STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385263	A. Building B. Wing	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Hermiston Nursing & Rehab Center	970 W Juniper Avenue Hermiston, OR 97838

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46053 Based on observation, interview and record review it was determined the facility failed to ensure dignity for 1 of 2 sampled residents (#40) reviewed for dignity. This placed residents at risk for lack of dignity. Findings include: Resident 40 was admitted to the facility in 2021 with diagnoses including stroke. A review of Resident 40's 9/27/23 Annual MDS Assessment revealed she/he had moderate cognitive impairment. Resident 40's Care Plan revised on 10/8/21 revealed she/he required extensive assistance from one staff member twice a week and as necessary to complete bathing tasks. Resident 37 was admitted to the facility in 2022 with diagnoses including muscle wasting and atrophy. A review of Resident 37's 10/7/23 Quarterly MDS Assessment revealed she/he had moderate cognitive impairment. On 11/14/23 at 1:42 PM Resident 40 was observed in a shower chair and partially covered by a bath blanket while Staff 17 (CNA) transported her/him to the 400 hall shower room. Resident 40's left buttock and left leg were completely exposed. On 11/14/23 at 1:44 PM Resident 37 was observed sitting in her/his wheelchair near the 400 hall shower room. She/he stated, Did you see that? That man was completely naked and they just rolled him down the hall naked for his shower. Resident 37 stated residents are frequently transported to and from the shower without being completely covered. She/he stated she/he thought it was not right to be transported naked. On 11/14/23 at 2:13 PM Staff 17 stated she did not notice Resident 40's buttock and leg were uncovered when she prepared her/him for her/his shower. She stated, Maybe I should have made sure [she/he] was more covered. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/16/23 at 11:57 AM Staff 18 (RN) stated CNAs and shower aides prepared residents for showers in the shower room or in the residents' rooms. She stated staff members were expected to make sure residents were completely covered while going between their rooms and the shower room. On 11/17/23 at 11:57 AM Staff 2 (DNS) stated when going to and from the shower room she expected residents to be covered completely for everyone's dignity and privacy.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 43691 Based on observation, interview and record review it was determined the facility failed to assess a resident for safe self-administration of medication for 1 of 2 sampled residents (#41) reviewed for medication self-administration. This placed residents at risk for unsafe medication administration. Findings include: Resident 41 was admitted to the facility in 2022 with diagnoses including asthma. A Physician Order from 3/17/23 instructed Resident 41 to inhale 2 puffs of albuterol 90 mcg for shortness of breath. The order included instructions the medication was to be administered by a clinician. On 11/13/23 at 3:38 PM an albuterol inhaler was observed on the residents bedside table. Resident 41 stated she/he had been assessed and approved to use the inhaler independently. On 11/15/23 at 8:43 AM Staff 32 (RNCM) stated a resident must have physician orders and an assessment for safety with self-administration of any medication. Review of Resident 41's orders with Staff 32 revealed Resident 41's albuterol medication was to be administered by a clinician and should not be left in her/his room. Staff 32 also confirmed a self-administration assessment was not performed on Resident 41 regarding self-administration of albuterol. Upon visit of Resident 41's room, Staff 32 confirmed Resident 41 had an albuterol inhaler by her/his bedside and removed the inhaler from Resident 41's room.

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F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 43691 Based on observation and interview it was determined the facility failed to ensure contact information for pertinent State agencies was posted and available to residents for 1 of 1 facility observed for required postings. This failure placed residents at risk for lack of information about how to file a complaint. Findings include: Review of the facility's required postings on 11/16/23 revealed a poster with State agency information on reporting a complaint was not posted in the facility. On 11/16/23 at 10:16 AM Staff 2 (DNS) stated the facility previously had a poster up with contact information for the pertinent State agencies, but the poster was removed a week ago. Staff 2 acknowledged no contact information for the pertinent State agencies was currently posted.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 46053 Based on observation and interview it was determined the facility failed to ensure survey results were readily accessible for 1 of 1 facility reviewed for resident rights. This placed residents and the public at risk for not being informed of the facility's survey history. Findings include: On 11/14/23 at 10:30 AM a binder containing the facility's survey results was observed lying flat on the counter adjacent to a closed roll-up window on the south side of the building. The binder was oriented away from the room and the label of the binder was not visible when observed from wheelchair height. A sign was observed on the outside of the door which read, PUBLIC ACCESS TO FACILITY IS LOCATED ON THE [north] SIDE OF THE BUILDING. On 11/14/23 at 10:33 AM Staff 9 (Activities Director) stated the south side of the building was the facility's back door. She stated the main entrance was located on the north side of building and residents and guests entered and exited through the north side doors. On 11/17/23 at 11:05 AM Staff 5 (RN) reported she knew the binder existed but did not know where it was. She stated I don't think residents even know about it, to be honest. On 11/17/23 at 11:50 AM Staff 1 (Administrator) confirmed the current location of the survey binder and stated That's where it's always been. From COVID this side was locked and was not a public entrance. He stated nursing stations are the most central locations where residents would be more likely to find the binder.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41458 Based on observation and interview it was determined the facility failed to maintain a homelike environment for 1 of 1 facility reviewed for environment. This placed residents at risk for living in an unkempt environment. Findings include: Observations of the facility's general environment and residents' rooms from 11/13/23 through 11/17/23 identified the following issues: -The 100 hall shower room was missing the threshold from the shower room to the hallway and was not cleanable. The tiles in the shower stall were worn down and chipped. The flooring was discolored. The overhead light was dirty and had a cracked plastic covering. -The skilled floor dining room had black marks along the wall under the window and black shoe prints on the wall near the sink. -room [ROOM NUMBER] had gouges in the wall above the bed and along the wall next to the bathroom. The heater was also gouged and had areas of missing paint. -room [ROOM NUMBER]'s bathroom light covering had come off and was on the floor by the toilet. In the corner of the room, the wall had gouges approximately five feet long. The wall under the window had numerous black markings. The wall edges where the corner of the wall met were gouged and needed repair. -room [ROOM NUMBER] had long dark marks on the wall entering the room, dark marks above the bed and along the wall near the head of the bed. The bathroom wall had several areas that needed repair. -room [ROOM NUMBER]'s wall had gouges near the head of the bed, the bathroom door with missing a chunk of wood and was scraped along the bottom of the door. The corner of the wall was gouged and needed repairs. -room [ROOM NUMBER]'s windows were dirty and hard to see out of. There were gouges near the head of the bed and along the wall, entering the room there were gouges on approximately four feet of the wall. The wall on the right side of the room was gouged and scraped. -room [ROOM NUMBER] had large black gouges in the floor and the window was dirty and hard to see out of. -room [ROOM NUMBER]'s window was dirty and hard to see out of. There were long gouges on the wall behind the bed and other walls that needed to be painted. The dresser and closet were scraped up. The bed protector on the wall was broken the entire length of the wall behind the bed. -room [ROOM NUMBER], when entering the room the wall had long gouges the length of the wall, the wall was scraped by the headboard, the dresser was scraped up, and there was missing plaster on the corner wall that needed to be repaired. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/17/23 at 9:57 AM Staff 11 (Maintenance Director) acknowledged the identified rooms were not homelike and the identified maintenance concerns needed to be repaired.

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F 0689 Level of Harm - 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** 41458 Based on observation, interview, and record review it was determined the facility failed to ensure the environment remained free from accident hazards related to mechanical lift transfers for 3 of 3 sampled residents (#s 4, 15 and 18) reviewed for accidents. This failure resulted in Resident 15 sustaining a hip fracture which required surgical intervention. Findings include: Resident 15 was admitted to the facility in 2018 with diagnoses including pain in her/his lower legs. Resident 15's [DATE] Annual MDS indicated the resident had no cognitive impairment. Resident 15 required the assistance of two-persons using a mechanical lift for transfers. An [DATE] 7:21 AM Fall Investigation revealed Resident 15 fell during a mechanical lift transfer because staff were unable to turn the mechanical lift which resulted in the mechanical lift tipping over and the resident landing on her/his right side. Resident 15 complained of pain to her/his right leg and shoulder and was sent to the hospital. A witness statement indicated multiple staff complained the wheels on the mechanical lift were getting stuck, nothing had been done and the lift was unsafe. The investigation concluded that the staff were in error and education and competencies would be completed. An [DATE] Hospital Discharge Summary revealed Resident 15 was admitted to the hospital on [DATE] for surgical intervention of a right hip fracture which was sustained after the resident was dropped from a mechanical lift. On [DATE] at 1:51 PM Staff 2 (DNS) was requested to provide mechanical lift education and competencies for the following staff on duty [DATE]: Staff 5 (RN), Staff 6 (CNA), Staff 7 (CNA), Staff 8 (CNA), Staff 12 (CNA), Staff 20 (CNA), Staff 21 (CNA), Staff 22 (CNA) and Staff 23 (CNA). The following competencies were provided: -Staff 6 completed on [DATE]; -Staff 7 completed on [DATE] and -Staff 23 completed on [DATE]. Staff 2 was unable to provide education and competencies for the remaining requested staff. The [DATE] through [DATE] monthly maintenance reports were provided for one of the five mechanical lifts. There was no additional evidence provided that monthly maintenance was completed on the additional four mechanical lifts. On [DATE] at 12:58 PM a mechanical lift was observed outside of Staff 11's (Maintenance Director) office. The wheels on the mechanical lift did not turn properly. When the mechanical lift was pushed it did not steer or turn in the direction being pushed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 3:24 PM Resident 15 stated staff were getting her/him up using the pumperoo type mechanical lift when part of the mechanical lift broke which caused her/him to fall. Resident 15 stated she/he injured her/his chest and broke her/his leg. On [DATE] at 4:11 PM Staff 4 (CNA) stated on [DATE], she and Staff 10 were getting Resident 15 up for breakfast. Staff 4 stated as she attempted to drive the mechanical lift the wheels became jammed. Staff 4 stated the mechanical lift could only move with the front wheels, the lift was not budging and with the momentum and the weight of the resident, the lift tipped over and Resident 15 fell on to the floor. Staff 4 stated the mechanical lift was taken off of the floor but the administration and maintenance said there was nothing wrong with the mechanical lift. On [DATE] at 4:35 PM Staff 10 (CNA) stated the mechanical lifts were wobbly and jiggly, the wheels got stuck and were difficult to turn. Staff 10 stated on [DATE] she attempted to transfer Resident 15 with Staff 4 (CNA). Staff 10 stated Staff 4 turned the mechanical lift, the legs and back wheels became stuck and the lift immediately stopped moving. Staff 10 stated Staff 4 tried to get the mechanical lift to move but the mechanical lift tipped over and Resident 15 fell to the ground. On [DATE] at 12:06 PM Staff 7 (CNA) stated the mechanical lifts did not always work. Staff 7 stated she brought her concerns to Staff 1 (Administrator) and Staff 11 and they just blame it on us. On [DATE] at 12:58 PM Staff 5 (RN) stated she told management on several occasions that the mechanical lifts were not operating properly and someone was going to get hurt. Staff 5 stated in ,d+[DATE], Resident 15 fell from the mechanical lift because the lift was not working properly and tipped over. Staff 5 stated earlier today, she attempted a mechanical lift transfer of a resident with Staff 12 (CNA) assisting and the mechanical lift nearly tipped over. Staff 5 stated as she took the mechanical lift down the hallway it would barely roll. She placed the lift outside of Staff 11's office. Staff 5 stated the batteries needed to operate the mechanical lifts were always dead or died in the middle of a transfer despite being on the battery charger all day. On [DATE] at 1:10 PM Staff 12 (CNA) stated often the wheels on the mechanical lifts did not move properly and got stuck. On [DATE] at 7:03 PM Staff 3 (CNA) stated the mechanical lifts were horrible. Staff 3 stated frequently there were mechanical lifts out of commission. Staff 3 stated the mechanical lifts were hard to push, difficult to steer and barely turned. On [DATE] at 7:09 PM Staff 17 (CNA) stated the wheels on three of the mechanical lifts got stuck and the legs did not move well. Staff 17 stated in the past, the pump mechanical lift locked at the top and the lift collapsed. Staff 17 stated at least one mechanical lift needed to be serviced every week. On [DATE] at 6:39 AM Staff 5 stated two malfunctioning mechanical lifts were taken off of the floor and new ones replaced them. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE] 2:29 PM Staff 1 stated the issues with the mechanical lifts had been going on for a long time. Staff 1 stated staff brought the mechanical lifts to the maintenance department and every time they were looked at by Staff 11, there was nothing wrong with them. Staff 1 stated Staff 11 was unable to recreate the issues. Staff 1 stated staff concerns with the mechanical lifts had been going on for months because the staff did not know how to use the mechanical lifts properly. On [DATE] 11:09 AM Witness 2 (Resident Advocate) reported she discussed concerns regarding the mechanical lifts with Staff 1 over a year ago and felt the concerns were minimized and there was no follow through. In addition, Witness 1 stated when concerns were brought forward to Staff 1, Staff 1 tended to minimize or say there was no problem thus concerns were usually not addressed. 43691 2. Resident 18 was admitted to the facility with diagnoses including hemiplegia (limited or no ability to move a side of the body). Resident 18's ,d+[DATE] Care Plan included the use of a mechanical lift for all transfers. On [DATE] at 3:34 PM Staff 16 (CNA) stated the mechanical lifts were difficult to use and dangerous. Staff 16 stated after the resident was raised in the air, the wheels lock and it is very difficult to push the mechanical lift for repositioning . I've had residents swing so much when we are trying to move them in it that I've had to catch the resident to prevent them from falling. On [DATE] at 7:03 PM Staff 3 (CNA) stated Resident 18 experienced a malfunctioning mechanical lift when she/he was transferred from a wheelchair to her/his bed in ,d+[DATE]. Staff 3 stated Resident 18 was being supported by the mechanical lift when it gave out and Staff 36 (CNA) was required to catch the resident who was halfway out of the mechanical lift sling, six inches from the floor. On [DATE] at 7:09 PM Staff 36 (CNA) stated she assisted Staff 3 when the mechanical lift malfunctioned. Staff 36 stated Resident 18 was being transferred with a mechanical lift when the lock disengaged and the mechanical lift collapsed which dropped Resident 18 towards the ground. Staff 36 stated she had to catch Resident 18 to prevent her/him from striking the ground. Staff 36 recalled Resident 18 having been afraid after the incident and stated Resident 18 has had a continued fear of mechanical lift transfers since. On [DATE] at 7:13 PM Resident 18 stated she/he experienced a near injury as a result of a faulty mechanical lift. Resident 18 reported the mechanical lift gave out and she/he was dropped from being fully raised to being six inches from the floor. Resident 18 stated they were not even touching it when the drop happened so it wasn't user error. Resident 18 stated she/he has felt afraid during transfers since she/he was nearly dropped to the floor. Resident 18 stated I don't feel [mechanical lifts] are safe for anyone. Still when they use [a mechanical lift] I wonder: Is it going to fall? Is it going to happen again? I am afraid it will happen again every time they use one. On [DATE] at 10:16 AM Staff 2 (DNS) stated she was unaware of the incident with Resident 18 but confirmed unsafe mechanical lifts should not be used for any transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE] 2:29 PM Staff 1 (Administrator) stated the issues with the mechanical lifts had been going on for a long time. Staff 1 stated staff brought the mechanical lifts to the maintenance department and every time they were looked at by Staff 11 (Maintenance Director), there was nothing wrong with them. Staff 1 stated staff concerns with the mechanical lifts had been going on for months because the staff did not know how to use the mechanical lifts properly. 3. Resident 4 was admitted to the facility with diagnoses including obesity and difficulty walking. Resident 4's ,d+[DATE] Care Plan included the use of a mechanical lift for all transfers. On [DATE] at 3:34 PM Staff 16 (CNA) stated the mechanical lifts were difficult to use and dangerous. Staff 16 stated after the resident was raised in the air, the wheels lock and it is very difficult to push the [mechanical lift] for repositioning . I've had residents swing so much when we are trying to move them in it that I've had to catch the resident to prevent them from falling. On [DATE] at 3:38 PM Resident 4 was observed receiving mechanical lift transfer assistance from Staff 16 (CNA) and Staff 3 (CNA). After Resident 4 was raised out of her/his wheelchair, Staff 16 and Staff 3 began to attempt to reposition the mechanical lift. The movements made were jerky and the resident began swinging back and forth while supported with the mechanical lift sling. Staff 16 and Staff 3 both were required to bend over and move the bottom portion of the mechanical lift when the wheels became stuck on the flat, smooth and unobstructed ground. On [DATE] at 3:45 PM Resident 4 stated the observed transfer was consistent with previous mechanical lift transfers. Resident 4 stated she/he did not feel safe with the use of the facility's mechanical lifts because the wheels often jammed and staff had to make adjustments to the mechanical lift for it to move, rather than focusing on the resident. On [DATE] at 10:16 AM Staff 2 (DNS) stated mechanical lifts should not require staff to bend over to allow for wheel movement. Staff 2 confirmed a mechanical lift requiring this practice should no be used. On [DATE] 2:29 PM Staff 1 (Administrator) stated the issues with the mechanical lifts had been going on for a long time. Staff 1 stated staff brought the mechanical lifts to the maintenance department and every time they were looked at by Staff 11 (Maintenance Director), there was nothing wrong with them. Staff 1 stated staff concerns with the mechanical lifts had been going on for months because the staff did not know how to use the mechanical lifts properly.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 48890 Based on observation, interview and record review it was determined the facility failed to ensure oxygen was administered as ordered for 1 of 1 sampled resident (#31) reviewed for respiratory care. This placed residents at risk for adverse respiratory effects and discomfort. Findings include: Resident 31 was admitted to the facility in 2021 with diagnoses including chronic respiratory failure with hypoxia (an absence of enough oxygen), pneumonia and chronic obstructive pulmonary disease (a lung disease that makes it difficult to breathe). The facility's 6/2023 Oxygen Administration Policy indicated the following: -It is the policy of this facility that oxygen therapy is administered, as ordered by the physician or as an emergency measure until order can be obtained. Resident 31's 8/12/21 Physician Order indicated the resident received two liters of oxygen per minute (LPM) via nasal cannula (a medical device to provide supplemental oxygen therapy to people with low oxygen levels). An 8/22/23 Annual MDS indicated Resident 31 received oxygen therapy. An observation on 11/16/23 at 10:59 AM revealed Resident 31's oxygen flow was set at three LPM. On 11/16/23 at 3:46 PM Staff 5 (RN) observed Resident 31's oxygen flow rate was set to three LPM and Staff 5 stated the oxygen flow rate was supposed to be at two LPM. Staff 5 confirmed any increase in oxygen rate required a physician order. On 11/17/23 at 10:44 AM DNS Staff 2 (DNS) acknowledged the resident was supposed to receive two LPM and three LPM was not according physician order. Staff 2 stated she expected physician orders to be followed.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41458 Based on observation, interview and record review it was determined the facility failed to ensure sufficient staffing to meet resident care needs for 1 of 1 facility reviewed for sufficient and competent staffing. This placed residents at risk for unmet care needs and lengthy call light response times. Findings include: On 11/13/23 the facility had a census of 72 residents. On 11/15/23 Staff 2 (DNS) provided a list of residents who: -Required two-person mechanical lift transfers: 24. -Were considered to be bariatric (obese) with a body mass index over 40: 9. -Had behavioral healthcare needs: 13. -Required frequent checks: 3. -Were determined to be at a high fall risk: 26. -Were dependent on staff for showers: 57. -Were dependent on staff for toileting: 44. -Required one-to-one assistance with eating: 6. The 1/2023 through 11/2023 Resident Council Meeting notes revealed residents' voiced concerns regarding long call light response times during every Resident Council meeting this year. Observations from 11/13/23 through 11/16/23 from the hours of 6:30 AM to 9:30 PM revealed the following concerns: -11/14/23 at 1:40 PM the resident in room [ROOM NUMBER] was yelling help me; -11/14/23 at 1:48 PM the call light in room [ROOM NUMBER] was activated for 35 minutes and the call light in room [ROOM NUMBER] was activated for 32 minutes; -11/14/23 at 3:21 PM the call light in room [ROOM NUMBER] was activated for 35 minutes; -11/15/23 at 10:13 AM the call light in room [ROOM NUMBER] was activated for 30 minutes; -11/15/23 at 2:50 PM Resident 28, identified to be at a high fall risk, attempted to self-transfer using a transfer pole and was unable to get to a standing position. No staff were observed in the hallway; and (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-11/16/23 at 11:16 AM a resident on the 200 hallway was yelling somebody help me. Interviews with staff revealed the following: On 11/13/23 at 3:35 PM Staff 16 (CNA) stated she typically was assigned 11 residents on evening shift and reported during the first week of 11/2023, there was a day when she was the only licensed CNA on the unit. Staff 16 stated it was very difficult because she was told she had to get all of the residents up for dinner and then change all of the residents' bedsheets. Staff 16 stated this was an impossible task. On 11/15/23 at 8:28 AM Staff 4 (CNA) stated staffing on the weekend was awful and Saturdays were consistently short one staff. Staff 4 stated because of low staffing, residents had falls and staff were unable to get residents up for meals because there were so many residents that require two-person mechanical lift transfers. Staff 4 stated the residents often did not get showered or toileted in a timely manner and residents did not receive restorative therapy at times because the restorative aid was pulled to the floor to work as a CNA. On 11/15/23 at 9:57 AM and 7:26 PM Staff 5 (RN) stated the long-term hallways had very heavy care residents. She stated many residents required two-person mechanical lift transfers, there were several residents with behaviors and it took at least one hour to provide routine care for one resident. Staff 5 reported the facility staffed to the state minimum ratios but that was not adequate based on the needs of the residents. Staff 5 stated the facility was short CNA coverage all the time and there were staff that frequently called in. Staff 5 reported as a result of the facility being short staffed, many residents had skin issues, recently a resident had a choking incident, showers were missed and the CNAs were unable to take breaks and had to stay past their shift in order to get their charting done. On 11/15/23 at 10:45 AM Staff 6 (CNA) stated the weekends were consistently incredibly short staffed. Staff 6 stated there were many new CNAs and NAs which made it hard for the veterans because the newly hired staff did not get enough training. Staff 6 stated due to low staffing, sometimes residents did not get showered and the CNAs did not take breaks or lunches at times. On 11/15/23 at 12:06 PM Staff 7 (CNA) stated the facility was typically short staffed. Staff 7 stated when the facility was short staffed the residents did not get showered and they got upset, wondering when they would receive a shower. Staff 7 stated if the facility was staffed over the state minimum ratios then staff got sent home. On 11/15/23 at 12:17 PM Staff 8 (CNA) stated staffing may look good on paper but there were not enough staff to meet the acuity needs of the residents. Staff 8 stated training of NAs was a big problem because they were not provided adequate training. Staff 8 stated the CNA staff were in a lose/lose situation due to inadequate staffing. Staff 8 stated residents did not get washed properly, their dentures did not get taken out and cleaned at night and skin care was not getting done. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/15/23 at 1:10 PM Staff 12 (CNA) stated in general the facility was short staffed almost every day. Staff 12 stated the new NAs were not adequately trained which took a lot of time from the experienced CNAs. Staff 12 stated when the facility was short staffed residents had to stay up longer than they should, were left in bed for meals, showers were missed and denture/oral care was not completed. Staff 12 stated CNAs had to work longer than their scheduled shift in order to get their charting completed. On 11/15/23 at 7:03 PM Staff 3 (CNA) stated evening shift CNAs often had 10 to 12 assigned residents. Staff 3 stated the facility had many residents who required two-person mechanical lift transfers which made it hard on the staff. Staff 3 stated often the staff had to bump showers and residents had to sit up in their chairs for long periods of time because staff did not have time to put the residents back to bed. On 11/16/23 at 10:52 AM Staff 9 (Activities Director) stated she participated in monthly Resident Council meetings and long call light times were a problem brought up by the residents' throughout the entire year. On 11/16/23 at 1:06 PM Staff 2 stated staffing was determined based on the state minimum staffing ratios. Staff 2 stated staff came to her stating the facility was short staffed and she told them the facility was staffed based on the state minimum staffing ratios so staffing was fine. Staff 2 acknowledged that the facility was supposed to staff according to the acuity needs of the residents but stated they had no acuity tools to use. Staff 2 stated the facility was not completing annual licensed staff competencies and she needed to get those going. On 11/17/23 at 11:09 AM Witness 2 (Resident Advocate) stated she brought staffing concerns to the attention of Staff 1 (Administrator) and the concerns were minimized. Witness 2 stated during visits in 9/2023 and 10/2023, call light times were over 40 minutes and residents frequently reported call light response times between 30 minutes to one hour. Witness 2 stated staffing issues lead to residents sitting in urine soaked clothing for long periods of time. Witness 2 stated staffing concerns continued to be an ongoing issue with the facility.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 48890 Based on interview and record review it was determined the facility failed to ensure CNA staff annual performance reviews were completed for 2 of 5 sampled CNA staff (#s 7 and 31) reviewed for sufficient and competent nurse staffing. This placed residents at risk for a lack of competent staff. Findings include: On 11/16/23 at 12:10 PM a review of the facility staff training records for CNAs employed over one year revealed the following: -Staff 7 (CNA), hire date 7/17/22; had no annual performance review documentation on file. -Staff 31 (CNA), hire date 10/1/21; had no annual performance review documentation on file. On 11/16/23 at 1:09 PM Staff 2 (DNS) confirmed she was unable to provide annual performance review documentation for Staff 7 and Staff 31.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43691 Based on observation and interview it was determined the facility failed to ensure food was labeled and stored in a manner to minimize spoilage and proper food handling practices were followed to prevent cross contamination in 1 of 1 kitchen reviewed for food safety. This placed residents at risk for foodborne illness and unappetizing meals. Findings include: 1. On 11/13/23 at 10:56 AM the following observations were made regarding dry food storage: -Three undated containers of pasta; -One undated container of croutons; and -One undated container of rice. On 11/13/23 at 11:13 AM Staff 33 (Cook) stated dry food containers were not dated. When questioned, Staff 33 was unable to say specifically how long they have had the dry foods. On 11/15/23 at 12:05 PM Staff 35 (Dietary Manager) confirmed all food should be dated. 2. On 11/15/23 at 11:39 AM Staff 34 (Cook) was observed preparing and plating lunch with no hairnet. On 11/15/23 at 12:05 PM Staff 35 (Dietary Manager) stated staff were to wear hairnets anytime they were in the kitchen area. Staff 35 confirmed Staff 34 was not wearing a hairnet when preparing and plating food. 3. On 11/15/23 at 11:40 AM the wall directly above the food plating area contained grease and food scraps. On 11/15/23 at 12:05 PM Staff 35 (Dietary Manager) stated staff were to maintain cleanliness of all areas of the kitchen, especially the area surrounding food plating. Staff 35 confirmed the grease and food on the wall was unacceptable.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 43691 Based on observation and interview it was determined the facility failed to ensure the garbage area dumpsters were covered and free from debris for 3 of 3 facility dumpsters reviewed for sanitation. This placed residents at risk for exposure to pests and rodents. Findings include: On 11/15/23 at 12:06 PM three dumpsters were observed, all with lids open. Two used medical gloves and one wet-wipe were observed around the two south dumpsters. On 11/16/23 at 9:25 AM three dumpsters were observed, all with lids open. Three used medical gloves were observed on the ground around the outside of the south dumpsters. Two medical gloves were observed on the ground around the outside of the north dumpster. On 11/16/23 at 10:10 AM the north and south dumpster areas were reviewed with Staff 11 (Maintenance Director). Staff 11 confirmed the dumpster lids were to be closed and used medical equipment was to be in the containers, not on the ground around the containers.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 48890 Based on interview and record review it was determined the facility failed to have a system in place to track annual nurse aide training (required 12-hour minimum every year) for 5 of 5 randomly sampled CNAs (#s 7, 8, 12, 30 and 31) reviewed for sufficient and competent nurse staffing. This placed residents at risk for lack of care by competent staff. Findings include: On 11/16/23 at 12:02 PM the following CNA staff training logs were requested and received from Staff 2 (DNS): -Staff 7 (CNA): received 0 hours of annual training; -Staff 8 (CNA): received 0 hours of annual training; -Staff 12 (CNA): received 0 hours of annual training; -Staff 30 (CNA): received 0 hours of annual training and -Staff 31 (CNA): received 0 hours of annual training. On 11/16/23 at 12:26 PM Staff 2 acknowledged the required 12 hours of annual in-service training was not completed for Staff 7, Staff 8, Staff 12, Staff 30 and Staff 31.