STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155283	A. BUILDING 00 B. WING	08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINTERSONG VILLAGE	1005 SOUTH EDGEWOOD DRIVE KNOX, IN 46534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 9, 10, 11, and 12, 2021. Facility number: 000181 Provider number: 155283 AIM number: 100266860 Census Bed Type: SNF/NF: 26 Total: 26 Census Payor Type: Medicare: 3 Medicaid: 21 Other: 2 Total: 26 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/16/21.	F 0000	This plan of correction is to serve as Wintersong Village's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Wintersong Village or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in the facility, nor does the submission constitute an agreement of admission of the survey allegations. We respectfully request of paper review of his plan of correction.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or			

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

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	enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on observation, record review and interview, the facility failed to ensure resident dignity was maintained related to an uncovered urinary catheter bag for 1 of 1 residents reviewed for dignity. (Resident 4) Finding includes: On 8/9/21 at 9:06 a.m., Resident 4 was observed	F 0550	**What Corrective Action(s) Will Be Accomplished for Those Residents Found to Have Been Affected By The Deficient Practice:** Resident will not have any adverse effects related to this alleged deficient practice. Urinary privacy cover for resident 4 was placed	09/03/2021

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	lying in bed. A catheter bag was hanging on the side of the bed with visible urine in the bag. There was not a covering over the bag. The bag was visible to the resident's roommate. On 8/10/21 at 10:19 a.m., Resident 4 was observed sitting in a wheelchair in her room. A catheter bag was hanging underneath the wheelchair with visible urine in the bag. There was not a covering over the bag. The bag was visible to the resident's roommate and also from the doorway. Record review for Resident 4 was completed on 8/10/21 at 10:29 a.m. Diagnoses included, but were not limited to, urinary retention and hypertension. The Admission Minimum Data Set (MDS) assessment, dated 6/5/21, indicated the resident was moderately cognitively impaired. The resident had an indwelling urinary catheter. Interview with LPN 1 on 8/10/21 at 10:20 a.m., indicated the resident's catheter bag should have been covered by a flap on the bag. If the bag did not have a flap then it should be placed inside a dignity bag. 3.1-3(a)		correctly over urinary bag. **How Other Residents Having the Potential to Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents have the potential to be affected, no other residents were affected by this alleged deficient practice. **What Measures Will Be Put into Place and What Systemic Changes Will Be Made to Ensure That the Deficient Practice Does Not Recur:** All residents with a catheter will have a urinary privacy cover placed over urinary bag. All nursing staff will be in-serviced over urinary privacy covers. **How The Corrective Action(s) Will Be Monitored to Ensure the Deficient Practice Will Not Recur:** DON/Designee will monitor catheter urinary bags to ensure privacy covers are present and applied correctly daily on scheduled workdays times 4 weeks, then 2 times per week times 4 weeks, then weekly times 2 months, then monthly times 2 months. Any negative findings will be forwarded to the Administrator and corrected immediately and will result in re-education and/or disciplinary action. A report of progress will be forwarded to the QAPI committee monthly for	

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			minimum of 6 months and plan adjusted accordingly.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review and interview, the facility failed to provide treatment as ordered related to application of an edema glove for 1 of 1 residents reviewed for positioning/ mobility. (Resident 8) Finding includes: On 8/9/21 at 10:07 a.m., Resident 8 was observed in her room seated in her wheelchair. Her left hand appeared contracted (in a fixed position) and edematous. There was no splint or glove in place. The resident was observed seated in her room without a splint or glove on her left hand on 8/10/21 at 9:26 a.m., 8/11/21 at 8:52 a.m., and 8/12/21 at 8:20 a.m. The resident's record was reviewed on 8/11/21 at 9:11 a.m. The Quarterly Minimum Data Set (MDS)assessment, dated 6/11/21, indicated the resident was cognitively intact and required extensive one person assistance for dressing. Diagnoses included, but were not limited to, left sided hemiplegia (severe loss of strength).	F 0684	· **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** ="" span Edema glove for Resident 8 was applied. · **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** ="" span="">
All residents residing in the facility have the potential to be affected. No other residents were affected by this alleged deficient practice. · **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;**	09/03/2021

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	An Occupational Therapy Discharge Summary, dated 3/12/21, indicated the resident was tolerating the left wrist edema glove well and to begin a daily schedule as tolerated. A Physician's order, dated 3/12/21, indicated the resident was to wear a left wrist compression glove daily, to be applied by CNAs and monitored by the nurse. The August 2021 Treatment Administration Record indicated the edema glove was applied daily as ordered. Interview with Resident 8, on 8/12/21 at 8:20 a.m., indicated she had a glove for her left hand somewhere, but she didn't know where it was, and she was unable to put it on by herself. Interview with CNA 1, on 8/12/21 at 8:25 a.m., indicated she did not put the edema glove on the resident every day, she would put it on her if she asked. She indicated she did not know why it wasn't applied daily. 3.1-37(a)		Treatments for residents will be completed per MD orders. All nursing staff will be in-serviced over Physician Orders. · **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** DON/Designee will monitor completion of treatments daily on scheduled workdays times 4 weeks, then 2 times per week times 4 weeks, then weekly times 2 months, then monthly times 2 months. Any negative findings will be forwarded to the Administrator and corrected immediately and will result in re-education and/or disciplinary action. A report of progress will be forwarded to the QAPI committee monthly for minimum of 6 months and plan adjusted accordingly.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.			

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	Based on observation, record review and interview, the facility failed to provide proper respiratory care and services related to oxygen tubing and humidification bottles not dated for 1 of 2 residents reviewed for oxygen. (Resident 4) Finding includes: On 8/9/21 at 9:09 a.m., Resident 4 was observed lying in bed and receiving oxygen through a nasal cannula. The oxygen tubing and humidification bottle on the oxygen concentrator did not have a date on them for when they were changed. On 8/10/21 at 10:19 a.m., Resident 4 was observed sitting in a wheelchair in her room. The resident was receiving oxygen through a nasal cannula. The oxygen tubing and humidification bottle on the oxygen concentrator did not have a date on them for when they were changed. Record review for Resident 4 was completed on 8/10/21 at 10:29 a.m. Diagnoses included, but were not limited to, ineffective gas exchange and hypertension. The Admission Minimum Data Set (MDS) assessment, dated 6/5/21, indicated the resident was moderately cognitively impaired. The resident had received oxygen therapy. The August 2021 Physician's Order Summary (POS), indicated orders for: -change oxygen tubing every Wednesday -change oxygen humidifier every Wednesday Interview with LPN 1 on 8/10/21 at 10:20 a.m., indicated the staff was to change and date the oxygen tubing and humidification bottle weekly.	F 0695	W**hat corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** **Oxygen tubing and humidification bottle was dated for Resident 4.** ="" span="">
="" p="">
Ho**w other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** **All residents residing the facility have the potential to be affected. No other residents were affected by this alleged deficient practice.** ="" span="">
="" p="">
W**hat measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Oxygen tubing and humidification bottles will be dated when changed. All nursing staff will be educated over dating oxygen tubing and humidification bottles when changed. Ho**w the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** DON/Designee will monitor	09/03/2021

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	3.1-47(a)(6)		oxygen tubing and humidification bottles for those residents on oxygen daily on scheduled workdays times 4 weeks, then 2 times per week times 4 weeks, then weekly times 2 months, then monthly times 2 months. Any negative findings will be forwarded to the Administrator and corrected immediately and will result in re-education and/or disciplinary action. A report of progress will be forwarded to the QAPI committee monthly for minimum of 6 months and plan adjusted accordingly.	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the			

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	reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure residents were free from unnecessary medications, related to laboratory tests not completed as ordered for 1 of 5 residents reviewed for unnecessary medications (Resident 10) Finding includes: Record review for Resident 10 was completed on 8/11/21 at 11:04 a.m. Diagnoses included, but were not limited to, iron deficiency anemia, hypertension, hyperlipidemia, and mood disorder. A Care Plan indicated the resident had a diagnosis of hyperlipidemia and was at risk for increased cholesterol levels and associated complications. An intervention included to monitor labs as ordered and report abnormals to the physician. A Care Plan indicated the resident received an anti-convulsant medication related to a mood disorder. An intervention included to educate about the side effects and/or toxic symptoms of drugs being given. A Care Plan indicated the resident required the use of a mood stabilizer to treat a mood disorder and was at risk for adverse side effects. An intervention included to monitor labs as ordered. The August 2021 Physician's Order Summary (POS) indicated the following laboratory orders: -obtain ammonia and valproic acid level every 3 months, ordered 3/8/21 -fasting lipid panel yearly, ordered 2/18/19	F 0757	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** **Ammonia Level, Fasting Lipid Panel, Valproic Acid Level, and Iron Profile was obtained for Resident 10.** ="" span<="" p="">**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** **All residents residing in the facility have the potential to be affected by this alleged deficient practice. A lab audit will be completed on all residents.** **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Lab orders will be completed per MD orders on all residents. All nursing staff will be educated over Lab policy and procedure and Physicians Orders Policy and Procedure. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and**	09/03/2021

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	-iron profile every 6 months, ordered 8/12/18. The August 2021 POS indicated the following medication orders: - Depakote (anticonvulsant) 250 mg (milligrams) twice a day related to mood disorder - pravastatin (cholesterol medication) 40 mg every evening - ferrous gluconate (iron supplement) 240 mg every day There was no documentation to indicate the ammonia and valproic acid level had been completed since 3/8/21. The fasting lipid panel hand not been completed in the past year and the iron profile had been completed since September 2020. Interview with RN 1 on 8/12/21 at 10:32 a.m., indicated the above laboratory orders had not been completed as ordered by the physician. 3.1-48(a)(6)		DON/Designee will monitor resident lab orders three times per week on scheduled workdays times 4 weeks, then 2 times per week times 4 weeks, then weekly times 2 months, then monthly times 2 months. Any negative findings will be forwarded to the Administrator and corrected immediately and will result in re-education and/or disciplinary action. A report of progress will be forwarded to the QAPI committee monthly for minimum of 6 months and plan adjusted accordingly.	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with			

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	applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review and interview, the facility failed to ensure a sanitary kitchen related to the dishwasher not at proper sanitation level and using expired testing strips to monitor the sanitation level in 1 of 1 kitchens observed. (Main Kitchen) Finding includes: The kitchen tour was completed on 8/12/21 at 11:55 a.m., with the Dietary Manager (DM). The dishwasher was observed and noted to be a chemical system. The DM obtained a testing strip, dipped it into the dishwasher water and compared it to the results on the side of the testing strip container. The results indicated less than 25 ppm (parts per million) of sanitizing solution. The DM ran the dishwasher through a cycle and repeated the test. The results were again less than 25 ppm. The policy titled, "Testing Sanitizer Concentration in Low Temperature Dish Machines", dated 6/2018, was received from the DM on 8/12/21 at 1:08 p.m., indicated, "...color of paper, which was dipped in rinse water, must compare with the color on vial relating to a minimum of 50 ppm in rinse water...." Interview with the DM during the kitchen tour, indicated she tested the water daily and it had	F 0812	**What Corrective Action(s) Will Be Accomplished for Those Residents Found to Have Been Affected By The Deficient Practice:** No residents will be affected by this alleged deficient practice. New sanitation testing strips have been obtained. **How Other Residents Having the Potential to Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents have the potential to be affected, no other residents were affected by this alleged deficient practice. New sanitation testing strips have been obtained. **What Measures Will Be Put into Place and What Systemic Changes Will Be Made to Ensure That the Deficient Practice Does Not Recur:** New sanitation testing strips have been obtained. All dietary staff will be educated over Testing Sanitizer Concentration Policy and Procedure. **How The Corrective Action(s)**	09/03/2021

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	been testing at 100 ppm. She had not tested it yet that day. She then indicated the testing strips had expired in April. She did not have additional testing strips. She indicated she would call the company that provided maintenance immediately. 3.1-21(i)(3)		**Will Be Monitored to Ensure the Deficient Practice Will Not Recur:** Dietary Supervisor/Designee will monitor the expiration date on the sanitation testing strips weekly times 4 weeks, then every 2 weeks times 4 weeks, then monthly times 4 months. Any negative findings will be forwarded to the Administrator and corrected immediately and will result in re-education and/or disciplinary action. A report of progress will be forwarded to the QAPI committee monthly for minimum of 6 months and plan adjusted accordingly.	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing			

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	services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to unvaccinated staff not using proper eye protection on 3 of 3 halls observed (100, 200 and 300) and staff not using proper PPE (personal protective equipment) in a TBP (transmission based precaution) room for 1 of 2 TBP rooms observed (Room 104). Findings include: 1. On 8/9/21 at 9:00 a.m., nursing and housekeeping staff on the 200 and 300 hall were observed wearing trauma glasses (plastic glasses that cover the eyes, but have gaps on the sides and tops). Multiple observations were made of staff entering resident rooms and providing care. Faceshields were observed to be available in the facility as staff donned faceshields and complete PPE to enter the 1 COVID positive resident room throughout the survey. The Indiana Department of Health COVID-19 Long Term Care (LTC) Infection Control Guidance Standard Operation Procedure, updated 7/21/21, indicated, "...Unvaccinated HCP (healthcare personal) must wear face mask	F 0880	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** No residents will be affected by this alleged deficient practice. All staff will wear proper PPE per ISDH guidelines during scheduled work shift while in the facility. **How Other Residents Having the Potential to Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents have the potential to be affected, no other residents were affected by this alleged deficient practice. All staff will wear proper PPE per ISDH guidelines during scheduled work shift while in the facility. **What Measures Will Be Put into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** All staff will be educated on how and when to don/doff PPE with	09/03/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155283	A. BUILDING 00 B. WING	08/12/2021

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	(medical) and eye protection with face shield /or goggles as a standard safety measure to protect LTC HCP (SNF/AL) who provide essential direct care within 6 feet of the resident, regardless of COVID-19 status, when there is moderate to substantial (high) community transmission..." The county COVID-19 positivity rate on July 27 was 15.94% and on August 4 was 20.7%, which indicated high transmission rates. On 8/9/21, the Director of Nursing (DON) provided a list of vaccinated staff. There were 13 of 53 staff who had received the COVID-19 vaccine, 40 staff were unvaccinated. During an interview with the DON, on 8/9/21 at 2:40 p.m., she indicated she was aware unvaccinated staff had to wear eye protection, but believed the eye protection they were using was appropriate. She was unaware of the current guidelines for eye protection. 2. During the breakfast room tray observation, on 8/9/21 at 8:29 a.m., RN 2 entered Room 104 with Styrofoam dishes with covered food and drinks without the proper PPE. RN 2 wore a surgical mask and trauma glasses into the room which had a "Droplet" sign on the door indicating what PPE to don before going into the room. The TBP room did not have any PPE outside the door. During an observation on 8/9/21 at 8:46 a.m., QMA 2 entered Room 104 wearing a surgical mask and trauma glasses only with a medication cup in her hand. After QMA 2 exited the room, she went directly into the room across the hall which was a non-TBP room. Interview with RN 2 on 8/9/21 at 8:47 a.m., indicated she did not think about putting on PPE		return demonstration. All staff will be educated, with return demonstration, including but not limited to mask, gloves, gown, and eye protection. A Root Cause Analysis will be completed, (attachment A). The LTC Infection Control Self-Assessment has been updated to reflect current status of facility (attachment B). All staff will be educated in regard to any area indicated on the facility assessment as an area of needed improvement. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** DON/Designee will complete daily IP rounds on scheduled workdays for 6 weeks and until compliance is maintained. Any negative findings will be forwarded to the Administrator and corrected immediately and will result in re-education and/or disciplinary action. A report of progress will be forwarded to the QAPI committee monthly for 6 months and the plan will be adjusted accordingly.	

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	prior to entering the TBP room due to the resident was tested negative last Wednesday and was asymptomatic. Interview with QMA 2 on 8/9/21 at 8:48 a.m., indicated she had just delivered medications to the resident in Room 104 and was unaware to don PPE. Interview with the Director of Nursing on 8/9/21 at 10:14 a.m., indicated there was a cart full of PPE by Room 104's door this weekend. She was unsure as to why the cart had been moved. The COVID-19 LTC Facility Infection Control Guidance Standard Operating Procedure, updated on 7/23/21, indicated the following: "Unknown COVID-19 status (Yellow): All residents in this category warrants (droplet and contact.) HCP will wear single gown per resident, glove, N95 mask and eye protection (face shield/or goggles). Gowns and gloves should be changed after every resident encounter with hand hygiene performed." 3.1-18(b)			