STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25E115	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Grove Retirement Home	209 Oak Circle Duncan, MS 38740

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598 Based on observation, interview, record review, and facility policy review the facility failed to ensure a grievance was documented and resolved for one (1) of four (4) residents present during the resident council meeting. Resident #33. Findings Included: Record review of the facility policy, Grievance Policy and Procedure, dated January 23, 2017, revealed Purpose: . To ensure each resident grievance will be followed up by prompt efforts to resolve grievance that the resident may have .Policy: All grievances will be investigated thoroughly and appropriate corrective action taken . Procedure: .4. Grievances made by a resident's family, a visitor, or the resident are to be documented on the grievance form . Record review of Resident Council Minutes dated 04/29/24 and 06/24/24 revealed Resident #33 attended the meetings and he reported that his toilet was loose and needed repair. On 7/28/24 at 12:45 PM, an interview with Resident #33, Resident Council President, revealed Social Services kept up with any complaints or needs brought up in the monthly resident council meetings. Resident #33 revealed he had reported that the toilet in his bathroom was loose at the base and said it rocked back and forth when he sat on it. He revealed the toilet in his bathroom had been loose ever since he had been in that room and it was aggravating to be unable to get anyone to fix it. On 7/29/24 at 09:50 AM, an interview with the Activities Director, revealed that he assisted the residents with scheduling the monthly resident council meetings and assisted with the meetings as needed. He revealed Social Services kept up with the grievances. He revealed if the residents had issues with anything, they would get the associated Department Head to come to the meeting and they would find out about the problem and proceed with fixing the issues. The Activities Director revealed that any concerns with the resident rooms, bathrooms, the building, or equipment was handled by Maintenance and they handled the issues promptly. (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/29/24 at 10:35 AM, an interview with Social Services revealed she was responsible for keeping a record of the grievances and she followed through until they were resolved. She revealed if a resident reported any issue involving needed repairs, she filled out a grievance form, and reported it to Maintenance. Social Services revealed once the issue was repaired, she documented that it was completed, marked it as resolved and she dated it. Social Services reviewed the Resident Council Minutes and confirmed Resident #33 had complained about his toilet needing repair. Social Services also reviewed the Grievance Log over the last six months and confirmed she did not fill out a grievance form on the needed repairs to Resident #33's toilet and said she should have. On 7/29/24 at 1:45 PM, the State Agency (SA) conducted a Resident Council Meeting with four (4) residents who regularly attended the monthly meetings. Resident #33 complained about his toilet in need of repair and revealed he had reported this issue in two (2) or three (3) previous resident council meetings but it didn't do any good. There were no other unresolved grievances identified during the meeting. On 7/29/24 at 2:30 PM, an interview with Maintenance, revealed they keep a maintenance log of anything reported that needed fixing and took care of things as soon as they could. He revealed that often things come up in the monthly resident council meetings, and the Activities Director or Social Services would report it to the appropriate Department Head. Maintenance revealed no one had reported to him about Resident #33's toilet needing repair and it was not in his log book. On 7/29/24 at 2:35 PM, an observation and interview with Maintenance of the toilet in Resident #33's room confirmed the toilet in the bathroom was loose at the base and stated, I'm going to get something now and see if I can tighten it. On 7/29/24 at 2:45 PM, an interview with the Administrator (ADM) revealed when a concern or need was brought up in resident council meeting, Social Services filled out a grievance form and took the issues to whatever department head was responsible and they took care of things as soon as possible. She revealed that after the grievances were fixed, Social Services completed the grievance form and marked it as resolved. The ADM revealed that she reviewed the maintenance log book and she confirmed Resident #33's loose toilet was not documented. Record review of Resident #33's Admission Record revealed an admitted [DATE] and diagnoses including Parkinson's Disease with Dyskinesia and Type 2 Diabetes Mellitus. Record review of Resident #33's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 06/20/2024 under Section C, revealed a Brief Interview for Mental Status (BIMS) Score of 12 which indicated that he had moderate cognitive deficits.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598 Based on staff interview, record review, and facility policy review, the facility failed to send written notification to the resident and/or Resident Representative (RR) upon transfer to the hospital for one (1) of 16 sampled residents reviewed. Resident #29. Findings Included: Record review of the undated facility policy Discharge/Transfer of the Resident Policy and Procedure revealed Procedure .5. Complete the Discharge Instructions form .iv. Give copy of form to the resident and/or representative or person(s) responsible for care. On 7/30/24 at 8:40 AM, an interview with Social Services revealed that she was responsible for notifying the RR when a resident was transferred to the hospital. She revealed the nurses completed the transfer form on the computer and she (Social Services) called the family by phone and let them know what was going on with the resident and about the transfer. She revealed that sometimes the RR didn't answer the phone, and she would leave a voicemail or try again later. Social Services confirmed she did not mail a notice of the transfer/discharge form to the RR when a resident transferred to the hospital and said that she didn't know she was supposed to. Record review of Resident #29's Progress Notes dated 4/03/24 revealed that he was transported to the hospital by ambulance for evaluation of left hip injured from a previous fall. It was determined that his left hip was fractured and he was admitted to the hospital for surgery. This progress note also revealed that Resident #29's RR was contacted by phone and given an update on his condition. There was no documented evidence that a written notice of transfer had been mailed to RR. Record review of Resident #29's Progress Notes dated 5/30/24 revealed that he was discharged to (Proper Name), a behavioral facility and his RR was notified by phone. There was no documentation to indicate a written notice of transfer had been mailed to the RR. Record review of Resident #29's Admission Record revealed an admitted [DATE] and that he had diagnoses including Cerebrovascular Disease and Schizophrenia. Record review of Resident #29's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 6/25/24 under Section C revealed, a Brief Interview for Mental Status (BIMS) Score of 03 which indicated that he had severe cognitive deficits.

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 47157 Based on observations, staff interview, record review, and facility policy review, the facility failed to develop comprehensive care plans related to pressure ulcer care (Resident #31 and #44) and failed to implement a care plan related to a splinting device (Resident #31) for two (2) of 16 residents reviewed for care plans. Resident #31 and #44 Findings include: Record review of the facility policy titled Care Plan Policy and Procedure undated, revealed .Policy: Each resident's care plan will remain current and inform staff of resident's needs, strengths, goals and approaches . Resident #31 An observation of Resident #31 on 7/28/24 at 11:00 AM revealed a contracture to right hand with no device in place. Record review of the care plan Focus: The resident has an ADL (activities of daily living) self-care performance deficit hemiplegia and hemiparesis following CVA (Cerebrovascular Accident) affecting right dominant side, contracture to muscle of right lower leg and left lower leg .Interventions/Tasks: Palm guards to hands. Remove Palm guards at bedtime . An observation on 7/28/24 at 2:52 PM revealed Resident #31 lying in bed with no palm guard observed on right hand. Record review of the care plans for Resident #31 revealed no care plan for the reopened stage IV pressure ulcer to the right hip that was identified on 7/6/24. Record review of the Order Summary Report with active orders as of 7/29/24 revealed an order dated 7/17/24 TX (treatment) Cleanse stage 4 pressure ulcer area to (R) right hip with wound cleanser. Apply light dusting of collagen particles, pack with calcium alginate and cover with bordered foam drsg (dressing) daily/PRN (as needed). An interview with the Administrator on 7/29/24 at 2:50 PM, she confirmed after review of the care plans for Resident #31 there was no care plan developed when the Stage IV to the right hip that had reopened. An interview with the Administrator on 7/29/24 at 3:50 PM, she revealed after review of the care plan related to contractures for Resident #31 that the intervention for the palm guards was not implemented. Record review of the Admission Record revealed Resident #31 was admitted by the facility on 8/01/2018 with diagnoses that included Hemiplegia and Hemiparesis following a Cerebral Infarction affecting the right dominant side. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #31's Annual Minimum Data Set (MDS) with an Assessment Reference date of 6/27/24, revealed Section GG0115: coded 2.) Impairment on both sides to upper extremities. Resident #44 Record review of Resident #44's Care Plans revealed a care plan was not developed for the pressure ulcer on the left lateral ankle. Review of Resident #44's physician orders revealed an order dated 7/19/2024, Clean left lateral ankle Stage 3 pressure ulcer with wound cleanser. Pat dry. Apply Mepilex AG to affected areas and cover with 4x4 gauze. Cover with ABD (abdominal) PAD and apply Kerlix (gauze wrap). Wrap wounds above ankles but not tight. Perform wound care every Monday, Wednesday and Friday daily . An interview with the Regional Clinical Director on 7/29/2024 at 2:10 PM, confirmed Resident #44's pressure ulcer care plan had been mistakenly resolved in May. 47874

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F 0657 Level of Harm - Actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 47157 Based on observation, staff interview, record review and facility policy review, the facility failed to revise a care plan related to pain risk for (1) one of 16 care plans reviewed. (Resident #31) Findings include: Record review of the facility policy titled, Care plan Policy and Procedure, undated, revealed, .Policy: Each resident's care plan will remain current .Procedure: . 3. The Resident's care plan will be updated quarterly and as needed . Record review of a care plan for Resident #31 with a revision date on 6/3/24 revealed The resident has risk for pain r/t (related to) dx (diagnoses) polyosteoarthritis, polyneuropathy, and arthritis of the right knee. The care plan had not been revised to include a Stage IV wound to the right hip that was identified on 7/6/24. During an observation of wound care on 7/29/24 at 9:50 AM, for Resident #31, with the Interim Director of Nursing (IDON), revealed the IDON remove the dressing to a reopened stage IV pressure ulcer on Resident #31's right hip. Resident #31 was observed flinching his arms and legs upward towards his chest, softly moaning, and squinting his eyes shut. The IDON asked Resident #31 if he was in any pain, and Resident #31 stated, Yes, my butt hurts. The IDON replied to Resident #31 that she would tell his nurse when she was finished to get him something for pain. The IDON continued with wound care, cleaned the wound bed once. Resident #31 was observed making a frowning expression, moaned softly, and again flinched his arms and legs in an upward motion towards his chest. The IDON cleansed the wound bed again and then patted the wound dry. Resident #31 continued flinching his arms and legs and made a grimacing frowning facial expressions and squinting his eyes shut with each touch to the wound. The IDON finished wound care and told Resident #31 again she would tell the nurse he was in pain. During an interview with the Administrator on 7/29/24 at 2:40 PM, she revealed after review of the care plan related to pain, the care plan had not been revised to include the Stage IV pressure ulcer that reopened on 7/6/24. The Administrator revealed the purpose of the care plan was to teach the staff what the resident problem was and how to overcome the problem. Review of the Admission Record revealed Resident #31 was admitted by the facility on 8/01/2018 with a diagnosis of Hemiplegia and Hemiparesis following a Cerebral Infarction affecting the right dominant side, Polyneuropathy, Contractures to muscle of right and lower leg.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 47874 Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to provide the wound care treatment as ordered by the physician during wound care for one (1) of three (3) wound care observations. Resident #44 Findings Include: Record review of the facility policy titled Wound Care Policy and Procedure undated, revealed Policy: Any resident identified with a wound skin concern will have a treatment in place to assist with healing of the wound/skin concern. Procedure: . 4. Treatment Nurse or designee will perform wound care/skin care as ordered by the physician per the eTAR (Electronic Treatment Administration Record) . An observation and interview on 7/28/2024 at 1:21 PM, revealed Resident #44 sitting in her wheelchair in the hallway with bandages on both heels. Resident #44 stated she had wounds on both feet. Review of Resident #44's physician orders revealed an order dated 7/19/2024, Clean left lateral ankle Stage 3 pressure ulcer with wound cleanser. Pat dry. Apply Mepilex AG to affected areas and cover with 4x4 gauze. Cover with ABD (abdominal) PAD and apply Kerlix (gauze wrap). Wrap wounds above ankles but not tight. Perform wound care every Monday, Wednesday and Friday daily . An observation of Resident #44's wound care, on 7/29/2024 at 11:14 AM, with the Interim Director of Nursing (IDON) revealed, after cleaning the wound she applied derma blue foam to the wound bed, which was not ordered by the physician for treatment of the pressure ulcer to the left lateral ankle. An interview with the IDON on 7/29/2024 at 11:50 AM, confirmed that she did not use the correct treatment order on Resident #44's wound. She revealed they were out of the Mepilex, and she used the derma blue foam because it was the most compatible treatment the facility had on hand. She confirmed that she did not notify the doctor they were out of the prescribed treatment and revealed she should have because this could cause the wound to worsen. An interview with the Administrator on 7/29/2024 at 12:14 PM, confirmed not using the physician prescribed treatment order for Resident #44's wound could cause the wound to worsen. Review of the Admission Record revealed the facility admitted Resident #44 on 6/10/21, with current medical diagnoses that included Non-pressure chronic ulcer of left ankle, Cerebrovascular disease and Hemiplegia affecting the left dominant side.

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 47157 Based on observation, staff interview, and record review, the facility failed to provide the services to assure a resident maintained his/her highest level of range of motion (ROM) and mobility for one (1) of four (4) residents for positioning and mobility. (Resident # 31) Findings include: Record review of a typed statement on facility letterhead, dated 7/30/24 and signed by the Nursing Home Administrator (NHA) revealed (Proper name of facility) does not have a policy for devices. An observation of Resident #31 on 7/28/24 at 11:00 AM, revealed a contracture to the right hand with no device in place. Record review of the Order Summary Report with active orders as of 7/29/24 revealed an order dated 5/31/23 Remove palm guards at bedtime. An observation on 7/28/24 at 2:52 PM, revealed Resident #31 lying in bed with no palm guard observed to right hand. An observation and interview on 7/29/24 at 9:45 AM, with Certified Nurse Assistant (CNA) #6 revealed no palm guard to Resident #31's hands. CNA #6 revealed she was assigned to Resident #31. She stated she was unable to find the palm guard for Resident #31 and stated it must be in laundry. She confirmed that Resident #31 should have been wearing the palm guard to his right hand on 7/28/24 and should also be wearing it at this time. In an interview with the Interim Director of Nursing (IDON) on 7/29/24 at 9:50 AM, she confirmed Resident #31 should be wearing a palm guard on his right hand because it is contracted. She then stated that the purpose of the palm guard is to prevent the contracture from worsening. In an interview with Licensed Practical Nurse (LPN) #2 on 7/29/24 at 9:55 AM, she revealed that the CNAs are supposed to be applying the palm guard to Resident #31 to prevent worsening of the contracture to the right hand. In an interview with the Administrator on 7/29/24 at 11:00 AM, she confirmed Resident #1 should have been wearing the palm guard on the right hand to prevent the worsening of the contractures. She revealed the previous DON was aware of the splints not being applied and had the Occupational Therapist staff in-service to the nursing staff a few months ago. She then revealed the previous DON did not follow up to ensure the splinting devices were applied because the problem of the devices not being applied continued. A phone interview with Occupational Therapist #1 on 7/29/24 at 12:54 PM, she stated about two months ago she noticed that staff were not applying Resident #31's palm guard. She stated she notified the previous Director of Nurses (DON) and provided an in-service on splint application with the nursing staff, but confirmed she continued to find residents without their splints in place. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	In a continued interview with the Administrator on 7/29/24 at 3:50 PM, she revealed after review of the physician's orders related to palm guards for Resident #31 that the order did not reflect when to apply the palm guard and who was to apply it. Record review of a typed document dated 7/30/24 and signed by the Occupational Therapist (OT) #2 revealed, . Pt (Patient) presents with some decline in PROM (Passive Range of Motion). Pt comorbidities and significant decline in functional use of RUE (Right upper extremity) is a contributing factor as well as proper maintenance schedule with periodic orthosis examination. PROM is difficult .Palmar guard seems appropriate . In an interview with OT #2 on 7/30/24 at 9:37 AM, he revealed he assessed Resident #31's right-hand contracture earlier in the morning. He confirmed that after review of an occupational assessment of Resident #31's hand completed on 3/30/24 and the assessment completed today, that Resident #31 did have a decline in passive range of motion (PROM) to his right hand. OT#2 confirmed that failure to apply the palm guard as ordered for proper maintenance may have contributed to the decline in range of motion in Resident #31's right hand. Review of the Admission Record revealed Resident #31 was admitted by the facility on 8/01/2018 with diagnoses that included Hemiplegia and Hemiparesis following a Cerebral Infarction affecting the right dominant side. Record review of Resident #31's Annual Minimum Data Set (MDS) with an Assessment Reference date of 6/27/24, revealed Section GG0115: coded 2.) Impairment on both sides to upper extremities.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 47157 Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident verbally expressing pain and showing physical nonverbal signs of pain was provided pain management during an observation of wound care for (1) one of 16 sampled residents. (Resident #31) Findings include: Record review of the facility policy titled, Pain Management Policy and Procedure, revealed, Purpose: To maintain the resident as pain free as possible with the least amount of medication required. Policy: Resident is to be assessed and addressed to meet individual needs . An observation of wound care for Resident #31 on 7/29/24 at 9:50 AM, with the Interim Director of Nursing (IDON), revealed the IDON remove the dressing to a reopened Stage IV pressure ulcer on Resident #31's right hip. Resident #31 was observed flinching his arms and legs upward towards his chest, softly moaning, and squinting his eyes shut. The IDON asked Resident #31 if he was in any pain, and Resident #31 stated, Yes, my butt hurts. The IDON replied to Resident #31 that she would tell his nurse when she was finished to get him something for pain. The IDON continued with wound care, cleaned the wound bed once. Resident #31 was observed making a frowning expression, moaned softly, and again flinched his arms and legs in an upward motion towards his chest. The IDON cleansed the wound bed again and then patted the wound dry. Resident #31 continued flinching his arms and legs and made a grimacing frowning facial expressions and squinting his eyes shut with each touch to the wound. The IDON finished wound care and told Resident #31 again she would tell the nurse he was in pain. An interview with the Licensed Practical Nurse (LPN) #2 on 7/29/24 at 10:02 AM, she revealed she gave Resident #31 had a pain pill last at 7:30 AM because he stated he was in pain, she confirmed that Resident #31 has as needed pain medications. Record review of the July 2024 Medication Administration Record revealed Resident #31 last received Tramadol 50 mg at 7:31 AM on 7/29/24. In an interview with the IDON on 7/29/24 at 10:03 AM, she confirmed she should have stopped doing wound care on Resident #31 when he stated he was in pain. She revealed she was unaware if Resident #31 had any pain medications ordered. She confirmed by continuing the treatment when the resident verbalized, he was in pain and had physical signs of pain she placed the Resident #31 at risk for worsening pain. In an interview with the Administrator on 7/29/24 at 11:00 AM, she confirmed the IDON should have stopped the treatment to the pressure sore and provided pain management and comfort. She stated that by failing to do so placed Resident #31 at risk of his pain escalating. She then revealed it is the practice of the facility to ensure residents with wounds are assessed for pain and medicated before treatment. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the Admission Record revealed Resident #31 was admitted by the facility on 8/01/2018 with a diagnosis of Hemiplegia and Hemiparesis following a Cerebral Infarction affecting the right dominant side, Polyneuropathy, Contractures to muscle of right and lower leg. Record review of Resident #31's Annual Minimum Data Set (MDS) with an Assessment Reference date of 6/27/24, revealed Section GG0115: coded 2.) Impairment on both sides to upper extremities. Section J indicated Resident #31 had pain at 06 on a scale of 00-10 over the last 5 days, with 0 indicating no pain and 10 as the worse pain you can imagine.

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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 - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 47874 Based on staff interview, record review, and facility policy review, the facility failed to provide sufficient weekend staffing to meet the individualized needs of the residents for seven (7) of the weekend days reviewed during the second (2nd) quarter 2024. Findings Include: Review of the facility policy titled Staffing Hours, Monitoring of Policy and Procedure undated, revealed Purpose: To assure the facility staffing meet federal and state guidelines Procedure: 1. Staffing hours will be monitored by DON (Director of Nursing) or designee daily or as applicable. Review of the Payroll-Based Journal (PBJ) Staffing Data Report for Quarter 2 (two) 2024, (January 1-March 31) revealed the facility submitted excessively low weekend staffing. An interview with Registered Nurse (RN) #1 on 7/28/2024 at 11:10 AM, revealed she worked every other weekend and was aware the facility had some recent staff changes and turnover in the facility. An interview with Certified Nurse Aide (CNA) #1 on 7/28/2024 at 11:16 AM, revealed she worked every weekend, and they do occasionally have three (3) or four (4) aides on day shift. She explained they do try to call and get someone to come in, but they cannot always find someone. CNA #1 revealed the assignments were difficult with 3 aides, but they work together and do their best to get the job done. An interview with the Administrator (ADM) on 7/29/2024 at 8:43 AM, revealed they tried to over staff and have extra, but that did not always work out. She revealed the Director of Nursing (DON) had been coming in to work when someone called in and stated, Unfortunately, it is almost every weekend. The ADM confirmed they had been short on Certified Nurse Aides (CNAs) and had a lot of staff turnover. She revealed that maintaining staff at the facility was difficult. An interview on 7/29/2024 at 10:10 AM, with the Administrator (ADM) revealed the acuity of the residents, determined their staffing needs. She confirmed that call-ins were the biggest issue they were facing with staffing. She revealed the staff member on call takes the call ins and they are responsible for calling to find a replacement. Furthermore, she explained that if they could not find a replacement and the care hours PPD (per patient day) was too low, they were required to come to the facility and work the shift. The ADM confirmed they do have trouble finding and keeping staff. She explained that they recently introduced changes to the staffing schedule to accommodate employees, in which they implemented the Baylor (weekend) shift. The staff could choose if they wanted to work during the week or the weekend. She revealed, even after the staff decided to work the weekends, they continued to have call ins.