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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415089 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/15/2024 |
| NAME OF PROVIDER OR SUPPLIER Alpine Nursing Home Inc | | STREET ADDRESS, CITY, STATE, ZIP CODE 557 Weaver Hill Road Coventry, RI 02816 | |

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) |
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| <p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p> | <p>Ensure each resident receives an accurate assessment.</p> <p>47939</p> <p>Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to ensure that the assessment accurately reflected the resident's status for 1 of 1 resident reviewed for hand contractures (shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become very stiff), Resident ID #23.</p> <p>Findings are as follows:</p> <p>Record review revealed the resident was admitted to the facility in January of 2022 with diagnoses including, but not limited to, age-related physical disability, tremors, and contracture of the right hand.</p> <p>Record review of an Occupation Therapy (OT) evaluation plan and treatment dated 4/10/2023 through 5/9/2023 revealed the resident was evaluated and treated for a contractures to his/her left-hand. Additional record review revealed s/he experienced a functional limitation due to this contracture.</p> <p>Record review of an OT evaluation plan and treatment dated 10/24/2023 through 11/22/2023 revealed the resident was evaluated and treated for contractures to his/her left and right hands. Additional review revealed s/he experienced functional limitations due to these contractures.</p> <p>During a surveyor observation of the resident on 4/10/2024 at approximately 9:00 AM revealed the resident's left and right hands appeared to be contracted.</p> <p>Record review of the Minimum Data Set (MDS) Assessments failed to reveal evidence of documentation the contractures to his/her upper extremities on the following dates after it was identified:</p> <p>-4/26/2023</p> <p>-6/23/2023</p> <p>-7/26/2023</p> <p>-9/13/2023</p> <p>-10/31/2023</p> <p>(continued on next page)</p> |

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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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p> | <p>-11/22/2023</p> <p>-1/12/2024 (annual)</p> <p>-1/31/2024</p> <p>-3/19/2024</p> <p>During a surveyor interview with the Therapy Manager on 4/15/2024 at approximately 9:00 AM, she indicated that therapy had been working with the resident during the above-mentioned dates related to his/her hand contractures. Additionally, she revealed that hand contractures, the limited range of motion and muscle shortness contributed to the resident overall decline in activities of daily living due to the inability to use his/her rolling walker.</p> <p>During a surveyor interview with the Director of Nursing Services on 4/15/2024 at 10:07 AM, she acknowledged the above mentioned MDS Assessments should have reflected the contractures to both of the resident's hands. Additionally, she was unable to provide evidence that the MDS assessments for Resident ID #23 were completed accurately, specific to his/her contractures.</p> | | |

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| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>21613</p> <p>Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to ensure that services provided meet professional standards of quality relative to following a physician's order for 1 of 1 resident reviewed for apical pulse (AP- a heartbeat measurement by listening with a stethoscope to the left center of the chest. This is the most accurate evaluation of a person's heart rate, particularly when an abnormality is detected), Resident ID #8.</p> <p>Findings are as follows:</p> <p>According to Mosby's 4th Edition, Fundamentals of Nursing page 314 states, The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients.</p> <p>Record review revealed the resident was admitted to the facility in December of 2022 with diagnosis including, but not limited to, bradycardia (a slow heart rate that can occur due to heart issues and other health conditions).</p> <p>Further record review revealed the resident has a physician's order dated 1/5/2024 and revised on 4/12/2024 for .Monitor ./AP daily. Pending cardiology follow up appointment for medication management .</p> <p>During a surveyor observation of Medication Technician, Staff A, on 4/12/2024 at 9:30 AM revealed she obtained the resident's radial pulse (pulse that can be felt/measured at the radial artery, which is located on the thumb side of the wrist) instead of the apical pulse as ordered.</p> <p>During a surveyor interview, following the above observation with Staff A on 4/12/2024 at 9:47 AM, she acknowledged she obtained the radial pulse instead of the apical pulse. Staff A further revealed she has been obtaining a radial pulse and documenting it on the Medication Administration Record (MAR) as if she was obtaining as apical pulse.</p> <p>Record review of the MAR for April 2024 revealed Staff A documented that she obtained the apical pulse on 8 out of 12 days</p> <p>-4/1/2024</p> <p>-4/3/2024</p> <p>-4/4/2024</p> <p>-4/5/2024</p> <p>-4/8/2024</p> <p>-4/9/2024</p> <p>(continued on next page)</p> | | |

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| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>-4/10/2024</p> <p>-4/12/2024</p> <p>During a surveyor interview with the Director of Nursing Services on 4/12/2024 at 10:00 AM, she acknowledged that Staff A obtained the radial pulse instead of the apical pulse and further indicated that it is her expectation that staff would follow the physician's order.</p> <p>47939</p> | | |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>47808</p> <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide respiratory care consistent with professional standards of practice for 2 of 2 residents reviewed for respiratory care, Resident ID #s 2 and 23.</p> <p>Findings are as follows:</p> <p>Record review of a facility policy undated and titled, Use of Oxygen, Nebulizers [medical device that turns liquid medication into a very fine mist that a person can inhale through a face mask or mouthpiece] & Supplies, states in part, .1. All nasal cannulas [a device used to deliver supplemental oxygen or increased airflow to a patient], masks, and humidifier bottles will be changed, labeled, and signed off on the emar [electronic medication administration record] once a week 2. Extension tubing and connectors will be changed once a week, labeled, and signed on emar .</p> <p>1. Record review revealed Resident ID #2 was readmitted to the facility in May of 2023 with diagnoses including, but not limited to, acute and chronic respiratory failure with hypercapnia (an elevated level of carbon dioxide in the blood), obstructive sleep apnea (obstruction of the upper airway during sleep), and pulmonary fibrosis (a lung disease that occurs when lung tissue becomes damaged and scarred).</p> <p>Review of a physician's order dated 7/29/2023, revealed change oxygen tubing every week on Saturdays, on 11-7 [11:00 PM to 7:00 AM].</p> <p>Review of the April 2024 Treatment Administration Records (TAR) revealed the nurse had signed off the physician's order that she changed the resident's oxygen tubing on 4/6/2024.</p> <p>During multiple surveyor observations on 4/10/2024 and 4/11/2024 revealed the resident was noted to have oxygen tubing labeled with a date of 3/31.</p> <p>During a surveyor interview with Licensed Practical Nurse, Staff B on 4/11/2024 at 12:30 PM while in the resident's room, she acknowledged the resident's oxygen tubing was dated 3/31.</p> <p>During a surveyor interview with the Director of Nursing Services (DNS) on 4/11/2024 at 12:40 PM immediately following the above observation and while in the presence of Staff B, she stated she would have expected the resident's oxygen tubing to be changed per the physician's order.</p> <p>2. Record review revealed Resident ID #23 was admitted to the facility in January of 2022 with diagnoses including, but not limited to, chronic obstructive pulmonary disease [a chronic inflammatory lung disease that causes obstructed airflow from the lungs] and heart failure.</p> <p>Review of a physician's order dated 10/6/2023, revealed o2 [oxygen] 2-4 liters per min via nasal cannula prn [as needed] for SOB [shortness of breath].</p> <p>During surveyor observations of the resident on 4/11/2024 at 2:50 PM and 4/12/2024 at 9:50 AM revealed oxygen was in place via nasal cannula and the liter flow was set at 1.5 liters per minute.</p> <p>(continued on next page)</p> | | |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During a surveyor interview with Registered Nurse, Staff C, on 4/12/2024 immediately following the above observation, she acknowledged the resident is receiving 1.5 liters per minute of oxygen when the physician's order is for the resident to received 2-4 liters per minute.</p> <p>During a surveyor interview with the DNS on 4/15/2024 at 10:29 AM she revealed that her expectation would be for the physician's order to be followed.</p> <p>47939</p> | | |

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| <p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>47808</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that residents who are trauma survivors receive trauma informed care in accordance with professional standards of practice and account for the resident's experiences and preferences for 5 of 15 residents reviewed for Trauma Informed Care, Resident ID #s 22, 26, 31, 50 and 51.</p> <p>Findings are as follows:</p> <p>Record review of State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities, states in part, S483.25(m) Trauma-informed care .Assessment Facilities should use a multi-pronged approach to identifying a resident's history of trauma .This would include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument (RAI), Admission Assessment, the history and physical, the social history/assessment, and others .</p> <p>Record review of a facility policy dated 7/25/2019 titled, Trauma-Informed Care & Compassion Fatigue, states in part, Trauma-Informed Care is a person-centered, culturally competent approach to care, which takes an individual's past traumatic experiences into account, recognizes the coping mechanisms that have resulted from the trauma and understands the behaviors that accompany the trauma; thereby, giving the individual a feeling of safety within his/her environment and a sense of well-being .as professional caregivers, we will encounter residents who have experienced trauma during their lives .we must have the ability to impact these individuals in a positive way through person-centered care .</p> <p>1. Record review revealed Resident ID #31 was admitted to the facility in August of 2020 with diagnoses including, but not limited to, depression, anxiety and dementia with psychotic disturbance (a diagnosis that affects the mind and makes it harder for someone to think clearly, make good judgments, respond emotionally and communicate effectively).</p> <p>Review of a social service quarterly assessment note dated 11/3/2023, revealed the resident's Power of Attorney disclosed to the social worker that the resident's past includes a history of trauma and also revealed that Resident ID #31 witnessed his/her spouse endure a tragic accident involving a fall, which resulted in his/her death.</p> <p>Record review of the psychiatric assessment notes dated 1/19/2024 and 2/16/2024, states in part, .though memory often seems reasonable .impresses me as having a H/O (history of) being traumatized but will not answer questions about past .</p> <p>Further record review failed to reveal evidence that an assessment for trauma was completed or that a care plan for trauma was developed or implemented for Resident ID #31.</p> <p>2a. Record review for Resident ID #22 revealed the resident was admitted to the facility in June of 2023 with a diagnosis including, but not limited to, vascular dementia.</p> <p>(continued on next page)</p> | | |

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| <p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>2b. Record review for Resident ID #26 revealed the resident was admitted to the facility in June of 2023 with a diagnosis including, but not limited to, dementia.</p> <p>2c. Record review for Resident ID #50 revealed the resident was admitted to the facility in August of 2023 with diagnoses including, but not limited to, Alzheimer's disease and anxiety.</p> <p>2d. Record review for Resident ID #51 revealed the resident was admitted to the facility in September of 2023 with diagnoses including, but not limited to, dementia and anxiety.</p> <p>Record review failed to reveal evidence that trauma informed care assessments were completed for the above-mentioned residents.</p> <p>During a surveyor interview with the Director of Nursing Services on 4/15/2024 at 11:48 AM and again at 11:50 AM, she revealed that the Trauma assessments are to be completed by the Social Worker. Additionally, she was unable to provide evidence that the above mentioned residents had trauma informed care assessments completed.</p> <p>47939</p> <p>49184</p> |

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| <p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>21613</p> <p>Based on surveyor observation, record review and staff interview it has been determined that the facility failed to ensure nursing staff have the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical well-being of each resident, as determined by resident assessments and individual plans of care, for 5 of 5 Medication Technicians (MTs) reviewed relative to obtaining an apical pulse (AP- a heartbeat measurement by listening with a stethoscope to the left center of the chest. This is the most accurate evaluation of a person's heart rate, particularly when pulse an abnormality is detected) for Staff A, D, E, F, and G.</p> <p>Findings are as follows:</p> <p>According to the State Operation Manual Appendix PP- Guidance to Surveyors for Long Term Care Facilities, last revised 2/3/2023 which states in part, .To assure that all nursing staff possess the competencies and skill sets necessary to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental and psychosocial well-being . 'Competency' is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully .</p> <p>Record review revealed Resident ID #8 was admitted to the facility in December of 2022 with a diagnosis including, but not limited to, bradycardia (a slow heart rate which can occur due to heart issues and other health conditions).</p> <p>Further record review revealed the resident has a physician's order dated 1/5/2024 and revised on 4/12/2024 for .Monitor .AP daily. Pending cardiology follow up appointment for medication management .</p> <p>During a surveyor observation of MT, Staff A on 4/12/2024 at 9:30 AM revealed she obtained the resident's radial pulse (a pulse that can be felt/measured at the radial artery, which is located on the thumb side of the wrist) instead of the apical pulse as ordered.</p> <p>During a surveyor interview, following the above observation with Staff A on 4/12/2024 at 9:47 AM, she acknowledged she obtained the radial pulse instead of the apical pulse. Staff A further revealed she has been obtaining a radial pulse and documenting it on the Medication Administration Record (MAR) as if she was obtaining an apical pulse.</p> <p>During a surveyor interview with the Director of Nursing Services (DNS) on 4/12/2024 at 10:00 AM, she acknowledged that Staff A obtained a radial pulse instead of an apical pulse. The DNS further revealed that there are 5 Medication Technicians (Staff A, D, E, F, and G) that work in the facility and she was unable to provide evidence that these Medication Technicians had demonstrated the competencies and skill sets for obtaining an apical pulse.</p> <p>47939</p> |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>21613</p> <p>Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to maintain medical records that are accurately documented in accordance with professional standards and practices for 2 of 2 residents reviewed relative to oxygen therapy, Resident ID #s 2 and 23.</p> <p>Findings are as follows:</p> <p>1. Record review for Resident ID #2 revealed s/he was admitted to the facility in May of 2023 with diagnoses including, but not limited to, acute and chronic respiratory failure with hypercapnia (an elevated level of carbon dioxide in the blood), obstructive sleep apnea (obstruction of the upper airway during sleep) and pulmonary fibrosis (a lung disease that occurs when lung tissue becomes damaged and scarred).</p> <p>Record review revealed a physician's order dated 7/29/2023 to change oxygen the tubing every week on Saturdays, during the 11:00 PM to 7:00 AM shift.</p> <p>Record review of the April 2024 Treatment Administration Record (TAR) revealed the nurse had signed off the physician's order that she changed the resident's oxygen tubing on 4/6/2024.</p> <p>During multiple surveyor observations on 4/10/2024 and 4/11/2024 the resident was observed to be receiving oxygen via nasal cannula (a device used to deliver supplemental oxygen or increased airflow to a patient), and the oxygen tubing was dated 3/31.</p> <p>During a surveyor observation and simultaneous interview with Licensed Practical Nurse, Staff B on 4/11/2024 at 12:30 PM, she acknowledged the date of 3/31 on the resident's oxygen tubing.</p> <p>During a surveyor interview with the Director of Nursing Services on 4/11/2024 at 12:40 PM, she was unable to explain why the nursing staff had inaccurately documented in the resident's record that they had changed the resident's oxygen tubing on 4/6/2024, when they did not.</p> <p>2. Record review revealed Resident ID #23 was admitted to the facility in January of 2022 with diagnoses including, but not limited to, chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and heart failure.</p> <p>Review of a physician's order dated 10/6/2023, revealed o2 [oxygen] 2-4 liters per min [minute] via nasal cannula prn [as needed] for SOB [shortness of breath].</p> <p>During surveyor observations of the resident on 4/11/2024 at 2:50 PM and 4/12/2024 at 9:50 AM revealed the oxygen was in place via nasal cannula.</p> <p>Record review of the April 2024 TAR revealed that the PRN oxygen order was not signed of as being administered on 4/11/2024 and 4/12/2024.</p> <p>(continued on next page)</p> | | |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During a surveyor interview with Registered Nurse, Staff C, on 4/12/2024 immediately following the above observation, she acknowledged that she did not sign the TAR for the oxygen being administered to Resident ID #23 on 4/12/2024.</p> <p>During a surveyor interview with the DNS on 4/15/2024 at 10:29 AM she revealed that her expectation is that nursing staff document when PRN oxygen is administered on the TAR.</p> <p>47808</p> <p>37158</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p>47939</p> <p>Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to conduct appropriate infection control practices relative to personal protective equipment (PPE) and hand hygiene for 2 of 2 staff members, Staff D and E, observed during care of COVID-19 positive residents, Resident ID #s 40 and 41.</p> <p>Findings are as follows:</p> <p>Record review of an undated facility policy titled, Alpine Nursing Home Infection Prevention and Control Program states in part, .Transmission Based Precautions .B. Droplet precautions personal protective equipment (PPE) will be used upon entering the room of a resident on respiratory droplet precautions . Contact Precautions-Personal Protective Equipment (PPE) will be used upon entering the room to prevent clothing of caregivers or visitors form contact with the infected resident, environmental surfaces or items in the room .</p> <p>During the entrance conference with the Director of Nursing Services (DNS) on 4/10/2024 at 10:04 AM she revealed that the facility was experiencing a COVID-19 outbreak for a total of 12 residents, including Resident ID #s 40 and 41. She indicated that these residents are on droplet and contact precautions.</p> <p>1. Record review revealed Resident ID #40 was admitted to the facility in April of 2022 with a diagnosis including, but not limited to, Alzheimer's disease.</p> <p>During a surveyor observation on 4/11/2024 at 12:55 PM revealed, an ungloved hand reaching out of Resident ID #40's room to remove a spoon from the medication cart in the hallway. Further observation revealed Medication Technician (MT), Staff D, administering eye drops to Resident ID #40 without wearing gloves. Additionally, she proceeded to touch the resident's bedside table and open his/her side table drawer without wearing gloves or performing hand hygiene.</p> <p>During a surveyor interview immediately following the above observation with Staff D on 4/11/2024, she acknowledged that she did not apply gloves prior to entering a COVID-19 positive room that required droplet and contact precautions. She indicated that she should have performed hand hygiene and donned (put on) gloves prior to administering the resident's eye drops.</p> <p>2. Record review revealed Resident ID #41 was admitted to the facility in January of 2022 with a diagnosis including, but not limited to, type 2 diabetes (high blood sugar level).</p> <p>During a surveyor observation on 4/11/2024 at 1:41 PM revealed, Nursing Assistant, Staff E, was performing nail care for the resident in his/her room without wearing gloves. Additionally, she was observed brushing the nail clippings off the resident's bed onto the floor. She also touched the resident's bedside table without wearing gloves.</p> <p>During a surveyor interview immediately following the above observation with Staff E, she acknowledged that she did not apply gloves prior to entering a COVID-19 positive room that required droplet and contact precautions.</p> <p>(continued on next page)</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415089 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/15/2024 |
| NAME OF PROVIDER OR SUPPLIER Alpine Nursing Home Inc | | STREET ADDRESS, CITY, STATE, ZIP CODE 557 Weaver Hill Road Coventry, RI 02816 | |
| 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | During a surveyor interview with the DNS on 4/15/2024 at 10:23 AM, she revealed that she would expect staff to follow proper infection control practices. Additionally, she was unable to explain why Staff D and E did not don appropriate PPE when they entered COVID-19 positive resident rooms. | | |