Printed: 03/27/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275047	A. Building B. Wing	12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Livingston Health & Rehabilitation Center	510 S 14th St Livingston, MT 59047

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 14005 Based on interview and record review, the facility failed to report an allegation of resident neglect within 24 hours of the incident, and the designated licensed nurse left the facility during his shift when he was the only nurse on duty at the time, leaving all 44 residents at risk for adverse events. This deficient practice increased the risk of harm or a negative outcome for any resident at the facility, due to the lack of a nursing availability. Findings include: Review of the facility staffing schedule, dated 12/25/26, showed the facility was scheduled to be staffed with one licensed nurse and two certified nurse assistants during the night shift. During an interview on 12/30/24 at 3:44 p.m., staff member A stated on 12/25/24 the facility was staffed with one agency LPN, one agency CNA, and one facility CNA during the night. Staff member A said the LPN, and the agency CNA, left the facility together. Staff member A said with those two staff gone, the facility would have been left with no licensed nurse coverage and only one CNA to care for the 44 residents. Staff member A said she did not know how long the facility was without licensed nurse coverage. Staff member A said she was not aware if any residents missed medications. Staff member A said the nurse documented a refusal of one medication, however the DON knows the resident wants to be awakened for her routine anti-anxiety medication. Staff member A said the nurse, and the CNA have not returned her calls, and the interim staffing agency is attempting to contact the nurse and CNA. Staff member A said she was made aware of this issue when there was no licensed staff coverage on 12/28/24. Staff member A said she informed the administrator so the potential neglect could be reported to the State Survey Agency. Staff member A said she did not have the ability to report the incident to the state. Staff member A said neither the CNA, or the LPN, clocked out during their absence, making it impossible to know exactly how long they left the residents unattended and without the licensed nurse coverage. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/30/24 at 6:15 p.m., staff member I said she worked on 12/25/24. Staff member I said the LPN and CNA (staff member M and N) approached her and told her they were both leaving to go to the store together. Staff member I said the LPN told her he would be taking the walkie talkie, and she should put her walkie talkie on, and she could call if she needed anything. Staff member I said they both left about 12:15 a.m. Staff member I said after the nurse had been gone approximately 30 minutes, she tried to contact the nurse via walkie talkie but did not get any response back. Staff member I said she texted the DON and left a message, but did not receive any information back from her. Staff member I said the nurse and other CNA returned to the facility by a back door more, but it was more than 1.5 hours after they left. Staff member I said she tried to do rounds and provide care but ended up answering call lights and trying to keep residents safe. Staff member I said no residents fell during the time she was left alone in the facility. Staff member I said when she returned to work on 12/27/24, another CNA asked her why so many residents were left very wet and soiled on her last shift, which would have been the morning of 12/26/24. The lack of the licensed nurse coverage occurred at 12:15 a.m., on 12/26/24, and the nurse's actions, leaving all the residents at the facility without nursing coverage neglecting resident care and oversight, was not not reported to the State Survey Agency reporting portal until 12/29/24 at 4:05 p.m. The facility investigation was still in progress as of 12/31/24.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 14005 Based on observation, interview, and record review, the facility failed to complete a thorough investigation regarding resident-to-resident abuse, including addressing or identifying interventions to stop further abuse, for 4 (#s 3, 21, 71 and 83) of 11 sampled residents. Findings include: 1. A review of a facility reported incident, dated 12/24/24, showed resident #3 and #83 had an allegation of resident-to-resident verbal and physical abuse. Resident #83 yelled and hit resident #3. Both residents were separated and monitored for side effects. The physician and responsible parties were notified. A review of the facility reported incident findings showed resident #83 was counseled that hitting was not appropriate and residents the were separated. The staff were instructed to keep these specific two residents at different tables while dining. During an observation on 12/30/24 during the noon meal, resident #3 and #83 were at the same dining table, sitting next to each other. During an interview on 12/30/24 at 12:20 p.m., staff member K was not aware of any recent resident to resident altercations. When asked about residents who should not sit together, staff member K said she was not aware of any residents who couldn't sit together right now while eating. During an interview on 12/30/24 at 3:44 p.m., staff member A said she did notice residents #3 and #83 sitting together at the dining room table at lunch time. Staff member A was not sure why the residents were sitting together, as the information to separate them was passed along to staff. Staff member A said the care plans should have been updated to notify staff of the changes, due to the altercation. During an interview on 12/30/24 at 4:13 p.m., NF3 said she was aware of the altercation between her family member and another resident, but was not aware her family member was hit. NF3 said her family member was moved to the other side of the table, but didn't like it because he couldn't see the lights on the Christmas tree, and he liked to watch them. 2. During an interview on 12/30/24 at 3:00 p.m., resident #21 said she was moved to her current room in attempt to ensure her medications were delivered on time. Resident #21 said she doesn't really get along with her roommate, resident #71. Resident #21 said her roommate cries out in pain frequently, and she tries to ignore the noise, but said sometimes she could not stand it, and it bothered her. Resident #21 said her and resident #71 both had TV remote controls, but resident #71 did not know how to use the remote. Resident #21 said she and a nurse took the batteries out of the remote so it would not work. Resident #21 said she gets frustrated when resident #71's family comes to visit, and they use her folding chair, without permission, and then they change the channel to a basketball game when she is in the middle of watching a movie. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/31/24 at 8:45 a.m., NF2 said the roommate situation is not very good. NF2 said [#71] and her roommate (#21) got into a verbal altercation sometime last night. NF2 was not able to identify what prompted the altercation. NF2 said both roommates argue and fight over the remote control. NF2 stated resident #21's oxygen concentrator irritates [#71]. NF2 said this is the first time he has ever heard [#71] say that she was just ready to give up rather than live like this. During an interview on 12/31/23 at 8:30 a.m., resident #71 was unable to be interviewed. During an observation on 12/31/24 at 1:00 p.m., resident #71 was moving away from resident #21, and going into a different room. During an interview on 12/31/24 at 2:05 p.m., resident #21 showed she did not have time for another interview. Resident #21 only said thank you, when asked about her roommate moving. A review of the nurse's note, dated 12/20/24, showed resident #71 was yelling and upsetting her room mate, resident #21. Resident #21 was getting upset and raising her voice, trying to correct #71.

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. 14005 Based on interview and record review, the facility failed to ensure a resident was prepared and oriented for discharge home, for 1 (#47) of 1 sampled resident. Findings Include: During an interview on 12/30/24 at 4:49 p.m., staff member G said she would expect discharge planning to be completed prior to the day, or even the day before, a discharge. Staff member G said she had seen the discharge note asking about home health for #47 at the time of discharge, but not prior to discharge. Staff member G was unaware if a referral to a home health agency had been completed. Staff member G said the social service staff person would usually be responsible for discharge planning, but the staff member was out of the facility at the time of #47's discharge, and the BOM was helping with discharges. During an interview on 12/31/24 at 9:19 a.m., NF1 said resident #47 was discharged home to a small town in rural Montana. NF1 said the facility sent some of his medications home when discharged , but not all of them, because the pain patches were not received. NF1 said resident #47 was not receiving home health services. During an interview on 12/31/24 at 11:47 a.m., staff member D said she did not take care of resident #47, so she was not really sure why the pain patches were not sent with him upon discharge. Staff member D said she thinks the patches were left in the narcotics drawer, and rather than continue to count them, her and one other nurse discarded the patches. Review of resident #47's Home Health Referral Form, dated 8/22/24, showed the physician signed for skilled nursing services, occupational therapy, and physical therapy to occur after resident #47's discharge. These discharge orders showed the resident was to be discharged with all his medications, including his narcotics. Review of a nurse's note, dated 9/7/24, showed resident #47 was discharged home with all medications. The nursing note showed the BOM was present, and the spouse was asked on the day of discharge, which home health agency the family would prefer for aftercare. The note did not reflect which company was chosen. Review of the facility discharge transition plan for #47, dated 9/7/24, showed, Prior to discharge the center will arrange home health, outpatient therapy and/or other community services for you. This will assist in your transition home and help you reach your goals. If you don't hear from the providers below within 24-48 hrs, please contact us or the company listed. There was no Home Health company listed on the discharge form. Resident #47's discharge transition form showed twenty-one different medications were to be sent home with the resident, including the fentanyl pain patches. The discharge plan had a location for the facility to document how many of each medication was sent with resident #47. All the quantity sections were blank. The section on the form showing when the next date and time the medications were due, was also blank. Review of the narcotic tracking sheets showed resident #47 had two narcotic tracking sheets. One sheet was for Fentanyl 12 mg, and the second sheet was for Fentanyl 25 mg. There were five 25 mg Fentanyl patches destroyed by two nurses on 9/9/24, along with four Fentanyl 12 mg patches.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 14005 Based on interview and record review, the facility failed to update resident care plans in a timely manner for 3 (#s 3, 71, and 83) of 11 residents sampled for physical altercations, weight loss, and pain management. Findings include: 1. A review of a facility reported incident, dated 12/24/24, showed resident #3 and #83 had resident to resident altercation resulting in verbal and physical abuse. Resident #83 yelled and hit resident #3. The initial plan was to separate the residents and both residents would be monitored for side effects. A review of the resident #83's nurse's note, dated 12/26/24, showed resident #83 was fixated on the altercation with resident #3. The note shows the #83 and #3 would remain separated in the dining room, and #83 had a recent failed gradual dose reduction attempt for the antipsychotic medication, Olanzapine. Resident #83's care plan was the original base line care plan which was initiated on 8/23/24, the day after his admission. The care plan was incomplete and not individualized. No additions or updates were made to this baseline care plan. The care plan had not been updated to address the altercation(s) between the two residents, or to keep the residents separated while in the dining room. The care plan did not show resident #83 was on a psychotropic medication. During an interview on 12/30/24 at 12:20 p.m., staff member K was not aware of any recent resident to resident altercations, and when asked about any residents who should not sit together, staff member K said she was not aware of any residents who couldn't sit together. During and interview on 12/31/24 at 7:04 a.m., staff member H said she was fairly new to the MDS work. Staff member H said she was not aware of any altercation between residents lately. Staff member H said to pick up on changes which needed care plan updates, she would look at the 72 hour charting. Staff H denied being aware of the altercation between resident #3 and #83, and said she had not updated the individual care plan's. 2. Review of resident #83's current care plan showed resident #83 was dependent upon staff for meeting his emotional and physical needs. The care plan was not updated with preventative interventions following the verbal and physical abuse he sustained from resident #3. 3. Review of the nutritional evaluation, dated 11/3/24, showed the dietitian requested to change resident #71's diet to a regular dysphasia mechanical soft diet and change the calorie dense medication pass to 60 ml three times a day. This was not included on the care plan. Review of resident #71's current care plan, dated 10/24/24, showed the resident was on a heart healthy mechanical diet. The care plan was not updated to show the resident's diet was changed to a regular dysphasia diet with fortified foods. The care plan was updated on 11/2/24 to direct staff to follow MD orders for diet. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a physician order, dated 12/23/24, showed resident #71's diet was changed to match the dietitian's recommendation from 11/3/24. This change was not added to the care plan Review of resident #71's current care plan showed there were multiple areas in the care plan that are inaccurate or incomplete, to include: - Direct her to do weight bearing activities. The resident is identified as bed bound on 10/22/24 as shown in several areas of the care plan. - BP taken with a (specify) size cuff. - Obtain BP reading (specify freq) - Monitor/record use/side effects of medication (specify) - Toilet use: the resident is totally dependent on (X) staff for toilet use. - Transfer: The resident requires mechanical life (specify) with (X) staff assistance for transfers. - Dressing: the resident is able to (specify).

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14005 Based on observation, interview, and record review, the facility failed to identify resident's with weight loss, implement weight loss interventions timely, and failed to monitor the effectiveness of weight loss interventions, for 2 (#s 47 & 71) of 11 sampled residents. Resident #47 had a severe 17% weight loss in 42 days, and #71 had a severe weight loss of 12.1% of her body weight in 63 days. Findings include: 1. Review of resident #47's Weights and Vitals summary form showed resident #47 was admitted on [DATE] and his weight was 150 pounds. The resident was not weighed again until 8/20/24. Resident #47 lost 21.4 pounds or 14.1% of his body weight during the first 28 days after admission. This was a severe weight loss. Review of #47's physician orders, dated 7/23/24, showed the resident was on a regular diet. Review of resident #47's nursing notes, dated 8/9/24, showed the skin, weight and nutrition meeting was held with the RD. The note showed the medications, diet, and intake were reviewed. No new supplements or diet changes were made. There were no weights documented in the chart from 7/23/24 to 8/12/24. Review of resident #47's care plan, initiated on 8/13/24, failed to have any dietary or nutritional interventions for resident #47. Review of resident #47's weights and vitals summary, dated 8/20/24, showed resident #47 weighed 128.6 pounds, for a loss of 21 pounds, or 14.3% of his body weight, in 28 days. Review of resident # 47's weight dated 9/3/24, showed resident #47's weight continued to decline to 124 pounds. Resident #47 had a severe weight loss, and lost 26 pounds, or 17% of his body weight. Review of resident #47's discharge recapitulation form showed resident #47's discharge weight was 124 pounds, and his weight was stable. However, according to the weights and vitals report, resident #47 had a severe weight loss of 26 pounds and 17% of his body weight, and he was continuing to decline throughout his stay at the facility. 2. Review of resident #71's weight and vital summary form, dated 10/22/24, showed resident #71's admission weight was 142.2 pounds. Review of resident #71's care plan, dated 10/22/24, showed resident #71 was on a heart healthy mechanical soft diet. Resident #71's care plan was then updated on 11/2/24. The updated care plan showed resident #71's diet was continued on a heart healthy mechanical soft diet, but the diet per MD orders was added to the care plan. The care plan did not include calorie dense medication pass three times a day. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of #71's nutritional evaluation, dated 11/3/24, showed the resident was admitted on an 1800 calorie dysphasia mechanical soft low fat low cholesterol diet, with a calorie dense medication pass of 237 cc three times a day. This evaluation did not show the root cause of the weight loss was resident #71's failure to eat. The resident's pain was not documented as being evaluated related to the lack of meal intakes or nutritional needs. The dietitian notes showed the following: - There was no indication of the need for the calorie-controlled diet or the fat and cholesterol limitation. - The high volume of Cal Dense could be negatively impacting meal intake. - Diet changed to regular dysphasia mechanical soft and change the Cal Dense to 60 cc tid (three times a day) between meals. Review of #71's Medication administration record, dated November 2024, showed resident #71 was to receive 120 cc of Calorie Dense Medication Pass, three times a day. The orders did not follow the dietitian recommendations. Review of resident #71's weight and vital summary form, dated 11/5/24, showed a weight of 133.4 pounds. This was a 6.2% weight change in 14 days. Review of a physician order for #71, dated 12/23/24, showed the resident's diet was changed to match the dietitian's recommendation from 11/3/24. There was a delay of 50 days before the diet was changed to meet the resident's nutritional needs. A review of resident #71's care plan showed it was not updated on 12/23/24, to show the resident's diet was changed to a regular dysphasia diet, with fortified foods. Review of the nutritional hydration skin committee review form, dated 12/13/24, showed the significant weight loss for #71 was not identified from admission through 12/13/24. The form showed the resident's admission weight as 142.2 lbs, and a weight on 11/5/24 was 133.4 lbs. The staff checked on the form that there was not a 5% or more weight loss from 10/22/24 through 11/5/24, however, this was a significant 8.8 pound, or a 6.2% weight loss. The dietitian note showed, Resident reviewed, inadequate intake suspected, increased CDMP supplement to 120 cc TID. Will continue to monitor. There was no documentation to show why the resident was eating minimal amounts of food. The severe weight loss was not addressed as needed. Review of the resident #71's weights and vitals summary, showed resident #71 continues to lose weight, even after the supplement was added. Review of resident #71's weight and vital summary form, dated 12/24/24, showed resident #71 weighed 125 pounds. This was severe loss of 12.1% weight loss in 63 days. During observation on 12/30/24 at 6:45 p.m., resident #71 was receiving her meal, which was scheduled to be served at 5:30 p.m. The doctors order for resident #71 was for the diet to be fortified. The doctors orders were not folloed whe resident #71 was served her sauerkraut, pickles, and cheddar cheese. There was no other food served to attempt to increase the resident's nutrition or caloric intake. The facility only provided her preferred meal with no other option. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/31/24 at 2:53 p.m., staff member G said the interim DON who was here in the past deleted all the weight loss alerts. If activated, the weight loss alerts could be generated onto a report which would give the dietitian a list of residents with significant weight loss. The dietitian could then assess and put interventions in place timely. Staff member G said some of the interventions were late because the dietitian was unaware of weight loss, and the new assessments were not done timely.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14005 Based on observation, interview, and record review, the facility nursing staff failed to assess and manage a resident's pain, and proceeded with the provision of care when the resident voiced pain, and showed other indicators of pain, to include crying and calling out and in pain, and refusing ADL care, for 1 (#71) of 11 sampled residents. Findings include: Resident #71 was admitted to the facility on [DATE], with a diagnosis of wedge compression fracture of T7-T8, subsequent encounter for fracture with routine healing, pain in left wrist, age related osteoporosis, and chronic pain. Review of resident #71's MAR for October 2024 showed resident #71 had pain interventions of: - Lidocaine patch placed on her mid back daily for 12 hours. - Diclofenac topical applied to the lower back topically two times a day for pain related to the wedge compression. - Acetaminophen 1000 mg by mouth three times a day. - Methocarbamol 750 mg three times a day for pain - Hydromorphone 2 mg every four hours as needed for pain. - Methocarbamol 500 mg every 8 hours as needed for pain. This medication was started 10/22/24 and discontinued 10/31/24 Review of resident #71's MAR for November 2024 showed: - Lidocaine patch was discontinued 11/4/24. - Diclofenac was discontinued on 11/4/24. - Acetaminophen 1000 mg by mouth three times a day. - Methocarbamol 750 mg by mouth three times a day, discontinued 11/4/24. - Methocarbamol 750 mg by mouth on 11/9/24. - Methocarbamol 750 mg by mouth three times a day from 11/5/24 to 11/8/24. - Methocarbamol 1500 mg by mouth three times a day. - Acetaminophen with Codeine 300-30 mg every eight hours as needed for pain. Review of resident #71's December MAR showed the resident was to take the following medications: (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	- Acetaminophen (325mg/10.15 ml) give 17 ml by mouth three times a day, starting 12/31/24. - Acetaminophen 1000 mg by mouth three times, and this was discontinued on 12/31/24. - Acetaminophen with Codeine (120-12 mg) give 10 mg by mouth every four hours as needed. This dose was ordered from 12/26 through 12/31/24. - Acetaminophen-Codeine tablet 300-30 mg - one tablet every 8 hours as needed for pain. This medication was given from 11/8/24 through 12/27/24. - Acetaminophen with codeine oral solution (120-12mg/5ml)-give 20 ml by mouth three times a day starting 12/31/24. - Methocarbamol 1500 mg by mouth three times a day, until it was discontinued 12/31/24. - Methocarbamol 1500 mg by mouth four times a day starting 12/31/24. Review of resident #71's pain care plan, initiated on 10/22/24, showed resident #71's pain was controlled at a 3 of 10 with Tylenol, however pain was limiting her ability to get up. The care plan was updated on 10/31/24 to give analgesics prn for pain. The care plan was not updated to show other techniques for managing resident #71's pain. Review of resident #71's MDS with an ARD of 10/28/24, showed the resident had a BIMs of 6 which show resident #71 was severely cognitively impaired. Review of a resident #71's physicians order dated 11/6/24 showed the physician discontinue the hydromorhpone per the residents request. The order was carried out even after identifying the resident was severely cognitively impaired and would not be able to appropriately direct her own care. Review of resident 71's MDS, with an ARD of 12/4/24, showed the resident had pain or was hurting during the last five days. The MDS showed the pain occasionally affected her ability to sleep at night. The MDS showed the pain occasionally limited resident #71's participation in rehabilitation sessions and frequently limited her day-to-day activities. Resident #71 also had a BIMS score of 7. A BIMS of 7 showed the resident had severe cognitive impairment, which may prohibit her from requesting pain medication when needed. Review of resident #71's MAR/TAR on the pain monitoring section, for December 2024, showed resident #71 had pain only six times on the day shift and six times on the night shift, throughout the month. The December 2024 MAR medication administration for Acemaninophen with codeine showed resident #71 needed pain medication administered 24 times for her pain which resident #71 said ranaged from a 3 to a 10. During an observation on 12/30/24 at 3:00 p.m., resident #71 could be heard from across the hallway and with the resident's door pulled closed. Resident #71 was crying and yelling Oh I hurt, I hurt, and no one cares. This crying went on for over 45 minutes. Review of the December MAR/TAR, showed resident #71's pain level for the day shift on 12/30/24 was a 0, however resident #71 was heard crying out in pain at 3:00 p.m. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/30/24 at 1220 p.m., staff member E said when resident #71 was first admitted she would get out of bed and into a chair. Staff member E said resident #71 has declined because of the pain, and now she doesn't get out of bed and hardly eats. Staff member E said the CNA's try to reposition her, but resident #71 usually just layed on her back. The staff try and put a pillow under resident #71's back to attempt to repositon her, but resident #71 does not tolerate lying on her side because of the pain. Staff member E said sometimes resident #71 yells and is combative with cares because of the pain. During an interview on 12/30/24 at 3:00 p.m., resident #21 said resident #71 cries out often, but she directed this surveyor to the nurse. During the interview, resident #71 quieted for a while. Resident #21 said #71's medication must be working, as the nurse was in earlier to give her medication. Resident #21 said it did bother her, the resident crying out, because the roommate was in pain. During an observation on 12/30/24 at 5:30 p.m., resident #71 was heard from the hallway crying in pain. Resident #71 was unable to be interviewed due to crying and having pain. During an observation on 12/30/24 at 6:15 p.m., resident #71 was still crying in pain. NF2 approached the surveyor and asked if pain medication could be provided. NF2 was directed to the facility staff. During an interview on 12/31/24 at 8:45 a.m., NF2 said the call light was on over 1/2 hour, and he then had to go find someone to get pain medication for the resident. NF2 said resident #71 does not always remember, or able to call the nurses consistently, when she has pain. NF2 said resident #71 rarely gets repositioned in the bed, and she was bed bound as she cannot get up using the lifts, because of the pain they cause. NF2 said today (12/31) was the first time he has ever heard resident #71 state she wanted to just give up and be done. NF2 said he feels like the staff have given up on her, and they just close the door and forget her.

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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. 14005 Based on interview and record review, the facility failed to ensure sufficient nursing staff were available for the provision of resident care and that a licensed nurse was always available. This deficient practice had the potential to affect all residents residing in the facility. Findings include: Review of the facility staffing schedule, dated 12/25/26 showed the facility was staffed with one licensed nurse, and two certified nurse assistants, during the night shift. During an interview on 12/30/24 at 3:44 p.m., staff member A said on 12/25/24, the facility was staffed with one agency LPN, one agency CNA, and one facility CNA during the night. Staff member A said the LPN and agency CNAleft the facility together. Staff member A said with the two of them leaving, the facility was left with no licensed nurse coverage, and only one CNA to care for the 44 residents. Staff member A said she did not know how long the facility was without a licensed nurse. Staff member A said she was not aware of any residents who may have missed medications, and said the nurse documented a refusal of one medication, however that resident wanted to be awakened for her routine anti-anxiety medication. Staff member A said the nurse and CNA have not returned her calls, and the interim staffing agency is attempting to contact the nurse and CNA. Staff member A said she was gathering information to submit to the state board of nursing regarding the licensed nurse abandoning the residents. During an interview on 12/30/24 at 6:15 p.m., staff member I said she had worked on 12/25/24. Staff member I said she was scheduled to work with the residents on the front half of the facility. Staff member I said the LPN and CNA (staff member M and N) approached her and told her they were both leaving to go to the store together. Staff member I said the LPN told her he would be taking the walkie talkie, and she should put her walkie talkie on, and she could call if she needed anything. Staff member I said they both left about 12:15 a. m. Staff member I said after the nurse had been gone approximately 30 minutes, she tried to contact the nurse via walkie talkie, but did not get any response back. Staff member I said she texted the DON and left a message, but did not receive any information back from her. Staff member I said the two staff who left returned to the facility more than one and a half hours after they left. Staff member I said she tried to do resident rounds, but she ended up answering call lights and trying to keep residents safe. Staff member I said when she returned to work on 12/27/24, another CNA asked her why so many residents were left so wet and soiled on her last shift, which would have been the morning of 12/26/24. During an interview on 12/31/24 at 12:14 p.m., resident #66 said she does not remember all the medications she takes or when she takes them. She did say that she wants to be woken up for her medication at night. Resident #66 does not remember is she has taken her medications every night or not. She said she does not remember any specific days.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14005 Based on observation, interview, and record review, the facility failed to sufficiently staff the dietary department with the necessary staff to carry out the normal functions of the department. This deficient practice caused meals to be served late and the department was not meeting resident preferences. Findings include: During an interview on [DATE] at 9:55 a.m., during the initial kitchen tour, staff member B said the kitchen was short staffed. Staff member B said he was not aware there were expired nutritional drinks in the reach in refrigerators. He also said the staffing shortage affected the cleanliness of the kitchen. Based on a typed form provided to the surveyor, mealtimes were to be 7:30 a.m. for breakfast, 11:30 a.m. for the noon meal, and 5:30 p.m. for the evening meal. Review of resident council meeting minutes, dated [DATE], showed the facility was changing meal times. The new times were explained by the dietary department, and the residents understood the change. During an observation on [DATE] at 12:01 p.m., there were three non-dietary staff members serving in the dining room. Prior to these staff getting to the dining room, the dietary staff had to page three times overhead to request all hands-on deck (request for other staff to come assist in the dining room) to come to the dining room to serve. During an interview on [DATE] at 12:20 p.m., staff member K said there are usually four certified nurse aides on duty, but there are only three CNAs working for the next few days. Staff member K said when the facility is staffed with three CNA's the resident trays (for resident's in their rooms) are served late on the hallways. Staff member K said there was only one CNA trying to serve all the hall trays. Staff member K was not aware of any residents complaining of cold food. During an observation on [DATE] at 5:50 p.m., residents were in the dining room waiting for the evening meal. Service had not started yet, even though service time was 5:30 p.m. During an observation on [DATE] at 5:53 p.m., there was one staff member in the dining room, and the first tray was just being served. The CNA serving the trays had to return several trays, due to resident preferences not being followed, and the residents were refusing meals. The return of multiple trays caused the meal tray service to be delayed, and this was completed approximately one hour after the time meals were to be served. During an observation on [DATE] at 6:45 p.m., residents on the 200 hallways were just receiving their meals. This was 1.25 hours after the posted mealtimes. During an interview on [DATE] at 8:45 a.m., NF2 said his family member did not receive her supper until after 6:45 p.m., on [DATE]. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on [DATE] at 1:00 p.m., a staff member was telling another staff member the resident's soup was cold. The meal was being served 1.25 hours after the posted meal service time, for the residents on the 200 hallway. During an interview with staff member C, on [DATE] at 11:55 a.m., staff member C said the kitchen had been short staffed. Staff member C said ideally there would be two morning staff and two afternoon or evening staff. Staff member C said one person would be the cook, and the other would work as the dietary aide. During an interview on [DATE] at 1:00 p.m., staff member F stated she had been working in the kitchen for a week. Staff member F stated, The facility is severely understaffed. I worked five days training last week and four days per week now. Staff member F said she was not trained on a cleaning schedule nor aware of any cleaning schedule. Staff member F said she just cleaned if she had time, based on her knowledge of what should be cleaned. Staff member F said she assisted with the meal service, tray line, and did the dishes. Staff member F said she helped serve but did not complete the Serve Safe training as of [DATE]. Review of the dietary staffing schedule, for [DATE] through [DATE], showed there were eight days when dietary staffing was less than what was needed to provide dietary services to the residents. Of those days, when staffing was less, there were two days where there was only two staff members scheduled instead of the four that were needed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14005 Based on observations, interviews, and record review, the facility failed to ensure sanitary conditions were maintained throughout the kitchen, and the dietary storage areas; failed to ensure kitchen staff labeled and dated food in the coolers; and, failed to maintain a clean (dietary/kitchen) environment. This deficient practice increased the risk for the development of foodborne illnesses and deficient practices related to sanitary conditions, for all residents who received food from the kitchen. Findings include: During the initial tour of the kitchen, on [DATE] at 9:55 a.m., the following observations were made: - The hot chocolate machine nozzles were soiled. - The juice machine nozzles, and the plates above the nozzles, were heavily soiled with orange and red colored sticky substances. - Small bowls were store in an upright position exposing the eating surface. - The handles on the three reach-in coolers were heavily soiled and sticky. - There were six covered souffle cups labeled OV and not dated. The contents appeared oily. - There were nine souffle cups with a white substance in the cup. The cups were covered and labeled H but did not contain a date. - A container of mixed fruit was in the cooler, unlabeled and undated. - Gallon pitchers of juice or drinks (orange, red, pale yellow, one pitcher containing tea bags) were not labeled or dated. - An opened cardboard container of almond breeze milk was opened and undated in the cooler. The carton showed it was to be discarded after 14 days. - An opened undated carton of butter pecan nutritional drink was not dated when opened. The container showed the contents were to be used or disposed of after 3 days from opening. - An open contained of cottage cheese was in the cooler. The use by date was [DATE]. - Two cans of beets were severely dented near the sealed edges. The beets were on a shelf labeled use first. - The cleaning bucket of water was tested for chemicals. The indicator strip showed no change in color, showing no sanitizing agent was present. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Two yogurt containers, which contained a resident name, expired on [DATE]. - Two containers of yogurt, with a resident name, expired on [DATE]. - A resident's salad dressing expired on [DATE]. - The resident refrigerator had brown stains on the door shelf, and pink liquid in the bottom under the drawer, which was not cleaned up. - There was a large open bag of green beans in the freezer. - There was a plastic wrapped package, with a breaded product, not labeled as to contents or date. - There were four large white tubular unlabeled and undated packages of food in the cooler. These packages were on the bottom shelf in a cooking tray. - There was one large clear unlabeled and undated bag with a meat product that was thawed on a cooking tray on the bottom shelf. - In the cooler there were containers of: one container of chicken salad dated [DATE], one large container of cream of mushroom soup, labeled [DATE], one container of pumpkin puree, dated ,d+[DATE], and one unlabeled food item was in the cooler not labeled or dated. - The microwave had food debris inside, on all sides. - The industrial can opener blade was heavily soiled with dried brown debris, and a white colored wet liquid substance. - The back of the oven and stove were highly soiled with greasy looking brown debris that had a fuzzy appearance. - There were two large dry bulk storage bins, which were very soiled, and neither contained a label as to the content or expiration date of the contents. Review of the December sanitation bucket chemical results showed that the sanitation level was checked 38 times of 122 possible opportunities. Review of food temperature logs for [DATE], [DATE], and [DATE] showed the food temperature was not taken on any food served for two of the three meals served that day. Review of the food temperature log on [DATE], showed the food temperature was taken for two of the three meals. Food temperature logs for all meals for ,d+[DATE] were requested, but no other December food temperature logs were received by the end of the survey. During an interview on [DATE] at 9:55 a.m., staff member B stated the kitchen was very short staffed. Staff member B said he was unaware there was outdated nutritional drink because he did not know it was in the cooler. Staff member B said the nutritional drink was not even supposed to be in the kitchen. Staff member B said left over food should be discarded after three days. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 10:45 a.m., staff member C stated the facility does not use the dented food cans. Staff member C said the dented cans should be sent back for credit. Staff member C was present for a portion of the kitchen sanitation tour. During an interview on [DATE] at 11:55 a.m., staff member C said she had not been working at the facility very long, but staffing was getting better. Staff member C said she had six staff currently. Staff member C said she needed four staff per day, two in the morning, and two in the afternoon/evening. Staff member C said there were days when there were not enough staff to work. During an interview on [DATE] at 1:00 p.m., staff member F said she had just recently started working there, and the facility was severely understaffed in the kitchen. Staff member F was unaware of any type cleaning schedule.