STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195494	A. Building B. Wing	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Baton Rouge	9105 Oxford Place Drive Baton Rouge, LA 70809

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44965 Based on interviews and record reviews, the facility failed to promote and facilitate resident self-determination through support of resident choice for 1 (#2 and #R4) of 3 (#1, #2, and #R4) residents reviewed for resident rights. The facility failed to ensure: 1. Residents #2 and #R4 were able to choose the type of bath they received; and 2. Resident #R4 was able to choose when she wanted to get back in bed. Findings: Review of the facility's policy revised in January 2024 titled, Bathing revealed the following, in part: Processes: Inquire with the resident concerning bathing preferences (Ex - type of bathing: shower, bed bath, etc.) Resident #2 Review of Resident #2's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Cerebral Infarction, Unspecified Dementia, Aphasia Following Cerebral Infarction, and Flaccid Hemiplegia Affecting Right Dominant Side. Review of Resident #2's Quarterly MDS with an ARD of 12/27/2024 revealed a BIMS of 99, which indicated the BIMS assessment was unable to be completed. An interview was conducted with Resident #2's family member on 03/26/2024 at 9:09 a.m. She stated Resident #2 was supposed to receive a shower in the shower room by the facility on Tuesdays, Thursdays, and Saturdays. She stated facility staff would give Resident #2 a bed bath on her scheduled bath days instead of taking her to the shower room. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with S16CNA on 03/26/2024 at 2:34 p.m. She stated she was the only CNA assigned to the hall and did not have a whirlpool aide. She stated when she was by herself and did not have a whirlpool aide, she was unable to bring the residents to the shower room. She stated on Saturday, Resident #2 was supposed to go on the gurney to the shower room because that was what her family wanted. She stated she gave her a bed bath, which was against her family's wishes. She confirmed it was the residents' right to choose which type of bath they received. Resident #R4 Review of Resident #R4's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Bilateral Primary Osteoarthritis of Knee, Muscle Wasting and Atrophy, Age-Related Physical Debility, and Morbid Obesity. Review of Resident #R4's Quarterly MDS with an ARD of 02/15/2024 revealed a BIMS of 15, which indicated intact cognition. An interview was conducted with Resident #R4 on 03/25/2024 at 1:30 p.m. She stated she required a Hoyer Lift for transfers. She stated S14CNA told her last Wednesday she could get her up but she could not put her back to bed before the end of her shift at 6:00 p.m. because she had other things to complete. She stated she decided to stay in bed because she did not want to have to wait for the night shift to put her back to bed. She stated the last three months there had been a staffing shortage and she did not understand what was going on. She stated she had a care plan meeting, and it was decided for her to go to the shower room on Wednesdays and a bed bath Mondays and Fridays. She stated about one month ago she started getting only bed baths every Monday, Wednesday, and Friday related to staffing. She explained it took two CNAs to get her onto the shower gurney. She stated she wanted to go to the shower room at least once per week. An interview was conducted with S14CNA on 03/25/2024 at 2:05 p.m. She stated Resident #R4 was scheduled for baths on Mondays, Wednesdays, and Fridays. She stated the shower aide was supposed to give the bath but if there was not a shower aide, she was responsible. She stated Resident #R4 had to have two staff for the shower gurney. She stated when she was responsible for Resident #R4's bath, she gave her a bed bath instead of putting her on the shower gurney. She stated one day last week, Resident #R4 asked to get out of bed after lunch. She stated she explained to Resident #R4 she was able to get her up but she would have to go back to bed on the 6:00 p.m. shift because there were not enough staff. She stated Resident #R4 decided not to get up because she did not want to wait for the next shift to put her back to bed. An interview was conducted with S4CNAS on 03/26/2024 at 11:01 a.m. She stated when it was a resident's bath day, they should be offered to be brought to the shower room. She stated Resident #2 had scheduled baths by the facility every Tuesday, Thursday, and Saturday, and she should have been brought to the whirlpool room. She stated Resident #R4 should have been brought to the shower room every Wednesday. She confirmed the residents should be able to choose when to get out of bed, go back to bed, and the type of bath they wanted to receive. An interview was conducted with S2DON on 03/26/2024 at 4:33 p.m. She confirmed if there was not a shower aide, the CNA assigned to the resident should still bring the resident in the shower room if it was their choice. She confirmed residents had the right to choose when to get out of bed and when to go back to bed.

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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 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** 44965 47500 Based on interviews and record reviews, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain good hygiene for 2 (#R4, and #R5) of 5 (#1, #2, #3, #R4, and #R5) residents reviewed for ADLs. The facility failed to ensure: 1. Residents #R4 and #R5 received baths as scheduled; and 2. Resident #R4 was provided incontinence care timely after calling for assistance. 1. Resident #R4 Review of Resident #R4's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses which included Muscle Wasting and Atrophy, Age-Related Physical Debility, and Morbid Obesity. Review of Resident #R4's Quarterly MDS with an ARD of 02/15/2024 revealed, in part, she had a BIMS of 15, which indicated intact cognition. Further review of the MDS revealed she was dependent on staff for showers/baths. Review of Resident #R4's current Care Plan revealed the following, in part: Problem: Self-care deficit; and Requires assistance with meeting ADLs and maintaining hygiene. Review of Resident #R4's Bath Documentation dated 03/21/2024 through 03/25/2024 revealed no documentation she received a bath. An interview was conducted with Resident #R4 on 03/25/2024 at 1:30 p.m. She stated she had not received a bath since Wednesday of last week. She stated she should have received a bath this past Friday because her bath days were Monday, Wednesday, and Friday. An interview was conducted with S11CNA on 03/25/2024 at 3:25 p.m. She confirmed she was assigned to Resident #R4 on Friday, 03/22/2024, from 6:00 a.m. to 6:00 p.m. She stated Resident #R4's scheduled bath days were Mondays, Wednesdays, and Fridays. She stated she was unsure if she or the shower aide were responsible for Resident #R4's bath on Friday. She confirmed she did not bathe Resident #R4 on 03/22/2024. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with S4CNAS on 03/26/2024 at 11:01 a.m. She stated Resident #R4's shower days were Mondays, Wednesdays, and Fridays. She stated she and S11CNA were responsible for Resident #R4's bath on 03/22/2024. She confirmed she did not give Resident #R4 a bath on 03/22/2024. An interview was conducted with S9CNA on 03/25/2024 at 1:19 p.m. She stated she was assigned to Hall B. She stated sometimes she had a shower aide for the hall and sometimes she did not. She stated when there was a shower aide, the shower aid was not always able to complete all baths and she was responsible for the incomplete baths. She stated sometimes she would be unable to complete the baths and they would not get done. She stated she would try to complete the bath the following day, but that did not always happen. Resident #R5 Review of Resident #R5's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses which included Muscle Weakness, Cognitive Communication Deficit, and Paroxysmal Atrial Fibrillation. Review of Resident #R5's Quarterly MDS with an ARD of 02/01/2024 revealed, Resident #R5 had a BIMS of 7, which indicated severe cognitive impairment. Further review revealed he was dependent on staff for showers/baths. The facility failed to provide evidence of bath documentation for Resident #R5's bath on 03/23/2024. An interview was conducted with Resident #R5 on 03/26/2024 at 10:15 a.m. He stated he had not had a bath in 5 days and wants to get in the whirlpool. An interview was conducted with S6CNA on 03/26/2024 at 3:41 p.m. She stated Resident #R5's bath days were Tuesday, Thursday, and Saturday. She confirmed on 03/23/2024 she did not bathe Resident #R5 and should have since it was his bath day. An interview was conducted with S2DON on 03/26/2024 at 4:30 p.m. She confirmed residents should receive their baths on the scheduled bath day. 2. Resident #R4 Review of Resident #R4's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses which included Muscle Wasting and Atrophy, Age-Related Physical Debility, and Morbid Obesity. Review of Resident #R4's Quarterly MDS with an ARD of 02/15/2024 revealed she had a BIMS of 15, which indicated intact cognition. Further review of the MDS revealed she was dependent on staff for toileting hygiene. Review of Resident #R4's current Care Plan revealed the following, in part: (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Problem: Incontinent of bowel and bladder Interventions: Peri-care after each incontinent episode. An interview was conducted with Resident #R4 on 03/25/2024 at 1:30 p.m. She stated this past Friday night, on 03/22/2024, her call light was on for two hours before she received assistance with incontinence care after having a bowel movement. She stated during the time her call light was on, she called the facility phone from her cell phone five times. She showed surveyor her call log, which revealed she made calls to the facility on [DATE] at 6:15 p.m., 6:20 p.m., 6:51 p.m., 8:08 p.m., and 8:09 p.m. She stated she initiated her call light at 6:10 p.m. and it was answered at 8:15 p.m. She stated S7WC answered the phone and verified the call light had been going off for two hours. An interview was conducted with S7WC on 03/25/2024 at 3:10 p.m. He stated he was the ward clerk from 2:00 p.m. to 10:00 p.m. on Friday, 03/22/2024. He confirmed, on the evening of 03/22/2024, Resident #R4 initiated her call light and called the facility phone five times asking to be cleaned up after having a bowel movement. He confirmed Resident #R4 waited two hours to be changed after initiating her call light. An interview was conducted with S8CNA on 03/26/2024 at 2:53 p.m. She confirmed she was assigned to Resident #R4 on 03/22/2024 from 6:00 p.m. to 6:00 a.m. She stated toward the beginning of her shift, she was notified by S7WC Resident #R4 had her light on and needed to be changed. She stated she was on another hall and had to finish her rounds before going to assist Resident #R4. She stated she was unaware the call light had been on for two hours. A telephone interview was conducted with S12LPN on 03/26/2024 at 3:53 p.m. She confirmed she was assigned to Resident #R4 on Friday night, 03/22/2024. She stated she was unaware Resident #R4 had initiated her call light to be changed. She stated a call light being on 2 hours was excessive. An interview was conducted with S3ADON on 03/26/2024 at 4:01 p.m. She stated a reasonable call light response time was twenty minutes. She confirmed two hours for a resident to wait to be changed was an extended period of time. An interview was conducted with S2DON on 03/26/2024 at 4:33 p.m. She stated a reasonable call light response time was twenty minutes. She stated a two hour call light wait time was an extended amount of time. She stated Resident #R4 should not have had to wait two hours for incontinence care.

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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** 44965 Based on observation, interviews, and record review, the facility failed to ensure each resident received adequate supervision to prevent accidents during a Hoyer Lift transfer for 1 (#R6) of 3 (#2, #R4, and #R6) residents reviewed who required a Hoyer Lift for transfers. Findings: Review of Resident #R6's Clinical Record revealed he was admitted to the facility on [DATE] and had diagnoses, which included Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side. Review of Resident #R6's Admission MDS with an ARD of 01/21/2024 revealed he had a BIMS of 99, which indicated the BIMS could not be completed. Review of Resident #R6's Lifting Plan revealed STOP - total lift. Further review of the lifting plan revealed a question and answer for staff, which stated, If lift is needed, how many staff are to be in attendance? Two. An observation was made of S13CNA entering Resident #R6's room with a Hoyer lift on 03/25/2024 at 9:53 a.m. S13CNA exited the room with the Hoyer lift at 10:01 a.m. An interview was conducted with S13CNA on 03/25/2024 at 10:01 a.m. She confirmed she assisted Resident #R6 out of bed into his wheelchair with the use of the Hoyer Lift independently. She stated there should always be two staff members when transferring a resident with the Hoyer lift. An observation was made of Resident #R6 on 03/25/2024 at 10:06 a.m. He was seated at the foot of his bed in his wheelchair with the lift pad under him. An interview was conducted with S4CNAS on 03/25/2024 at 2:38 p.m. She stated all Hoyer lift transfers required assistance of two staff members to prevent accidents, and it was never acceptable to have one staff member present while utilizing a Hoyer lift. An interview was conducted with S2DON on 03/26/2024 at 4:33 p.m. She reviewed Resident #R6's Clinical Record and confirmed he required assistance of two staff members for Hoyer lift transfers. She confirmed two staff members should have been present for Resident #R6's Hoyer lift transfer.

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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** 44965 47500 Based on record review, interviews, and observations, the facility failed to have sufficient certified nursing assistant staff to provide direct care and related services to maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 4 (#1, #2, #R4 and #R5) of 6 (#1, #2, #3, #R4, #R5, and #R6) residents reviewed for staffing. Findings: Review of the facility's PBJ Staffing Data Report for Fiscal Year 2024 Quarter 1 (October 1 - December 31), with a run date of 03/22/2024 revealed the facility had a 1-star staffing rating. Review of the facility's CNA Staffing Assignment Sheet dated 03/22/2024 revealed, in part, from 6:00 a.m. to 6:00 p.m. 1 CNA was assigned to Hall A, 1 CNA was assigned to Hall B, and 1 CNA was assigned to Hall C; 1 CNA was assigned to the shower room for Hall A and Hall B; and from 6:00 p.m. to 6:00 a.m. 1 CNA was assigned to Hall A and the odd numbered rooms of Hall B and 1 CNA was assigned to Hall C and the even numbered rooms of Hall B. Review of the facility's CNA Staffing Assignment Sheet dated 03/23/2024 revealed, in part, from 6:00 a.m. to 6:00 p.m. 1 CNA was assigned to each Hall A, Hall B, and Hall C; and from 6:00 p.m. to 6:00 a.m. 1 CNA was assigned to Hall A, 1 CNA was assigned to Hall B, and 1 CNA was assigned to Hall C. Further review revealed, on 03/23/2024, from 6:00 a.m. to 6:00 p.m. there was no shower aide assigned to Hall A, Hall B, and Hall C. Review of the facility's CNA Staffing Assignment Sheet dated 03/24/2024 revealed, in part, from 6:00 a.m. to 6:00 p.m., 1 CNA was assigned to Hall A, 1 CNA was assigned to Hall B, and 1 CNA was assigned to Hall C; and from 6:00 p.m. to 6:00 a.m. 1 CNA was assigned to Hall A, 1 CNA was assigned to Hall B, and 1 CNA was assigned to Hall C. Review of the facility's CNA Staffing Assignment Sheet dated 03/25/2024 revealed, in part, from 6:00 a.m. to 6:00 p.m. 1 CNA was assigned to each Hall A, Hall B, and Hall C; and from 6:00 p.m. to 6:00 a.m. 1 CNA was assigned to each Hall A, Hall B, and Hall C. Resident #1 Review of Resident #1's Clinical Record revealed she was admitted to the facility on [DATE] with a diagnoses which included Muscle Weakness, and Unspecified Atrial Fibrillation. Review of Resident #1's MDS with an ARD of 01/30/2024 revealed Resident #1 had a BIMS score of 9, which indicated she had moderate cognitive impairment. Further review revealed she was always incontinent of bowel and bladder and required partial/moderate assistance with eating and was dependent with shower/bath. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/26/2024 at 10:54 a.m., an interview was conducted with Resident #1's RP. She stated she visited every other day in the afternoon from 2:00 p.m. until after dinner to feed Resident #1. She stated if Resident #1 was not fed she would not eat. She stated hospice bathes Resident #1 every other day and the facility does not bathe Resident #1 on the other days. She stated Resident #1 would prefer a whirlpool bath on the opposite days of her hospice bed bath. Resident #2 Review of Resident #2's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Cerebral Infarction, Unspecified Dementia, Aphasia Following Cerebral Infarction, and Flaccid Hemiplegia Affecting Right Dominant Side. Review of Resident #2's Quarterly MDS with an ARD of 12/27/2023 revealed she had a BIMS score of 99, which indicated she was unable to complete a BIMS assessment. Further review revealed she was dependent on staff for toileting and bathing. On 03/26/2024 at 9:09 a.m., an interview was conducted with Resident #2's family member. She stated Resident #2 was supposed to receive a shower in the shower room by the facility on Tuesdays, Thursdays, and Saturdays. She stated the facility staff would give Resident #2 a bed bath on her scheduled bath days instead of taking her to the shower room or she would not get a bath at all. On 03/26/2024 at 2:34 p.m., an interview was conducted with S16CNA. She confirmed she was assigned to Resident #2 from 6:00 a.m. to 6:00 p.m. on 03/22/2024, 03/23/2024, and 03/24/2024. She stated on 03/23/2024, Resident #2 was unable to shower in the shower room because there were not enough staff to get Resident #2 on the shower gurney. Resident #R4 Review of Resident #R4's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Bilateral Primary Osteoarthritis of Knee, Muscle Wasting and Atrophy, Age-Related Physical Debility, and Morbid Obesity. Review of Resident #R4's Quarterly MDS with an ARD of 02/15/2024 revealed she had a BIMS of 15, which indicated she was cognitively intact. Further review of the MDS revealed she was dependent on staff for toileting hygiene and bathing. On 03/25/2024 at 1:30 p.m., an interview was conducted with Resident #R4. She stated she required a Hoyer Lift for transfers. She stated, on 03/20/2024, S14CNA told her S14CNA could get her up, but she could not put Resident #R4 back to bed before the end of her shift at 6:00 p.m. because she had other tasks to complete. She stated she decided to stay in bed because she did not want to have to wait for the night shift to put her back to bed. She stated, on the night of 03/22/2024, her call light was on for two hours before she received assistance with incontinence care after having a bowel movement. She stated she initiated her call light at 6:10 p.m. and it was answered at 8:15 p.m. She stated being left soiled in feces for two hours made her feel anxious, helpless, and frustrated. She stated in the last three months, she had been missing baths due to short staffing. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/25/2024 at 3:10 p.m., an interview was conducted with S7WC. He stated he was the ward clerk from 2:00 p.m. to 10:00 p.m. on 03/22/2024. He confirmed, on the evening of 03/22/2024, Resident #R4 initiated her call light asking to be cleaned up after having a bowel movement. He confirmed Resident #R4 waited two hours to be changed after initiating her call light. He stated there were only two CNAs for Hall A, Hall B, and Hall C on 03/22/2024 from 6:00 p.m. to 6:00 a.m. On 03/26/2024 at 2:53 p.m., an interview was conducted with S8CNA. She confirmed she was assigned to Resident #R4 on 03/22/2024 from 6:00 p.m. to 6:00 a.m. She stated toward the beginning of her shift, she was notified by S7WC Resident #R4 had her light on and needed to be changed. She stated she was on another hall and had to finish her rounds before going to assist Resident #R4. She stated she was unable to provide timely care to the residents that night because there was not enough staff. On 03/25/2024 at 2:05 p.m., an interview was conducted with S14CNA. She stated she regularly was assigned to Resident #R4, and Resident #R4 was scheduled for baths on Mondays, Wednesdays, and Fridays. She stated the shower aide was supposed to give the bath but if there was not a shower aide, she was responsible. She stated Resident #R4 required the gurney for baths, which required assistance of two staff members. She stated when there was not a shower aide, she would have to give Resident #R4 a bed bath because of staffing. She stated Resident #R4 required a Hoyer lift for transfers. She stated one day last week, Resident #R4 asked to get out of bed after lunch. She stated she told her she was able to get her up but she would have to go back to bed on the 6:00 p.m. shift because of the amount of tasks there were for her to complete between 4:00 p.m. and 6:00 p.m. when the next shift arrived. She stated Resident #R4 decided not to get up that day because she did not want to wait for the next shift to put her back to bed. Resident #R5 Review of Resident #R5's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses which included Muscle Weakness, Cognitive Communication Deficit, and Paroxysmal Atrial Fibrillation. Review of Resident #R5's MDS with an ARD of 02/01/2024 revealed, he was always incontinent of bowel and bladder and was dependent with toileting hygiene and bathing. On 03/26/2024 at 10:15 a.m., an interview was conducted with Resident #R5. He stated he had not had a bath in 5 days and wanted to get in the whirlpool tub. On 03/25/2024 at 9:05 a.m., an interview was conducted with S9CNA. She stated she was responsible for all the residents on Hall B, which was 16 residents. She stated she had trouble completing her tasks for all the residents. She stated residents have missed baths. She stated she had 6 residents who required total feeding assistance, and she would often have to let the oncoming shift know who had not eaten yet for the oncoming staff to complete the task. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195494	A. Building B. Wing	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Baton Rouge	9105 Oxford Place Drive Baton Rouge, LA 70809

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/25/2024 at 1:19 p.m., an interview was conducted with S9CNA. She stated there was sometimes an assigned shower aide for Hall A, Hall B, and Hall C. She stated when there was one shower aide for Halls A, B, and C, the shower aide was not able to complete all baths, and she would be responsible for the baths the shower aide was unable to complete. She stated that would cause her to have to rush to feed residents and rush to give a bath. She stated sometimes the bath did not happen that day, and she would try to get it done the following day. She stated sometimes she was unable to complete the bath following day as well. She stated she was assigned to more total care residents than independent. She stated she had reported the staffing concerns to S4CNAS. On 03/25/2024 at 10:20 a.m., an interview was conducted with S10CNA. She stated she was responsible for Hall C. She stated most days, residents would wait up to an hour to be changed. On 03/25/2024 at 2:05 p.m., an interview was conducted with S14CNA. She stated she was assigned to Hall A, which currently housed 19 residents. She stated she almost always was assigned to the hall by herself. She stated there were also days when she was on the hall by herself and there was not a shower aide. She stated she completed the tasks she could. She stated when there was no shower aide, she provided bed baths for the scheduled baths. She stated it was impossible to do rounds every two hours on all of her residents. She stated she was unable to complete her charting with the current amount of workload and staff. She stated there were 13 residents who were incontinent or who required assistance to the bathroom on her hall. She stated there were 3 residents on the hall that had to be fed. She stated there were 4 residents who utilized a stand-up lift or Hoyer lift, which required two staff members. She stated sometimes the residents who required two staff members for transfers and assistance had to wait a while to get up because she could not find another staff or they were busy. She stated she reported to S4CNAS multiple times there was not enough staff to complete all of her tasks. On 03/25/2024 at 3:10 p.m., an interview was conducted with S7WC. He stated when the facility was short staffed, the call lights would go off for thirty minutes to an hour. He stated on 03/22/2024 , a CNA called in and was not replaced so residents had to wait a long time for their call light to be answered. On 03/26/2024 at 9:32 a.m., an interview was conducted with S15CNA. She stated there was supposed to be two shower aides to split Hall A, Hall B, and Hall C, a split hall CNA then 1 CNA for Hall A, 1 CNA for Hall B, and 1 CNA for Hall C. She stated there had not been a split hall CNA so the hall CNAs were assigned to the whole hall independently, and they were unable to complete their tasks timely. She stated the residents were not being checked and changed every two hours. On 03/26/20124 at 2:34 p.m., an interview was conducted with S16CNA. She confirmed she was assigned to Hall B from 6:00 a.m. to 6:00 p.m. on 03/22/2024, 03/23/2024, and 03/24/2024 . She stated she was the only CNA assigned to Hall B, and she did not have a shower aide. She stated when she was by herself and did not have a shower aide, she was unable to bring the residents to the shower room. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/26/2024 at 3:41 p.m., an interview was conducted with S6CNA. She stated when there was no shower aide, residents did not get a bath because it was impossible to perform baths and make rounds every two hours. She stated residents have waited longer than two hours between rounds for incontinence care. She stated there was no shower aide on Saturday, 03/23/2024, and she could not complete all the baths scheduled on 03/23/2024 on Hall C and make rounds to assist residents with ADL tasks. She stated Resident #R5's bath days were Tuesday, Thursday, and Saturday. She confirmed on 03/23/2024 she did not bathe Resident #R5 and should have since it was his bath day. On 03/26/2024 at 1:14 p.m., an interview was conducted with S4CNAS. She stated there was not enough CNAs scheduled to care for the residents on Hall A, Hall B, and Hall C. She stated today there was 53 total residents. She stated they should have had 4 CNAs working the floor on Hall A, Hall B, and Hall C, which was one CNA per hall and one split CNA. She stated today, Hall A, Hall B, and Hall C each had 1 CNA which was not enough to care for all the residents. She stated most of the dependent residents resided on Halls A, B, and C. She stated it was not staffed with enough CNAs on day shift. She stated when there were no shower aides, the hall CNAs were responsible for baths and sometimes had to perform bed baths instead of showers to be able to get it completed. She stated some of the CNAs had communicated with her they did not have enough time to complete their tasks, such as baths and documentation. She stated she lost 4 CNAs in the last 2 weeks due to the workload. She stated S2DON was aware of the CNA staffing concerns. On 03/26/2024 at 4:30 p.m., an interview was conducted with S2DON. She confirmed there was no shower aide on 03/23/2024. She also confirmed there was 1 CNA assigned to Hall A, 1 CNA assigned to Hall B, and 1 CNA assigned to Hall C on 03/22/2024, 03/23/2024, and 03/24/2024 from 6:00 a.m. to 6:00 p.m. and there should have been 4 CNAs. She confirmed on 03/22/2024 from 6:00 p.m. to 6:00 a.m. 1 CNA was assigned to Hall A and the odd numbered rooms of Hall B and 1 CNA was assigned to Hall C and the even numbered rooms of Hall B; and there should have been 3 CNAs from 6:00 p.m. to 6:00 a.m.