STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265786	A. Building B. Wing	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosewood Rehab and Healthcare Center	1415 West White Oak Independence, MO 64050

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 45403 Based on interview and record review, the facility failed to ensure two sampled residents (Resident #1 and #6) out of ten sampled residents received adequate supervision and assistance. On [DATE], staff did not check on Resident #1, who had a diagnosis of dementia and a known history of pulling his/her indwelling catheter, from 12:00 A.M. until 7:00 A.M. At 7:05 A.M., the resident was found lying on his/her side in a pool of blood, urine, and feces. EMS pronounced the resident deceased . On [DATE], CNA A transferred Resident #6 with a Hoyer lift (mechanical lift) by him/herself resulting in the resident sustaining an abrasion to the resident's foot. The facility census was 275 residents. The Administrator was notified on [DATE] at 5:18 P.M., of an Immediate Jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE] as confirmed by surveyor onsite verification. Review of the facility's undated Rounding Policy showed: -All residents are to be rounded on no less than every two hours. -This includes all independent residents as well. -If a resident is in need of attention, you must deliver that care. -There are certain residents that require more frequent rounding, please review the resident Kardex in Plan of Care and discuss with your charge nurse the expectations. 1. Review of Resident #1's Admission Record showed the resident admitted on [DATE], with diagnoses including: -Metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood that can lead to personality changes). -Benign prostatic hyperplasia with lower urinary tract symptoms (a condition in men in which the prostate gland is enlarged and not cancerous resulting in difficulty with urination). Review of the resident's Quarterly Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning), dated [DATE], showed the resident: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Severely cognitively impaired. -No behaviors. -Used a walker for mobility. -Required partial, moderate assistance with bathing, dressing, and bathroom privileges. -Required set up and supervision for meals and walking. -Had an indwelling catheter and was frequently incontinent of bowel. -Had diagnoses including: -- Obstructive uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow). --Dementia. --Malnutrition. Review of the resident's Order Summary Report, dated [DATE], showed: -Catheter care every shift. -Catheter securement device in place every shift. -Foley Catheter (transports urine from the bladder to the outside of the body) 18 French, 30 cubic centimeter (cc) balloon, change as needed (PRN). Review of the resident's undated Care Plan showed: -Full Code Status. --If cardiac arrest, do CPR, call 911. -Resident has ADL (activities of daily living) self-care performance deficit related to impaired cognition. -The resident was at risk for falls related to an unwitnessed fall on [DATE]. ---Ensure call light within reach. -The resident had an indwelling urinary catheter due to obstructive uropathy. --Maintain patency and prevent acute urinary tract symptoms. ---Catheter care every shift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	---Monitor and report blood or excess debris in tubing or bag. Review of the resident's Nursing Note, dated [DATE] at 3:12 A.M., showed: -The resident was confused and restful. -Blood was noted on the floor from the bathroom to his/her bed. -He/she had pulled his/her Foley catheter from his/her urethra. -Call made to the provider. -To reinsert the catheter. -His/her room was cleaned. -His/her catheter was reinserted as ordered and the resident received a shower. Review of the resident's Medication Administration Record (MAR) dated [DATE] through [DATE], showed: -Catheter care and securement device in place documented as completed on [DATE] for the night shift. -Catheter change PRN documented as completed on [DATE] at 4:08 AM. Review of the facility Investigation Summary, dated [DATE], showed: -On [DATE] at approximately 7:05 A.M., Restorative Aide (RA) A arrived at the resident's room. -The resident was noted to be lying on his/her left side beside the bed. -The resident's catheter was noted to be dislodged with the bulb still inflated with blood noted on the resident and the floor. -RA A stepped in the doorway of room and called for assistance from (Registered Nurse) RN A. -RN A was unable to determine if the resident had a pulse. RN A obtained a pulse oximetry and readings reported were heart rate 37 beats per minute (normal range is 60 to 100 beats per minute) and oxygen 89% (normal range is 95% to 100%). -Licensed Practical Nurse (LPN) A contacted 911 while RN A was assessing the resident. -RA A left the room to obtain the automated external defibrillator (AED - a medical device designed to analyze the heart rhythm and deliver an electric shock to victims of ventricular fibrillation to restore the heart rhythm to normal). -RA A returned with AED, MDS Coordinator, and the crash cart. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-RN A stayed with resident to monitor for changes and noted his/her vitals started to fluctuate. -EMS arrived. Review of the resident's Nursing Note, dated [DATE] at 5:36 P.M., showed: -At 7:10 A.M. on [DATE], the Assistant Director of Nursing (ADON) was notified by the MDS Coordinator there was an issue on 3 North. -ADON arrived at the facility at 7:20 A.M. and went directly to the unit. -Upon entering the room, the resident was noted to be lying on the floor beside the bed. -The resident was lying on his/her back with his/her knees bent up. -His/her Foley catheter bag with tubing and inflated bulb were on the floor at his/her feet. -The resident had on a t-shirt and a sheet beside him/her. -His/her pants and brief were beside his/her recliner. -There was blood and feces on the resident, floor, and bed. During an interview on [DATE] at 8:47 P.M., Certified Nursing Assistant (CNA) A said: -He/She was working the night shift on [DATE] through [DATE]. -He/She provided care for the resident around midnight. -The resident was in bed with his/her catheter in place. -He/She emptied the catheter while in the room. -The resident was alert and did not appear to be in any distress. -The resident was sitting on the edge of the bed, which was in a low position. -He/She had reported to the evening nurse and LPN A earlier the resident had some blood in his/her brief and catheter tubing. -Around 1:00 A.M. on [DATE] he/she was notified of break-ins in the parking lot, which included his/her car. -He/She left the facility between 2:00 A.M. and 3:00 A.M. -There was a supervisor present when he/she left the facility and he/she was aware he/she was leaving. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-When he/she left there was one nurse and one aide to care for the residents on the unit. -He/She did not feel that was enough staff to meet the needs of the residents. -He/She was not aware of the resident's death until he/she was contacted by the ADON. During an interview on [DATE] at 8:16 A.M., CNA B said: -He/She worked the night shift of [DATE] through [DATE]. -There was another CNA (CNA A) with him/her on the shift until about 1:30 A.M. -Once the other CNA left, he/she was responsible for all the residents. -CNA A did not give report before leaving. -He/she was off the unit from about 1:30 A.M. to 4:45 A.M. after discovery of car break-in -Upon returning to the unit there were several call lights going off and the nurse was at the computer. -He/She did not recall seeing the resident throughout his/her shift. -He/She was answering call lights and had another resident fall early in the shift. -If a resident did not have the call light on, he/she did not have contact with the resident. -He/She did not have time to check on the residents, but it should have been done. -He/She said there was so much going on with the staff car break-ins and the call lights. -He/She was not aware of the resident's death until he/she was contacted by the ADON. -He/She was doing the best he/she could just to keep the call lights answered. -There were about five staff outside due to the break-ins, as well as him/her, talking about the break-ins, and then to the police. -There was not enough staff to provide the cares for the residents. During an interview on [DATE] at 7:53 P.M., LPN A said: -He/She was working a night shift on [DATE] through [DATE]. -He/She had not seen the resident throughout his/her shift. -He/She had been notified during oncoming shift report that the resident had pulled his/her catheter out and may have some blood in his/her urine. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-There was a pungent odor of feces and blood in the room. -When he/she returned to the room with RN A, they turned the resident onto his/her back and noticed stiffness in the body. -The resident's shirt had blood all over the front and feces/urine on the front and back. -RN A assessed the resident to have a pulse and measured an oxygen level while the resident was still on his/her side. -The resident was pale with bluish purple discoloration to the side of his/her face. -RN A was checking the resident for a pulse and repeatedly calling the resident's name. -RN A told LPN A to call 911. -He/She ran to get another nurse and the crash cart. -The MDS Coordinator grabbed the AED and verified the resident was a full code with LPN A, shortly thereafter EMS arrived. -Once EMS had entered the room all facility staff exited the room. During an interview on [DATE] at 7:07 P.M., RN A said: -On [DATE] he/she arrived at the facility at around 6:40 A.M. and went to the nurses station. -He/She only saw LPN A from the night shift. -There was no unusual concerns during report from LPN A. -As they finished report RA A came to him/her asking for him/her to go to the resident's room. -Upon entering the resident's room at approximately 7:05 A.M., he/she realized there was something very wrong. -He/She first noticed blood splattered in a half-moon shape at the end of the bed. There was a strong odor of blood, urine, and feces in the room. -He/she noticed the resident laying on his/her left side in a dried pool of blood. -The resident was not wearing pants or undergarments. His/her catheter was pulled out and the balloon inflated. -There was no bedding on the bed and the bed was covered in feces and blood. -The chair had smeared blood on it. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The resident was covered in a layer of dried blood from his/her belly button down to his/her feet. -The resident was wearing a t-shirt covered in dried blood. -RA A checked for a radial pulse and was not able to obtain a pulse. -He/She left the room to get a pulse oximetry machine. -The readings on the machine said pulse of 37 and oxygen of 89%. -He/She asked LPN A to call 911 and RA A went to get help from the MDS Coordinator. -RA A and MDS Coordinator brought the AED and the crash cart to the room. -They turned the resident onto his/her back and noticed the entire side of the resident's face was purple. -The resident's legs were very stiff and remained in a bent position, even when turned on his/her back. -The pulse oximetry showed different numbers with movement. -When the resident was turned over the discoloration to his/her face moved and appeared to dissipate somewhat. -He/She believed the resident was still alive due to the readings on the pulse oximetry. -When EMS arrived he/she left to get a face sheet for the resident. -EMS placed EKG (electrical signals to the heart) leads on the resident and reported the resident to be in asystole (when your heart's electrical system fails entirely, which causes your heart to stop pumping). -He/She was told due to the resident's age, diagnoses, unknown amount of time the resident was down and rigor mortis (the post-mortem stiffening of muscles caused by the depletion of adenosine triphosphate (ATP) from the muscles) being present no lifesaving efforts were made by EMS. -He/She did not recall any responses from the resident during the assessment and contact with the resident. -He/She did not observe any chest wall movement during the assessment. -LPN A reported not seeing the resident throughout the entire night shift he/she worked. -LPN A reported a CNA left the floor around 3:00 A.M. -At 7:17 A.M. he/she contacted the Nurse Practitioner to report the resident's death. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 4:07 P.M., the Assistant Fire Chief said: -He/she confirmed there was a call from the facility about a resident with barely a pulse. -Upon arrival they found an obviously deceased person with a large amount of blood and feces on him/her and all over the room. -The dayshift had found the resident during morning rounds. During an interview on [DATE] at 9:54 A.M., the Paramedic said: -The resident was on the floor when they arrived. -The resident's Foley catheter was pulled out and on the floor. -There was a ton of blood on the bed and floor. -There was dried feces on the bed. -There were non-dried feces on the resident's floor and on the resident. -The overall concern was the condition the resident was found in. -The resident was expired upon their arrival. -The resident's catheter was pulled out once before, maybe the night before. During an interview on [DATE] at 3:16 P.M., the MDS Coordinator said: -He/She was in his/her office on the 3rd floor on [DATE] when RA A came to him/her to go to the resident's room. -RN A reported the resident having a pulse. -He/She took the AED to the room and was getting the crash cart and LPN A. -Staff did not put the AED on the resident. -EMS arrived within five minutes of the 911 call. -He/She saw blood and feces everywhere and the resident's catheter was out on the floor. -He/She did not know when the resident was last checked by staff. -The resident was pale and still on the floor on his/her side. -The resident was not wearing pants or undergarments. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/She was using the Hoyer lift alone. -As he/she was transferring the resident in the Hoyer from the shower chair to the resident's bed, the resident's foot got caught on the control box of the Hoyer, resulting in the injury. -He/She had the resident elevated in the sling and began to move the Hoyer lift. -Another CNA came into the room in the middle of the transfer after the foot was hit on the control box and assisted with completing the transfer. -He/She is aware the Hoyer is to be used with two staff. -The resident was becoming agitated while sitting in the shower chair and he/she decided to transfer the resident alone instead of waiting for another staff to help him/her. Review of the resident's Injury Investigation Report, dated [DATE] at 4:40 P.M., showed: -The resident's foot was brushed against the control box on the Hoyer lift during transfer post shower from shower chair to bed. -One CNA started to transfer the resident by him/herself in the Hoyer lift to assist the resident to bed. -In the middle of cares, a second CNA returned to assist. -The resident had an abrasion to his/her left toes. Review of the resident's Order Summary Report dated [DATE] showed abrasions to left dorsal foot: paint with skin prep, ensure surrounding areas is painted as well. Do not wash off between applications, one time a day and as needed if soiled or unscheduled removal. During an interview on [DATE] at 10:56 A.M. the resident said: -He/She sustained an injury on [DATE] while being transferred. -After his/her shower he/she was brought back to his/her room. -One CNA C was using the Hoyer to transfer him/her from the shower chair to his/her bed. -During the transfer with just one staff member his/her left foot got lodged on the control box on the Hoyer, pinching the top of his/her foot. -He/She said the injury was an accident. During an interview on [DATE] at 2:09 P.M., the ADON said: -He/She expects two staff to be present when using all mechanical lifts, Hoyer lifts. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Staff are expected to hook the lift up correctly, be sure to ask for assistance and be gentle. -Although the policy does not indicate two people are to be utilized for lift operation, the manufacturer's guidelines state two people are required to use the lift safely. During an interview on [DATE] at 5:00 P.M., the Administrator said he/she expected staff to follow the policy while using mechanical lifts. NOTE: At the time of the survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s). MO00240194, MO240120

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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** 45403 Based on interview and record review, the facility failed to ensure there were enough staff present to meet the care needs for one sampled resident (Resident #1) out of 10 sampled residents, when on [DATE] Resident #1 had not been checked on for approximately seven hours due to the lack of enough staff on 3 North, was found in his/her room with a large amount of blood and feces smeared all over the room, the indwelling catheter on the floor with the bulb inflated, and the resident was deceased with rigor mortis present. The facility census was 275 residents. Review of the Facility Assessment, dated ,d+[DATE], showed: -The purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. -Use this assessment to make decisions about your direct care staff needs, as well as your capabilities to provide services to the residents in your facility. -Using a competency-based approach focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being. -Number of beds licensed to provide care for: 185. NOTE: Facility bed details licensed for 300 bed effective [DATE]. -Average weekly admissions of 31 residents. -Average weekly discharges of 27 residents. -May accept residents with or may develop the following: --Psychiatric or mood disorders: Psychosis (hallucinations, delusions, etc.), impaired cognition, mental disorder, depression, bipolar disorder (i.e., mania or depression), schizophrenia, post-traumatic stress disorder, anxiety disorder, behavior that needs interventions. History of substance abuse. Personality disorders. --Musculoskeletal system: Fractures, osteoarthritis, other forms of arthritis, MS, weakness, muscle wasting, abnormal posture, difficulty walking, abnormal gait and mobility. --Genitourinary System: renal insufficiency, nephropathy, neurogenic bowel or bladder, renal failure, end stage renal disease, benign prostatic hyperplasia, obstructive uropathy, urinary incontinence. -Services and Care offered based on resident's needs: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Mobility and fall, fall with injury prevention: transfers, ambulation, contracture prevention and care, supporting resident independence in doing as much of these activities by himself/herself, daily risk management meeting for IDT to review falls. --Bowel and bladder: bowel and bladder toileting programs, incontinence prevention and care, intermittent or indwelling or other urinary catheter, ostomy, responding to requests for assistance to the bathroom or toilet promptly to maintain continence and promote resident dignity. --Mental health and behavior: Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma, PTSD, other psychiatric diagnoses, intellectual or developmental disabilities. Review behaviors weekly in risk management. Referrals to psych and behavioral health as needed. -Facility resources needed to provide competent support and care for the resident population every day and during emergencies. --Direct care staff total licensed or certified: ---Days 36 direct care staff. ---Evenings 24 direct care staff. ---Nights 18 direct care staff. Review of the Facility's undated Rounding Policy showed: -All residents are to be rounded on no less than every two hours. -This includes all independent residents as well. Review of the facility's Midnight Census, dated [DATE], showed: -The total facility census was 275 residents. -3 North census was 45 residents. Review of the facility needs document per unit for [DATE] showed: -Most resident's for 3 North were on skilled care and services. -Nine residents were always incontinent. -Six residents were dependent for assistance with the sit-to-stand mechanical lift. -Two residents required substantial/maximum assistance with the sit-to-stand mechanical lift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Four residents required partial/moderate assistance with the sit-to-stand mechanical lift. -Six residents were dependent for assistance with toileting. -One resident required substantial/maximum assistance with toileting. -Five residents required partial/moderate assistance with toileting. -Two residents had PEG (feeding tube) tubes. -One resident had a catheter. Review of the facility's Direct Care staffing sheet, dated [DATE], showed Certified Nursing Assistant (CNA) A for 3 North clocked out on [DATE] at 3:47 A.M., leaving Licensed Practical Nurse (LPN) A and CNA B for the unit. Review of the facility staffing sheets and time clock records from [DATE] to [DATE] showed no staff were brought in to replace CNA A once he/she left the unit. 1. Review of Resident #1's Admission Record showed the resident was admitted on [DATE] with diagnoses including metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood that can lead to personality changes), benign prostatic hyperplasia with lower urinary tract symptoms (a condition in men in which the prostate gland is enlarged and not cancerous resulting in difficulty with urination), and need for assistance with personal care. Review of the resident's Quarterly MDS, dated [DATE], showed the resident: -As severely cognitively impaired. -Was depressed with low energy, poor appetite, and sometimes socially isolated. -Had no behaviors. -Used a walker for mobility. -Required partial moderate assistance with bathing, dressing, and bathroom privileges. -Required set up and supervision for meals and walking. -Had an indwelling catheter and was frequently incontinent of bowel. --Dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses). Review of the Investigation Summary, dated [DATE], showed: -On [DATE] at approximately 7:05 AM, Restorative Aide (RA) arrived to the resident's room. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident was noted to be lying on his/her left side beside the bed. -The resident's catheter was noted to have been dislodged with the bulb still inflated with blood noted on the resident and the floor. -RA A stepped in the doorway of room and called for assistance from Registered Nurse (RN) A. -RN A was unable to determine if the resident had a pulse. -RN A obtained a pulse oximeter and readings reported were heart rate of 37 beats per minute (normal resting heart rate for adults ranges from 60 to 100 beats per minute) and oxygen of 89% (normal pulse oximeter reading for your oxygen saturation level is between 95% and 100%). -LPN A contacted 911 while RN A was assessing the resident. -RA A left the room to obtain an AED (a portable device that can be used to treat a person whose heart has suddenly stopped working). -RA A return with AED, MDS Coordinator, and the crash cart. -RN A stayed with resident to monitor for changes and noted vitals started to fluctuate. -EMS arrived and update provided from RN A. During an interview on [DATE] at 8:47 P.M., CNA A said: -He/She was working the night shift on [DATE] through [DATE]. -He/She last provided cares for Resident #1 around midnight. -Resident #1 was in bed with his/her catheter in place. -Resident #1 asked for water, he/she gave him/her some water and emptied the catheter while in the room. -The resident was alert and did not appear to be in any distress. -Resident #1 was sitting on the edge of the bed, which was in a low position. -He/She had reported to the evening nurse and LPN A earlier the resident had some blood in his/her brief and catheter tubing. -Around 1:00 A.M. on [DATE] he/she was notified of break-ins in the parking lot, which included his/her car. -He/She left the facility between 2:00 A.M. and 3:00 A.M. -There was a supervisor present when he/she left the facility and aware he/she was leaving. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-When he/she left there was one nurse and one aide to care for the residents on the unit. -The charge nurse knew he/she was leaving after the window in his/her car was broken out. -He/She did not feel that was enough staff to meet the needs of the residents, because even with two CNAs there is too much to do. During an interview on [DATE] at 7:53 P.M., LPN A said: -He/She worked the night shift [DATE] through [DATE] and from about 3:00 A.M. was left with only one CNA (CNA B) to work the unit. -CNA A left the facility at 3:00 A.M. with no replacement provided by the house supervisor. -He/She had not seen the resident throughout his/her shift. -He/She had been notified during oncoming shift report the resident had pulled his/her catheter out and may have some blood in his/her urine. -He/She observed CNA B busy checking on residents and answering call lights. -He/She did not know when the last time the resident was seen alive. -RA A found the resident laying on the floor covered head to foot with feces and blood all over the place. -He/She did not know if the resident was deceased , but the resident looked purple. -He/She did not feel there was enough staff to provide cares for the residents. During an interview on [DATE] at 8:16 A.M., CNA B said: -After CNA A left the unit on [DATE] about 1:30 P.M., he/she was responsible for all the residents. -CNA A did not give report before leaving. -He/she was off the unit from about 1:30 A.M. to 4:45 A.M. after discovery of car break in. -Upon returning to the unit there were several call lights going off and the nurse was at the computer. -During his/her shift there was a fall and he/she was kept busy answering call lights. -He/she did not check on the resident during his/her shift. -If the resident did not have the call light on, he/she did not have contact with the resident. -He/She said there was so much going on with the break-ins on staff cars and call lights. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She was not aware of the resident's death until he/she was contacted by the Assistant Director of Nursing (ADON). -There was not enough staff to check on everybody every two hours. During an interview on [DATE] at 7:07 P.M., RN A said: -On [DATE] he/she arrived at the facility at around 6:40 A.M. and went to the nurses station and found only LPN A from the night shift. -During report with LPNA A, Restorative Aide (RA) A reported a need to go to the resident's room. -LPN A reported CNA A left at around 3:00 A.M. -LPN A reported not seeing the resident throughout the entire night shift he/she worked. During an interview on [DATE] at 1:49 P.M., the Nurse Practitioner said: -He/She said the goal is to check on residents every two hours. -He/She expected the resident to at least be looked in on between midnight and 7:05 A.M. -There was usually one nurse and two CNAs for the ,d+[DATE] people on the unit. -He/She said there should be more staff to provide cares for the residents. During an interview on [DATE] at 2:30 P.M. the Physician said: -He/she expected the staff to round like they were supposed to in a timely manner. -If the protocol was to round every two hours, then staff should have checked on the resident every two hours. -It was possible the resident succumbed at midnight and was not found until 7:00 A.M. During an interview on [DATE] at 3:16 P.M. the MDS Coordinator said: -He/She expected the staff to check the resident catheter during rounds frequently to ensure the catheter was secured in place. -The policy and expectation for nursing staff was for residents to be checked and or rounded around every two hours. -On [DATE], when the resident was not checked between 12:00 A.M. and 7:00 A.M. was not in compliance with facility policy and expectations. -When asked if there was enough staff he/she shook his/her head no. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 5:00 P.M. the Administrator said: -On the night of the resident's death there was a lot of confusion in the facility due to car break-ins. -If the resident was in need, the resident could have used the call light to get assistance. -The staff would respond to residents using the call light to check on them. -The expectation was for residents to be rounded on every two to three hours and call lights to be answered. During an interview on [DATE] at 4:00 P. M., the Staffing Coordinator said: -Staffing ratio was done according to the facility assessment provided. -Expectations for direct care staff: --Day shift: one nurse, one CMT, three CNAs, and one bath aide on Monday, Tuesday, Thursday and Friday per unit. --Evening shift: one nurse, one CMT, three CNAs, and one bath aide on Monday, Tuesday, Thursday and Friday per unit. --Night shift: one nurse, and two CNAs per unit, except 3 North because it was the heaviest care. -The night of [DATE] there were four staff that left the facility due to break-ins. -He/She did not know if any staff were replaced. -Staff were supposed to clock in for day shift at 6:30 A.M., evening shift at 2:30 P.M. and night shift at 10:30 P.M. -Staff were expected to stay until the next shift comes in and do walking rounds together. -Staff were allowed to leave on their meal breaks, but were to clock out when leaving the facility. -He/She said there were three staff scheduled on 3 North to ensure there was enough staff to care for the residents. MO00240120