STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045220	A. Building B. Wing	09/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fayetteville Health and Rehabilitation Center	3100 Old Missouri Rd Fayetteville, AR 72703

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 308) was substantiated, all or in part, with these findings: Based on record review and interview, the facility failed to ensure a resident was free of physical and mental abuse, as evidenced by Certified Nursing Assistant (CNA) #1 who placed her mask and hand over a resident's mouth and held it on the face of 1 of 1 (Resident #1) case mix resident who was alleged victim of physical and mental abuse. This failed practice resulted in Past Immediate Jeopardy, which caused or could have caused serious harm, injury or death for Resident #1 who was physically and mentally abused by CNA #1. The Administrator was notified of Past Immediate Jeopardy on 08/20/2020 at 4:20 PM. The findings are: Resident #1 had [DIAGNOSES REDACTED]. The 5-day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/20/2020 documented resident scored 0 (0-7 indicates severely impaired) on the Brief Interview of Mental Status (BIMS) and required extensive assistance of two staff members for all personal hygiene. a. The Plan of Care with a revision date of 6/4/2020, documented, make bathing process pleasant . Quality of Life . explain procedures before and during care and attempt later if resistance . Explain procedures prior to preforming to decrease anxiety or fear . b. The Office of Long-Term Care (OLTC) Incident and Accident Report Division of Medical Services (DMS) form documented RN (Registered Nurse) #1 Title . RN .Date Submitted to OLTC 08/15/2020 . Time .12:56 (p. m.) Date and time of incident 08/14/2020 at 2300 (11:00 p.m.) .Type of incident . Physical .Name of Involved Resident (Resident #1). At approximately 2300 (11:00 p.m.) on 8/14 (CNA #2 and #3) were in (Resident #1) room providing him with a bath. Resident was being combative and spitting at them during this care, (CNA #3) was rubbing resident's hand to help calm him during the care that was effective. At that time another (CNA #1) entered room and stated, we don't have to take this kind of abuse, he needs to be transferred out of this facility. At that time the witnesses state that (CNA#1) removed her surgical mask from her face and placed over the resident's face as he had gotten upset again and started spitting. Resident removed the mask himself per staff, then (CNA#1) placed mask over residents face held it there with her hand. (CNA #2) left room at time to go notify nurse of what was going on. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2020

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Fayetteville Health and Rehabilitation Center	3100 Old Missouri Rd Fayetteville, AR 72703

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(Nurses #1 and #2) entered room and at that time (CNA#1) had removed the mask from resident's face and placed back on her face. Nurses had all staff leave room. Resident was in safe place for staff to leave. (Nurse #2) notified (Director of Nursing (DON)) and at that time (CNA#1) was suspended pending investigation. (CNA#1) was asked to provide witness statement for investigation. c. The OLTC Witness Statement Form dated 08/14/2020 at 11:30 PM CNA #2 documented, (CNA #3) and I went to give resident a bed bath and were in the process of doing it when (CNA#1) walked into the room she was the CNA on the hall. When (CNA#1) comes in she put gloves on and stood and watched she noticed resident was trying to spit on (CNA #3) and she took her mask off of her face and put it over his mouth so he couldn't spit. I took it off and (CNA#1) put it back on. Resident then rips it off to spit on her and she put her hand over his mouth and left it there. I immediately left the room and let the nurse know. When I return to room resident tries to spit and hit us again right after that she began laugh saying he needs to be transferred facilities. She kept making rude remarks towards him, the nurses, (Nurse #1 and #2) came into the room and pulled us all out. When she put the mask on her face it was forceful. Resident is always this way, especially with bathing. It's his normal personality it does not take much to calm him down though. She did not take her hand off his face until me and the nurses were heard walking in.' d. The OLTC Witness Statement Form dated 08/14/20 at 11:30 PM CNA #3 documented, (CNA #2) and I enter resident #1 room to give him a bed bath. (CNA#1) enters room and proceed to see (Resident #1) spitting and states no one should have to put up with this behavior. Resident proceeds hit and spit at (CNA #2) and myself and pinch myself. I try to calm (Resident#1) down by rubbing his hand he goes to spit and (CNA#1) proceeds to take personal mask off and places it on (Resident #1) face (around his ears and placed correctly at first). This causes a reaction out of (Resident#1) even more than before. He pulls it up over his head she yanks it back down to wear it was first placed before he pulls it up (CNA#1) covers his whole face with it, and begins to laugh that it made him upset I said please take it off him he is starting to get more upset. She states she was trying to get him to not spit at us he basically is blowing air out with his tongue. He get turn to proceed the bed bath towards me and he spits and scratches me. (CNA#1) proceeds to place hand over (Resident's #1) mouth. (CNA #2 and #3) get to brief on and (CNA #2) gives me the hey I gotta go get something, I'll be back. I knew she was going to get our nurse, I stayed to continue working with resident. e. The OLTC Witness Statement form dated 08/14/20 at 12:00 a.m. completed by CNA #1 documented, I was helping girl 1&2 control (Resident #1) during bed bath and changing sheets on bed. I went in the room to get vitals first then noticed (Resident #1) was hitting, spitting, scratching them so I stepped in to help them and I put a mask on (Resident#1) because he was spitting and running a temp which I had notified the nurse about the temp she said take it again took it three times every time over 100, so for the safety of us in the room I put a mask on resident since COVID is transfer through body fluid. We rolled him to make bed and put brief on him swinging arms and spitting because he took the mask off shortly after I put it on. f. The OLTC witness statement completed by LPN (Licensed practical Nurse) #1 dated 08/14/2020 at 11:40 PM. Documented, .made aware of the allegation by (LPN #2.) (LPN#2) and I went to evaluate the situation and assess resident made sure resident was safe and unharmed. Ask all aides to leave room. Followed protocol with reporting incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	g. On 08/19/2020 at 9:44 a.m., the Director of Nursing (DON) was asked, How did you ensure that the other residents were safe? She stated, Body audits and assessing the residents. (CNA#1) was pulled out of the room and not left alone until suspended. The DON was asked, Who notified you of the alleged abuse? She stated, (LPN #2) called. I instructed her to get statements and let (CNA#1) know that she is to leave, and she was suspended. The DON was asked, Did you report the alleged abuse the administrator? She stated, Yes, that night and the police was called.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 308) was substantiated, all or in part, with these findings: Based on record review and interview, the facility failed to ensure an allegation of abuse was reported to the Office of Long Term Care (OLTC) and other agencies in within 2 hours of discovery for 1 (Resident #1) of 1 sample resident who had allegation of abuse. This failed practice had the potential to affect 1 residents, as documented on as listed of the Midnight Census provided by Registered Nurse (RN) #2 on 08/18/2020. The findings are: Resident #1 had [DIAGNOSES REDACTED]. The 5-day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/20/2020 documented resident scored 0 (0-7 indicates severely impaired) on a Brief Interview of Mental Status (BIMS); and required extensive assistance of two staff members for all personal hygiene. a. The Plan of Care with a revision date of 6/4/20 documented, .make bathing process pleasant . Quality of Life . explain procedures before and during care and attempt later if resistance . Explain procedures prior to preforming to decrease anxiety or fear . b. The Office of Long-Term Care (OLTC) Incident and Accident Report Division of Medical Services (DMS) form documented RN (Registered Nurse) #1 Title . RN .Date Submitted to OLTC 08/15/2020 . Time .12:56 (p. m.) Date and time of incident 08/14/2020 at 2300 (11:00 p.m.) .Type of incident . Physical .Name of Involved Resident (Resident #1). At approximately 2300 (11:00 p.m.) on 8/14 (CNA #2 and #3) were in (Resident #1) room providing him with a bath. Resident was being combative and spitting at them during this care, (CNA #3) was rubbing resident's hand to help calm him during the care that was effective. At that time another (CNA #1) entered room and stated, we don't have to take this kind of abuse, he needs to be transferred out of this facility. At that time the witnesses state that (CNA#1) removed her surgical mask from her face and placed over the resident's face as he had gotten upset again and started spitting. Resident removed the mask himself per staff, then (CNA#1) placed mask over residents face held it there with her hand. (CNA #2) left room at time to go notify nurse of what was going on. (Nurses #1 and #2) entered room and at that time (CNA#1) had removed the mask from resident's face and placed back on her face. Nurses had all staff leave room. Resident was in safe place for staff to leave. (Nurse #2) notified (Director of Nursing (DON)) and at that time (CNA#1) was suspended pending investigation. (CNA#1) was asked to provide witness statement for investigation. c. On 8/18/2020 at 10:00 a.m., the DON was asked, Did you report it in two hours? She stated, No. We thought because there was no injury that we had 24 hours to report it. The DON was asked, Was there abuse? She stated, Yes. The DON was asked, How did you ensure that the other residents were safe? She stated, We did body audits and assessed the residents.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Complaint # (AR 188) and Complaint # (AR 270) was substantiated, all or in part, with these findings: Based on observation, record review, and interview, the facility failed to ensure residents who were in isolation received baths on scheduled bath days and failed to ensure nails were cleaned and trimmed for 4 (Resident #2, #3, #4, #5) of 5 sampled residents who required baths and nail care. This failed practice had the potential to affect 55 residents who were in isolation and required baths and nail care according to a list provided by the Director of Nursing (DON) on 8/21/2020 at 11:15 am. The findings are: 1. Resident #2 had [DIAGNOSES REDACTED]. The Part A Discharge Assessment Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/24/2020 documented the resident scored 12 (8-12 indicates moderately impairment) on a Brief Interview for Mental Status (BIMS) and required extensive assistance of two-person physical assistance for bed mobility, personal hygiene, and bathing. a. On 08/19/2020 at 10:48 am, Resident #2 stated, I am supposed to get a shower two times a week. I went 4 weeks not being bathed until recently. I finally started getting bed baths then on Tuesday I got a shower. b. Record Review of the Bath report roster received from the DON on 8/20/2020 at 10:42 a.m. documented Resident #2 missed 5 baths since 08/03/2020. 2. Resident #3 had [DIAGNOSES REDACTED]. The Quarterly Assessment Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/21/2020 documented the resident scored 12 (8-12 indicates moderate cognitive impairment) on a Brief Interview for Mental Status (BIMS); and was independent with walking and activities of daily living. a. On 08/18/2020 at 11:23 am, Resident #3 was lying in the bed. The resident raised his right hand and showed this surveyor his nails. His nails were long and unkept. His nails were approximately an inch over the fingertips and were discolored. Resident #3 was asked if he would like his nails trimmed? Resident #3 stated, Yes. I would. b. On 08/18/2020 at 11:25 am, the Assistant Director of Nursing (ADON) was asked if the resident's nails should be cleaned and clipped? The ADON stated, It should be done with their showers. The ADON asked Resident #) if he would like nail care done. Resident #3 stated, Yes. I would. c. On 08/20/2020 at 9:15 am, Resident #3 was asked if he got a bath while he was in isolation for Covid-19? Resident #3 stated, No. Resident #3 was asked how long he went without a bath and he stated, Quite some time. d. Record Review of the bath Report roster provided by the DON on 8/20/2020 at 10:42 a.m. documented Resident # 3 had received 1 bath since 07/19/2020. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #4 had [DIAGNOSES REDACTED]. The Part A Discharge Assessment Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/08/2020 documented the resident scored 11 (8-12 indicates moderate cognitive impairment) on a Brief Interview for Mental Status (BIMS) and required extensive assistance of two-person physical assistance for all Activities of Daily Living. a. On 08/18/2020 at 12:40 pm, Resident #4 was lying in bed in a hospital gown. Resident #4 was asked if she had a bath since being in the Covid unit? Resident #4 stated, No. I have not had a bath in 3 weeks. b. On 08/19/2020 at 9:35 am, the Director of Nursing (DON) was asked, How often the residents receive a shower? The DON stated, They should be offered two times a week. The DON was asked where the shower area was in the Covid unit? The DON stated, They are doing bed baths on the Covid unit. There is no shower area on that hall. 4. On 08/19/2020 at 12:45 pm, Resident # 5 stated, I have no idea when I have had a bath last. a. Record Review of the Bath Report roster provided by the DON on 8/20/2020 documented Resident #5 had not received a bath since 07/20/2020.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a Air scrubber system was in an area of the residents' room to prevent a fall or trip hazard. This failed practice had the potential to affect 42 residents who had HEPA Air scrubber systems in their rooms according to a list provided by the Director of Nursing (DON) on 8/21/2020 at 11:15 a.m. The findings are: Resident #3 had [DIAGNOSES REDACTED]. The Quarterly Assessment Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/21/2020 documented the resident scored 12 (8-12 indicates moderately impairment) on a Brief Interview for Mental Status (BIMS); and was independent with walking and activities of daily living(ADL's). a. On 08/18/2020 at 11:23 am, there was a large air scrubbing machine in Resident #3's room. The unit was sitting in the middle of the floor and the cord was stretched across the floor. Resident #3 was unable to get out of the bed without stepping over the cord in the floor. b. On 08/18/2020 at 11:25 am, the Assistant Director of Nursing (ADON) was asked to come to Resident #3's room. The ADON was asked if she could identify any potential hazard in the room? The ADON removed the machine from the room.

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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 a Continuous Positive Airway Pressure (C-PAP) machine was consistently administered as ordered by the physician, to minimize the potential for [MEDICAL CONDITION] or other respiratory complications for 1 (Residents #4) of 1 sampled resident who had physician's orders [REDACTED]. The findings are: 1. Resident #4 had [DIAGNOSES REDACTED]. The Part A Discharge Assessment Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/08/2020 documented the resident scored 11 (8-12 indicates moderate impairment) on a Brief Interview for Mental Status (BIMS); and required extensive assistance of two-person physical assistance for all Activities of Daily Living (ADL's). a. A physician order [REDACTED]. Apply c-pap at HS (hours of sleep) and remove in AM (morning). b. The Plan of Care with a revision date of 6/19/2020 documented . assist me with wearing my [MEDICAL CONDITION] during hours of sleep. c. On 08/18/2020 at 12:40 pm, there was no [MEDICAL CONDITION] machine in the resident's room. e. On 08/20/20 at 9:30 am, the Assisted Director of Nursing (ADON) was asked if Resident #4 had a [MEDICAL CONDITION]? The ADON stated, Yes. The ADON was asked, Where is it located? The ADON stated, I am looking for it. Her bag is empty, but I found some of the accessories for it. The ADON was asked, Is the [MEDICAL CONDITION] in one of the boxes containing her belongings. The ADON stated, I hope so. The ADON was asked, Should the [MEDICAL CONDITION] have been over in the COVID unit with the resident? The ADON stated, I'm praying it was over there. The ADON was asked if the boxes of personal belongings went with the resident to the COVID unit since she stated that is where the [MEDICAL CONDITION] was thought to be? The ADON stated, I'm looking for it. f. On 08/20/20, at 9:33 am, the DON was asked, Is the resident supposed to have her [MEDICAL CONDITION] every day? The DON stated, Um, I am going to have to look into that. g. On 08/20/20 at 9:45 am, Resident #4 was asked had the [MEDICAL CONDITION] machine been with them while they were in the COVID unit. The ADON stated, I believe this box came with her from the COVID unit. Resident #4 stated, It did not, you are lying. I haven't had it in 6 weeks.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. Based on observation, and interview the facility failed to ensure staff who provided direct care services had appropriate competencies and skill set to provide nursing and related services to assure resident safety. This failed practice had the ability to affect all 87 residents according to list provided by Director of Nursing (DON) on 8/31/2020. The findings are: On 09/01/2020 at 12:20 p.m., Certified Nursing Assistant (CNA) #7 was taking vital signs. The CNA went into a resident's room with an automatic wrist blood pressure cuff, and pulse oximeter (ox). CNA #4 did not have a watch. CNA #7 took vital signs on both of the residents in the room. When exiting the room, the Director of Nursing was standing outside the room door. a. On 9/1 2020 at 12:22 p.m., CNA #4 was asked to see the vital sign sheet. The sheet contained blood pressure, pulse, respirations, pulse ox. The CNA was asked, How did you get the respirations? She stated, I counted it out on my fingers to 15 while watching the chest rise and fall. When I get to 15, I multiply that number by 4. The Director of Nursing found a clock and handed to the CNA and explained that a watch was part of her uniform and instructed the Licensed Practical Nurse to do education with CNA #4.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Complaint # (AR 340) and Complaint # (AR 408) was substantiated, all or in part, with these findings: Based on observation, record review, and interview, the facility failed to ensure staff followed the Centers for Disease Control and Prevention (CDC) guidance to reduce the spread of COVID-19, including the consistent, appropriate use of personal protective equipment (PPE) and for storing biohazard appropriately, and failed to ensure staff were preformed hand hygiene before and after contact with the residents and after contact with objects and surfaces in resident environment; and failed to ensure a resident on observation unit for Covid-19 was wearing a mask while being propelled in a wheelchair by staff. Theses failed practices had the potential to affect all 87 residents who reside in the facility as documented on a list provided by the Director of Nursing (DON) on 08/31/2020. The findings are: 1. On 09/02/2020 at 09:05 a.m., the Director of Nursing (DON) was asked to show this surveyor where the biohazard was being stored. We exited the building on the E hall. Between the E hall and F the hall was a large white storage pod. Located against the building on the F hall side was three rubber maid storage units. The first unit was approximately 4-feet-tall and five foot wide. It did not contain a lock. When it was opened it contained clothing. The second unit d was approximately seven-feet-tall and 3-foot-wide and it had a lock. The third unit was approximately 4- feet-tall and 5 foot wide. The lock was lying on top of the unit. When the unit was opened it contained a box of books that was sitting on top of a locker and a red biohazard bag. The DON was asked, Should Biohazard be mixed with the resident personal belongings? She stated, No. She opened the biohazard bag and it contained hangers and cloths. She stated, I think they just put it in this bag for storage. The DON was asked, Do you know that for sure? She stated, No. The DON called the maintenance helper. At 9:09 AM Maintenance helper was asked, Where is biohazard stored? He stated, In the POD. The DON opened the POD. The POD contained 8 boxes clearly marked Biohazard. The maintenance helper was asked, When was Biohazard picked up? He stated, Yesterday. He was asked, Can you tell me what the sign above the boxes says? He stated, No hazardous material allowed. He was asked, Do you have any biohazard signs anywhere out here to show that there is biohazard here? He stated, No. b. On 9/1/2020 at 12:20 a.m., Certified Nursing Assistant (CNA) #6 was walking down the hallway. CNA #6 had on a surgical mask, no gown, and no gloves. The DON stopped CNA e and asked her where her PPE was, and she stated. I could not find a mask. The DON asked her, Did you look in the storage room? She stated, No. She was asked, Why do you not have on gown and gloves? She stated, I don't know. CNA #6 was asked, Should you have on Personnel Protective Equipment? She stated, I already tested positive. The DON stated, You should always be wearing PPE on this unit. The DON was asked, Should CNA's be wearing a mask on the COVID unit? She stated, Yes. Always The DON was asked, What type of mask should the staff wear on the COVID unit? She stated, N95. c. On 08/18/2020 at 12:35 pm, CNA #4 delivered lunch trays to the residents on the Covid unit. There was a resident on the Covid unit walking in the hallway. The resident was wandering in other rooms and walking toward the hall cart where the lunch trays were located. CNA# 4 assisted and redirected the resident multiple times and then would return to passing lunch trays to the other residents. CNA #4 failed to perform hand hygiene after direct resident contact and before touching the lunch trays being delivered to the residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045220	A. Building B. Wing	09/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fayetteville Health and Rehabilitation Center	3100 Old Missouri Rd Fayetteville, AR 72703

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 - Some	d. On 08/19/2020 at 12:45 pm, CNA #4 was in the Covid unit, assisting a resident that had wandered into the therapy room. CNA #4 did not perform hand hygiene after contact with the resident and before entering another residents room. e. On 08/20/2020 at 9:48 am, there was a resident being propelled in a wheelchair by a staff member down the hall in the Covid observation unit. The resident did not have a mask on. The CNA pushed the resident through the doors into the main hall without a face covering or mask on. f. On 08/20/2020 at 10:29 am, the DON was asked if the resident leaving the COVID observation hall should have had a mask on when leaving the observation area? The DON stated, Yes. I think she thought she was only going to the shower.