

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515086	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2024
NAME OF PROVIDER OR SUPPLIER Beckley Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Heartland Drive Beckley, WV 25801	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>49650</p> <p>Based on observation and staff interviews the facility failed to provide a safe, clean comfortable, and homelike environment. A resident room door entrance rubber threshold was partially unadhered from floor and presenting a trip hazard. Room Identifier #E9. Census: 195.</p> <p>Findings Include:</p> <p>During a tour of the facility on 04/16/24 at approximately 12:29 PM the rubber threshold at the door entrance of Room #E9 was observed to be partially unadhered from the floor and laying out in the egress presenting a trip hazard. During an interview with Maintenance Technician (MT) #106 on 04/16/24 at approximately 12:30 PM, he agreed this presented a trip hazard and began to repair the rubber threshold.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45173</p> <p>Based on record review and staff interview, the facility failed to ensure Resident #61 was free from abuse which includes freedom from physical restraints to restrict movement. This is true for one (1) of one (1) residents reviewed during the survey.</p> <p>This will be cited as past non compliance because the facility identified what had happened and took immediate steps to correct the failure to ensure it does not reoccur. All components of the of plan of correction were completed prior to this survey beginning.</p> <p>This did occur and because Resident #61 did not have the cognitive ability to indicate how this affected her the reasonable person standard was applied. A reasonable person would suffer psychosocial harm from being tied to a chair and being unable to move against their will therefore this will be cited as actual harm at past non compliance. Resident Identifier: #61. Facility Census: 195.</p> <p>Findings Include:</p> <p>a) Resident #61</p> <p>On 04/15/23 at 10:00 AM, a record review was completed for Resident #61. The record review found a documented incident which occurred on 04/04/24 at 8:30 PM. An allegation of the resident being tied to a scoot chair with a sheet was made by an anonymous source.</p> <p>The resident was admitted to the facility on [DATE]. The resident was transferred on 04/16/24 to another skilled nursing facility per family request. The resident had the following diagnoses:</p> <ul style="list-style-type: none"> --unspecified dementia, severe, with mood disturbance --unspecified severe protein-calorie malnutrition --coronary artery disease --muscle weakness --dysphagia, oropharyngeal phase --unspecified lack of coordination --other abnormalities of gait and mobility --generalized anxiety disorder --chronic kidney disease, stage 2, mild --stiffness of right knee, not elsewhere classified <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>--stiffness of left knee, not elsewhere classified</p> <p>--stiffness of right shoulder, not elsewhere classified</p> <p>--stiffness of left shoulder, not elsewhere classified</p> <p>--stiffness of the right hip, not elsewhere classified</p> <p>--stiffness of the left hip, not elsewhere classified</p> <p>--unspecified dementia, severe with anxiety</p> <p>--depression, unspecified</p> <p>--history of falling</p> <p>--anemia, unspecified</p> <p>--allergic rhinitis, unspecified</p> <p>--gastro-esophageal reflux disease without esphagitis</p> <p>--neuralgia and neuritis, unspecified</p> <p>--bipolar disorder, unspecified</p> <p>--repeated fall</p> <p>--urinary tract infection, site not specified</p> <p>The Quarterly Minimum Data Set (MDS) dated [DATE] was reviewed on 04/16/24 at 9:30 AM. The Brief Interview of Mental Status (BIMS), found under section C, a score of -0- (zero), which indicates severe cognitive impairment. The resident is non-verbal and rarely speaks. The resident does not have capacity and has a resident representative in place.</p> <p>On 04/15/24 at 10:30 AM, a review of the facility reportables was completed. The review found a reportable dated 04/05/24 at 10:36 AM by Social Services Director (SSD) #105. The incident took place on 04/04/24 at approximately 8:30 PM. The allegation was the resident was tied to her scoot chair with a sheet at Nurses' station 1 which was reported by an anonymous source. The reportable was faxed to all appropriate state agencies and the (Name of the Sheriff's Department).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The investigation started immediately on 04/05/24. A written statement was obtained from Nurse Aide (NA) #223 on 04/05/24. The written statement states, I did tie the sheet around (Name of Resident). She was very anxious and wouldn't stay in her chair. I tried to lay her down prior but she kept trying to get out of bed. I immediately got her back up in chair and brought her to the nurses station. She was still trying to get up and down and move from chair to chair. I assumed it would be best protect her while I had to attend to another resident who was yelling help. As soon as I came back up the hall, I took her back down and laid her back down. She only had the sheet on for 10 min at most. I was not aware it was abuse. I was honestly trying to protect her from hurting herself. Incident happened approximately 11:30 PM. (Typed as written.)</p> <p>The NA #223 was placed on unpaid suspension as of 04/05/24 to the completion of the investigation. The disciplinary form was signed by NA #223 and Registered Nurse (RN) #90 with the date of 04/05/24. Multiple witness statements were obtained by other staff members regarding the incident from 04/08/24 through 04/10/24. All the other staff members denied knowledge of the incident or denied observing the incident.</p> <p>The five (5) day follow up investigation was submitted by SSD #105 on 04/11/24 at 2:10 PM stating, Allegation resident was tied to her chair with a sheet was substantiated CNA (certified nursing assistant) stated she did tie the resident to the chair while she took care of another resident to keep resident from falling. (Typed as written.)</p> <p>On 04/16/24 at approximately 3:00 PM, the Administrator provided a copy of the Abuse Abatement Plan dated 04/05/24. The Abatement Plan states the following:</p> <p>Plan of Correction:</p> <p>Resident's Head to toe assessment completed 04/05/24</p> <p>Resident's Pain assessment complete. 04/05/24</p> <p>Resident's MD (medical doctor) and RP (resident representative) notification of incident. 04/05/24</p> <p>Resident placed on q (every) shift charting x (times) 72 hours starting 04/05/24</p> <p>Resident Social services referral. 04/05/24</p> <p>Care plan reviewed- 04/11/24</p> <p>All agencies and police notified of incident. 04/05/24</p> <p>Employee placed on suspension pending investigation. 04/05/24</p> <p>Identification of Others:</p> <p>All competent residents on G hall interviewed regarding abuse. Head to toes skin sweeps conducted on residents residing on G hall who are unable to be interviewed. Skin sweeps of like residents on E and F hall completed for residents with a BIM of 0-7 (zero to seven). No additional residents identified 04/05/24</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Education:</p> <p>Educate all staff (nursing, rehab (rehabilitation), EVS (environmental services), laundry,maintenance, dietary, laundry, administrative) on abuse prevention policies. 04/05/24 and ongoing.</p> <p>Education will be provided to all new employees upon hire and annually on the abuse policy 04/05/24 and ongoing.</p> <p>System Change:</p> <p>Education will be provided to all new employees upon hire and annually on the abuse policy 04/05/24 and ongoing.</p> <p>Facility Leadership team to conduct daily ambassador rounds and interviews to assure residents with potential for abuse are identified, investigation initiated and reported to the state timely per guidelines.</p> <p>Monitoring:</p> <p>Nursing supervisor and/or Social worker will complete 10 random observations/interviews [NAME] x 5 d (days), then weekly for 3 (three) weeks and then monthly x 3 (three). Audits will be reviewed weekly during adhoc () at QAPI. (The entire Abatement plan was typed as written.)</p> <p>A further review of Resident #61's record did indicate a head to toe assessment and a pain assessment were completed on 04/05/24. However, due to the resident being non-verbal, the facility was unable to confirm what happened during the incident. The completed assessments by nursing staff documented no indication the resident had any physical injuries and the resident did not have any signs or symptoms to indicate pain.</p> <p>On 04/16/24 at 6:00 PM, a review of the skin sweeps dated 04/05/24 was completed. The review found the following residents did have a skin assessment completed on 04/05/24:</p> <p>--#5</p> <p>--#13</p> <p>--#18</p> <p>--#30</p> <p>--#41</p> <p>--#45</p> <p>--#56</p> <p>--#57</p> <p>(continued on next page)</p>

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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>--#81</p> <p>--#97</p> <p>--#106</p> <p>--#114</p> <p>--#117</p> <p>--#135</p> <p>--#142</p> <p>--#148</p> <p>--#152</p> <p>--#167</p> <p>A review of the staff education was completed on 04/16/24 at approximately 10:00 AM. All staff signatures were obtained and included one (1) new employee. The staff signatures were verified via the staff roster.</p> <p>On 04/16/24 at 2:30 PM, a review of the daily observations and/or interviews were completed on 04/05/24, 04/06/24, 04/07/24, 04/08/24, 04/09/24, 04/10/24, 04/15/24 and 04/16/24. The initial observations and/or interviews were conducted on the G unit. All additional observations and/or interviews were completed on all units A-F as well as the G unit.</p> <p>An interview was conducted on 04/16/24 at approximately 3:00 PM with the Administrator and the Director of Nursing (DON). Both the Administrator and the DON confirmed the incident which involved Resident #61 did happen as reported. The Administrator, also stated, NA #223 has not entered the building since the incident and will be terminated per the corporate policy.</p>

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<p>F 0604</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45173</p> <p>Based on record review and staff interview, the facility failed to ensure Resident #61 was free from restraints, which includes freedom from physical restraints to restrict movement. This is true for one (1) of one (1) residents reviewed during the survey.</p> <p>This will be cited as past non compliance because the facility identified what had happened and took immediate steps to correct the failure to ensure it does not reoccur. All components of the of plan of correction were completed prior to this survey beginning.</p> <p>This did occur and because Resident #61 did not have the cognitive ability to indicate how this affected her the reasonable person standard was applied. A reasonable person would suffer psychosocial harm from being tied to a chair and being unable to move against their will therefore this will be cited as actual harm at past non compliance. Resident Identifier: #61. Facility Census: 195.</p> <p>Findings Include:</p> <p>a) Resident #61</p> <p>On 04/15/23 at 10:00 AM, a record review was completed for Resident #61. The record review found a documented incident which occurred on 04/04/24 at 8:30 PM. An allegation of the resident being tied to a scoot chair with a sheet was made by an anonymous source.</p> <p>The resident was admitted to the facility on [DATE]. The resident was transferred on 04/16/24 to another skilled nursing facility per family request. The resident had the following diagnoses:</p> <ul style="list-style-type: none"> --unspecified dementia, severe, with mood disturbance --unspecified severe protein-calorie malnutrition --coronary artery disease --muscle weakness --dysphagia, oropharyngeal phase --unspecified lack of coordination --other abnormalities of gait and mobility --generalized anxiety disorder --chronic kidney disease, stage 2, mild --stiffness of right knee, not elsewhere classified <p>(continued on next page)</p>

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<p>F 0604</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>--stiffness of left knee, not elsewhere classified</p> <p>--stiffness of right shoulder, not elsewhere classified</p> <p>--stiffness of left shoulder, not elsewhere classified</p> <p>--stiffness of the right hip, not elsewhere classified</p> <p>--stiffness of the left hip, not elsewhere classified</p> <p>--unspecified dementia, severe with anxiety</p> <p>--depression, unspecified</p> <p>--history of falling</p> <p>--anemia, unspecified</p> <p>--allergic rhinitis, unspecified</p> <p>--gastro-esophageal reflux disease without esphagitis</p> <p>--neuralgia and neuritis, unspecified</p> <p>--bipolar disorder, unspecified</p> <p>--repeated fall</p> <p>--urinary tract infection, site not specified</p> <p>The Quarterly Minimum Data Set (MDS) dated [DATE] was reviewed on 04/16/24 at 9:30 AM. The Brief Interview of Mental Status (BIMS), found under section C, a score of -0- (zero), which indicates severe cognitive impairment. The resident is non-verbal and rarely speaks. The resident does not have capacity and has a resident representative in place.</p> <p>On 04/15/24 at 10:30 AM, a review of the facility reportables was completed. The review found a reportable dated 04/05/24 at 10:36 AM by Social Services Director (SSD) #105. The incident took place on 04/04/24 at approximately 8:30 PM. The allegation was the resident was tied to her scoot chair with a sheet at Nurses' station 1 which was reported by an anonymous source. The reportable was faxed to all appropriate state agencies and the (Name of the Sheriff's Department).</p> <p>(continued on next page)</p>

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<p>F 0604</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The investigation started immediately on 04/05/24. A written statement was obtained from Nurse Aide (NA) #223 on 04/05/24. The written statement states, I did tie the sheet around (Name of Resident). She was very anxious and wouldn't stay in her chair. I tried to lay her down prior but she kept trying to get out of bed. I immediately got her back up in chair and brought her to the nurses station. She was still trying to get up and down and move from chair to chair. I assumed it would be best protect her while I had to attend to another resident who was yelling help. As soon as I came back up the hall, I took her back down and layed her back down. She only had the sheet on for 10 min at most. I was not aware it was abuse. I was honestly trying to protect her from hurting herself. Incident happened approximately 11:30 PM. (Typed as written.)</p> <p>The NA #223 was placed on unpaid suspension as of 04/05/24 to the completion of the investigation. The disciplinary form was signed by NA #223 and Registered Nurse (RN) #90 with the date of 04/05/24. Multiple witness statements were obtained by other staff members regarding the incident from 04/08/24 through 04/10/24. All the other staff members denied knowledge of the incident or denied observing the incident.</p> <p>The five (5) day follow up investigation was submitted by SSD #105 on 04/11/24 at 2:10 PM stating, Allegation resident was tied to her chair with a sheet was substantiated CNA (certified nursing assistant) stated she did tie the resident to the chair while she took care of another resident to keep resident from falling. (Typed as written.)</p> <p>On 04/16/24 at approximately 3:00 PM, the Administrator provided a copy of the Abuse Abatement Plan dated 04/05/24. The Abatement Plan states the following:</p> <p>Plan of Correction:</p> <p>Resident's Head to toe assessment completed 04/05/24</p> <p>Resident's Pain assessment complete. 04/05/24</p> <p>Resident's MD (medical doctor) and RP (resident representative) notification of incident. 04/05/24</p> <p>Resident placed on q (every) shift charting x (times) 72 hours starting 04/05/24</p> <p>Resident Social services referral. 04/05/24</p> <p>Care plan reviewed- 04/11/24</p> <p>All agencies and police notified of incident. 04/05/24</p> <p>Employee placed on suspension pending investigation. 04/05/24</p> <p>Identification of Others:</p> <p>All competent residents on G hall interviewed regarding abuse. Head to toes skin sweeps conducted on residents residing on G hall who are unable to be interviewed. Skin sweeps of like residents on E and F hall completed for residents with a BIM of 0-7 (zero to seven). No additional residents identified 04/05/24</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>49650</p> <p>Based on record review and staff interview the facility failed to develop and implement the individualized comprehensive care plan. This was true for five (5) of twelve (12) residents reviewed for history of illicit drug usage. Resident Identifiers: Resident #40, #52, #70, #91, and #93. Facility Census: 195.</p> <p>Findings Include:</p> <p>a) Resident #40</p> <p>On 04/15/24 at approximately 10:00 AM during a review of the facility identified residents with a diagnosis of illicit drug use, Resident #40 was identified to have a diagnosis of other psychoactive substance abuse in remission, onset of 08/23/23. During a review of Resident #40's care plan dated 08/24/23, it was identified that the facility failed to develop or implement an individualized comprehensive care plan for this diagnosis.</p> <p>b) Resident #52</p> <p>On 04/15/24 at approximately 10:00 AM during a review of the facility identified residents with a diagnosis of illicit drug use, Resident #52 was identified to have a diagnosis of other psychoactive substance abuse with psychoactive substance-induced persisting dementia, onset of 12/01/22. During a review of Resident #52's care plan dated 08/12/22, it was identified that the facility failed to develop or implement an individualized comprehensive care plan for this diagnosis.</p> <p>c) Resident #70</p> <p>On 04/15/24 at approximately 10:00 AM during a review of the facility identified residents with a diagnosis of illicit drug use, Resident #70 was identified to have a diagnosis of other psychoactive substance abuse, uncomplicated, onset of 01/18/23. During a review of Resident #70's care plan dated 01/17/23, it was identified that the facility failed to develop or implement an individualized comprehensive care plan for this diagnosis.</p> <p>d) Resident #91</p> <p>On 04/15/24 at approximately 10:00 AM during a review of the facility identified residents with a diagnosis of illicit drug use, Resident #91 was identified to have a diagnosis of other psychoactive substance abuse, unspecified with unspecified psychoactive substance-induced disorder, onset of 05/19/23. During a review of Resident #91's care plan dated 05/20/23, it was identified that the facility failed to develop or implement an individualized comprehensive care plan for this diagnosis.</p> <p>e) Resident #93</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515086	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2024
NAME OF PROVIDER OR SUPPLIER Beckley Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Heartland Drive Beckley, WV 25801	
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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/15/24 at approximately 10:00 AM during a review of the facility identified residents with a diagnosis of illicit drug use, Resident #93 was identified to have a diagnosis of opioid dependence, in remission, onset of 03/25/21 and sedative, hypnotic or anxiolytic abuse, in remission, onset of 03/25/21. During a review of Resident #93's care plan dated 01/30/23, it was identified that the facility failed to develop or implement an individualized comprehensive care plan for this diagnosis.</p> <p>During an interview with the facility Administrator and Director of Nursing on 04/15/24 at approximately 12:30 PM the Director of Nursing acknowledged that Resident #40, #52, #70, #91, and #93 had not been care planned for their illicit drug usage diagnosis as they should have been.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45173</p> <p>Based on observation, record review and staff interview, the facility failed to maintain appropriate infection control standards during a COVID-19 outbreak. This failed practice had the potential to affect more than an isolated number of residents. These were random opportunities for discovery. Facility Census: 195.</p> <p>Findings Include:</p> <p>Upon arrival to the facility on [DATE] at 9:30 PM, Receptionist #8 advised the surveyors the facility was in a COVID outbreak. Receptionist #8 stated, everyone has to wear a surgical mask while in the facility. The Administrator confirmed the COVID outbreak began on 04/04/24.</p> <p>On 04/16/24 at approximately 10:45 AM, a tour of the facility units was conducted. During the tour of the units, nurses' station 1 (one) was approached at approximately 11:10 AM. Two (2) employees were observed with their surgical masks pulled down below their noses. The two (2) employees were Licensed Practical Nurse (LPN) #128 and Nurse Aide (NA) #27. NA #27 stated, I pulled it down I have allergies. On 04/16/24 at 11:14 AM, LPN #128 was observed a second time with her mask pulled down below her nose. LPN #128 did not make any statements.</p> <p>Upon reaching the double doors to return to the administration offices on 04/16/24 at 11:17 AM, the Activities Leader #44 was observed with his mask pulled down below his nose. The Activities Leader #44 did not make any statement.</p> <p>On 04/16/24 at 11:25 AM, the Administrator and the Director of Nursing (DON) were notified. Both the Administrator and the DON confirmed the staff should be wearing a surgical mask correctly and corrective action would take place.</p> <p>An additional tour of the facility units at 12:00 PM, Housekeeper #2 was observed with her mask pulled down below her nose.</p> <p>On 04/16/24 at 12:00 PM, the DON approached this surveyor and stated, the staff who weren't wearing their masks correctly have been disciplined. At this same time, the DON, also, observed Housekeeper #2 with her mask pulled down below her nose.</p> <p>On 04/16/24 at 12:38 PM, NA #97 was observed with her mask pulled down and her nose exposed. NA #97 stated, I just needed a breath .just for a minute.</p> <p>On 04/16/24 at 12:41 PM, the Administrator and the DON were notified of the additional incident. Both the Administrator and the DON again confirmed the staff should be wearing a mask correctly and corrective action would take place.</p> <p>On 04/16/24 at approximately 2:00 PM, the Administrator stated, all the staff who weren't wearing their masks have been disciplined.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/16/24 at 3:33 PM, the DON confirmed the procedure in the facility during a COVID-19 outbreak. The DON stated, If there is active COVID on the hall, the staff will wear N-95s; and, the other areas of the facility are in surgical masks.</p> <p>No further information was obtained during the survey process.</p>		