1 also stated that residents were usually left in place until paramedics arrived if the fall was unwitnessed, the resident could not describe the events of the fall and the resident sustained [REDACTED]. #1 stated that Resident #1 screamed/yelled out when touched and assessed by Paramedic #1. Paramedic #1 stated she asked staff several times if this was the Resident's baseline and she was told that yelling/screaming was the Resident's baseline. Paramedic #1 further stated that before EMS moved Resident #1 from her bed to the stretcher, a cervical collar was placed to Resident #1's neck to minimize any further injury to the head/neck since it could not be determined if the resident sustained [REDACTED]. No other injuries were identified. A telephone interview with the Director of Nursing (DON) occurred on 5/13/20 at 12:52 PM. The DON stated she was in the facility on 5/1/20 when Resident #1 fell . The DON went to the room when she was notified that Resident #1 fell in her room. The DON observed Resident #1 on the floor on her back with Nurse #1 and Nurse #2 present. The DON stated the staff were talking to Resident #1, but the Resident could not explain what happened. The DON described that Resident #1 was confused and crying and had a gash to her forehead that was bleeding. The DON further stated that she did not witness the nursing assessment of Resident #1, but was advised that after Resident #1 was assessed, NA #1 used a Hoyer lift to put her back to bed prior to the arrival of EMS. The DON stated, We did not immobilize the head, we did not see a reason to. The DON stated that she expected nursing staff to follow the facility's falls policy which indicated that if a resident sustained [REDACTED]. The DON stated that if the nurse noticed a concern with how the head/neck was positioned, like if it were extended, then she would expect the head/neck to be stabilized before the resident was moved, otherwise, she would not expect the nurse to stabilize the head/neck prior to moving the resident. During a follow up telephone interview on 5/22/20 at 3:00 PM with the DON she stated Resident #1 was moved from a face down position to her back so the nurse could identify where the blood was coming and then moved off the floor prior to EMS arriving due to being found face down, bleeding from her head and due to her high risk of aspiration. A telephone interview with the Resident's physician occurred on 5/13/20 at 1:39 PM. During the interview, the physician stated her office was notified of an unwitnessed fall with head injury for Resident #1 on 5/1/20. Nursing staff described that Resident #1 sustained a 4 cm laceration to her forehead. A physician's orders [REDACTED]. The physician stated that she assessed Resident #1 on 4/30/20 and described Resident #1 with significant decline, increased agitation and a life expectancy of less than 30 days. The physician further stated review of hospital records from 5/1/20 revealed no indication of injury to the spinal cord, previous cervical surgery, a [MEDICAL CONDITION] cervical vertebra and small [MEDICAL CONDITION] of the 5th cervical vertebra. She stated that the hospital records did not indicate that the fractures were acute. The physician stated that she expected staff to conduct a thorough exam of the head/neck of a resident who sustained head injury after an unwitnessed fall, complete neuro checks and to stabilize the head before moving the resident if the head/neck was noted in a strange position or awkward angle. A telephone interview with the ED physician occurred on 5/15/20 at 3:00 PM. The ED physician confirmed that he was the physician who assessed Resident #1 in the ED on 5/1/20. The ED physician stated Resident #1 arrived in the ED via Paramedics with a cervical collar in place and a head injury. He assessed Resident #1 with severe neurological impairment, and unable to report the events of her fall, so he ordered a CT scan. He stated the CT scan identified a [MEDICAL CONDITION] cervical vertebra and small [MEDICAL CONDITION] of the 5th cervical vertebra, but that the scan was not definitive regarding the age of the fractures. He described Resident #1 as a complicated case because of her neurological impairment. The ED physician stated that moving a patient like this prior to ruling out significant injury, spine clearance, prior to EMS arrival and stabilizing the head would depend on how the resident was found. If the resident had complaints of head/neck pain or the position of the head/neck was of concern, then stabilizing the head/neck would be beneficial prior to moving the resident.</p> <p>Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility's policies on Initiating Transmission-Based Precautions and Personal Protective Equipment (PPE), the facility failed to implement their policies and procedures by not posting transmission-based precaution signage on the room entrance door for 1 resident (Resident #8) and when a Personal Care Assistant (PCA) was observed wearing a facial mask that did not cover her nose for 1 of 2 hallways (100 hall) reviewed for infection control. These failures occurred during a COVID-19 pandemic. Findings included: 1. A facility policy titled Isolation-Initiating Transmission-Based Precautions, last revised October 2018 was reviewed. The policy read in part: Policy Interpretation and Implementation: When Transmission-Based Precautions are implemented, the Infection Preventionist (or designee): A. Clearly identifies the type of precautions, the anticipated duration, and the personal protective equipment (PPE) that must be used. B. Determine the appropriate notification on the room entrance door and on the front of the resident's chart so that personnel and visitors are aware of the need for and type of precautions: The signage informs the staff of the type of Centers of Disease Control (CDC) precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room. Resident #8 was admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Resident #8 had a physician order [REDACTED]. Resident #8's baseline care plan dated 5/6/2020 revealed he was cognitively intact and received special treatments/ procedures- contact precautions. An observation was completed on 5/12/2020 at 10:05 AM of Resident #8 and his room. Resident #8 was observed from the hallway asleep in bed. Observation of Resident #8's room door revealed an over the door isolation storage unit which contained a stethoscope and blood pressure cuff, gowns, gloves, and masks. Further observation of Resident #8's door revealed no signage posted indicating the type of transmission-based precaution being implemented, instructions for use of PPE and/or instructions to see the nurse before entering the room. An interview was completed on 5/12/2020 at 10:25 AM with Nurse #3. She stated she had one resident on transmission-based precautions which was Resident #8. Nurse #3 expressed Resident #8 was on contact</p>		
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F 0880 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>(continued... from page 2)</p> <p>precautions [MEDICAL CONDITION]. Nurse #3 verbalized signage could not be on the resident's room door indicating the type of transmission-based precautions due to privacy. She expressed staff would check with the nurse on the hall prior to entering the resident's room. The nurse would inform staff which transmission-based precautions were being implemented. Nurse #3 also communicated transmission-based precaution information was also located on the resident's cardex (plan of care) at the nurse's station. An interview was completed on 5/12/2020 at 10:30 AM with the Unit Manager (UM) who explained when a resident was on transmission-based precautions the information was kept at the nurse's station on the residents cardex (plan of care). She further stated the isolation storage unit on Resident #8's door was another identifier that a resident was on transmission-based precautions. The UM verbalized anything other than contact precautions would have signage in place on the resident's room door. She communicated she would verify this information with her Infection Preventionist/ Control Nurse. An interview was completed on 5/12/2020 at 10:40 AM with the MDS Coordinator who stated Resident #8 was on contact precautions. She further indicated she was not certain whether signage stating the type of transmission-based precautions should be posted or not. A follow-up interview was completed on 5/12/2020 at 10:42 AM with the Unit Manager (UM). She explained per the Infection Preventionist/ Control Nurse signage should be posted which indicated the type of transmission-based precaution being implemented for Resident #8. The UM communicated she would place transmission-based precaution signage on Resident #8's door immediately. An observation was completed of Resident #8's room door on 5/12/2020 at 10:47 AM. Transmission-based precaution signage was visible indicating contact precautions and type of PPE required. An interview was completed on 5/12/2020 at 11:00 AM with the Infection Preventionist/ Control Nurse (IPCN). She verbalized staff checked the resident's cardex (plan of care) at the nurse's station to determine what type of transmission-based precautions were being implemented. She continued to express appropriate signage would be visibly posted on the resident's room door. The IPCN was not certain as to why signage was not posted on Resident #8's room door. An interview was completed on 5/12/2020 at 3:00 PM with the Administrator. He verbalized signage should be posted on the resident's room door and visible. This would alert staff of the type of transmission-based precautions which were being implemented. An interview was completed on 5/13/2020 at 2:09 PM with the Director of Nursing (DON). She communicated signage should be posted on resident's doors that describe the type of transmission-based precautions being implemented by nursing staff. Information was also available on the resident's cardex (plan of care) at the nurse's station. The DON was not certain as to why the signage was not posted. The DON expressed education would be provided to all shifts regarding posting transmission-based precaution signage on resident's doors that were on precautions. 2. A facility policy titled Personal Protective Equipment, last revised October 2018 was reviewed. The policy read in part: Personal Protective Equipment: Place the mask over the nose and mouth A facility policy titled Covid-19: Infection Prevention and Use of Personal Protective Equipment (no date) was reviewed. The policy read in part: Policy Interpretation and Implementation: Universal source control will be required for everyone in the facility. Everyone entering the facility must wear a cloth face covering or facemask. An observation was completed on 5/12/2020 at 10:20 AM of a personal care aide (PCA) #1 leaving a resident's room on the 100 hall with bed linen in a clear plastic bag. She was observed to exit the room with her facial mask not covering her nose. PCA #1 continued down the 100 hall and deposited the bed linen in the soiled utility room. She proceeded back to the 100 hall with her facial mask still not covering her nose. An interview was completed on 5/12/2020 at 10:35 AM with PCA #1. Her nose remained uncovered with the facial mask. She explained she had received training on wearing her PPE properly, specifically how to place a facial mask on and how to take a facial mask off, by facility administration. She communicated her facial mask should cover her nose and mouth. The PCA #1 stated her facial mask slid down when assisting on the hall. She could not explain why her facial mask continued to not be applied properly to cover her nose. An interview was completed on 5/12/2020 at 10:45 AM with the Medication Aide (MA) #1. She explained she had received training on wearing her PPE properly, specifically how to place a facial mask on and how to take a facial mask off, by facility administration. MA #1 verbalized she monitored her staff on the hall and provided reminders to staff to ensure they had their PPE on properly. MA #1 was not certain as to why PCA #1's facial mask was not covering her nose. She stated she would speak with her immediately. An interview was completed on 5/12/2020 at 11:00 AM with the Infection Preventionist/ Control Nurse (IPCN). She communicated all staff had been trained on wearing PPE properly, inclusive of taking on/ taking off facial masks. She indicated that PCAs were included in this all staff training. The IPCN verbalized staff should have on appropriate PPE and it should be worn properly. The nose and mouth should be covered when wearing a facial mask. She explained charge nurses and medication aides should be monitoring staff throughout the day to ensure PPE was being worn correctly. An interview was completed on 5/12/2020 at 3:00 PM with the Administrator. He stated staff should wear PPE, specifically facial masks, per manufacturer's recommendation. The Administrator verbalized the facial mask should be covering the nose and mouth area. An interview was completed on 5/13/2020 at 2:09 PM with the Director of Nursing (DON). She stated all staff received in-servicing regarding PPE specifically donning (placing on) and doffing (taking off). She explained PCA #1 received education and participated in a return demonstration. The DON continued to verbalize PCA #1 had since received additional education with return demonstration of wearing a facial mask properly. She communicated all staff were being re-educated on wearing PPE properly. The DON was not certain as to why PCA #1 did not have her facial mask on correctly.</p>		