STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Rehabilitation and Healthcare Center	1070 Old Ocean Highway Bolivia, NC 28422

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 32968 Based on record review, observations, Administrator, and Maintenance Director interviews, the facility failed to remove the black greenish substance from the commode base caulking in resident rooms (200, 201, 205, 207, 208, 209, 305, and 411), failed to repair resident's overhead lights that were non-functioning in resident rooms (202 and 411). These failures occurred on 3 of 5 hallways (200, 300, and 400 Halls) observed for a safe, clean, homelike environment and failed to maintain hot water temperatures in 2 of the 2 shower rooms on the 300-hall (Spa #1 and Spa #2) reviewed for hot water. Findings included: 1. An observation of the two 300-hall shower rooms was completed during a round on 02/17/25 which started at 9:45 AM with the Maintenance Director. The shower hot water temperature in Spa #1 fluctuated from 85 degrees Fahrenheit (F) to 89 degrees F, and the shower in Spa #2 hot water temperature fluctuated from 83 degrees F to 101 degrees F. Both shower water temperatures were obtained using the calibrated thermometer provided by the Maintenance Director and the temperatures were obtained after 5-minutes of continuous hot water monitoring in both shower rooms. The Maintenance Director stated during the observation the water was too cold for showers, which should have been around 114 degrees F. The Maintenance Director said he would try to adjust the faucets and mixing valve to bring the hot water temperature up to around 114 degrees F. An interview was conducted on 02/21/25 at 12:00 PM with the Administrator and he stated as of September 2024, their paper water temperature logs were no longer being used, since they updated to the electronic Maintenance TELS (The Equipment Lifecycle System) (an online system used to help manage maintenance in a facility). The Administrator explained he had their new electronic TELS water testing log did not include testing water temperatures in the shower rooms. The Administrator further explained he hired a new Maintenance Director and because the 3 shower rooms were inadvertently not added in the TELS water testing log, the Maintenance Director did not track the shower water temperatures which resulted in the 3 shower rooms water temperatures not being monitored. The Maintenance Director said another reason the water in the shower rooms might be cold was due to the hot water having to travel all the way from the boiler to the shower rooms and staff were not waiting 3-5 minutes for the water to heat up. 2. An observation on 02/18/25 at 12:00 PM revealed resident commode base caulking in resident rooms (200, 201, 205, 207, 208, 209, 305, and 411), were noted to have black greenish substance located around the base of the commodes. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview and observation were conducted on 02/18/25 at 1:30 PM with the Maintenance Director. He stated there were areas on the 200, 300, and 400 halls that needed to be addressed, repaired, or replaced. He stated he was new to the building and had no assistant but was slowly keeping up with facility repairs. He said he did not know what the black greenish substance was around some of the commodes commode base caulking in resident rooms (200, 201, 205, 207, 208, 209, 305, and 411). He said maintenance was responsible for repairing or replacing items in the facility, and that some of the commodes caulking needed to be replaced. 3. An observation on 02/18/25 starting at 12:15 PM revealed overhead lights that were non-functioning, in rooms (202 and 411). All four alert and oriented residents in the two rooms said they told their nurses about the non-functioning lights, but nothing had been done. They said they primarily use the lighting from the outside window and keep the hallway door open. An interview was conducted on 02/18/25 at 1:30 PM with the Maintenance Director. He stated there were still areas on the 200, 300, and 400 halls that still needed to be addressed, repaired, or replaced. He said maintenance was responsible for repairing or replacing items in the facility, and that some of the overhead lights were not working and needed new ballasts. An interview was conducted with the Administrator on 02/18/25 at 1:50 PM. He revealed they were making progress and were improving residents' living environment to make it more home-like, and that it would take time. He said there were still areas in the facility that still needed to be addressed, and they were actively putting plans in place to address areas concern observed during the survey. The Administrator stated it was his expectation for all the residents to have a safe and homelike environment that was clean and in good repair.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 40044 Based on observations, record review, and staff interviews, the facility failed to protect a residents' right to be free from neglect when a nurse (Nurse#5) failed to perform the daily wound care to an infected Stage IV left heel pressure wound and an unstageable right heel pressure wound both of which were facility acquired. This failure occurred for 1 of 3 residents reviewed for neglect. Findings included. This tag is cross referenced to: F686: Based on observations, record review, staff, the Medical Director and the Wound Physician interviews, the facility failed to provide wound care according to the physician's order for a Stage IV pressure ulcer on the left heel and an unstageable deep tissue injury on the right heel. This occurred for 1 of 3 residents (Resident #60) reviewed for wound care.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40044 Based on observations, record review, and staff interviews, the facility failed to provide bathing and showers (Resident #39, Resident #53, and Resident #60) and incontinence care (Resident #7) to residents who were dependent on staff assistance with activities of daily living (ADL). This occurred for 4 of 5 residents reviewed for ADL care. Findings included. 1a.) Resident #39 was admitted to the facility on [DATE] with diagnosis including Alzheimer's disease. The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #39 was severely cognitively impaired. She had no rejection of care. She had impaired range of motion in her bilateral upper and lower extremities and was dependent on staff for activities of daily living (ADL). A care plan dated 1/16/25 revealed Resident #39 had ADL self-care performance deficit related to her diagnosis of Alzheimer's disease, primary osteoarthritis, diabetes, and hypertension. Interventions included to encourage participation in tasks. During an interview on 2/16/25 at 5:00 PM Nurse #5 stated Resident #39 did not receive her scheduled shower last night on Saturday 2/15/25. She stated it was reported to her this morning when she came on duty by the night nurse and Resident #39 still had not had a shower as of now. She indicated she did not know why the showers weren't done by the Nurse Aides. She stated Resident #39 was scheduled for showers to be given on night shift on Wednesday and Saturday nights. During a phone interview on 3/4/25 at 8:30 PM Nurse Aide #9 stated he was the assigned Nurse Aide on 2/15/25 from 7:00 AM until 7:00 PM. He stated baths were not given to any residents during his shift on 2/15/25 because he was the only Nurse Aide assigned on the locked unit that day and there was no time to give baths. During an interview on 2/18/24 at 3:00 PM Nurse Aide #7 stated he worked Saturday night 2/15/25 on the locked unit from 7:00 PM until 7:00 AM. He stated he was an agency nurse aide, and he was made aware of who needed showers when he came on shift. He stated three residents were supposed to get showered that night but stated he was busy during the shift and just didn't get the showers done on any of the three residents which included Resident #39. He stated there were two nurse aides on duty and assigned to the locked unit along with the nurse on Saturday night from 7:00 PM until 7:00 AM which was the usual number of staff on the locked unit. During an interview on 2/16/25 at 2:51 PM Nurse Aide #5 stated she was the assigned Nurse Aide on the locked unit today and was scheduled to work from 7:00 AM until 7:00 PM. She stated the second Nurse Aide who was scheduled this shift called out this morning, so it was just her and the nurse until approximately 10:00 AM. She stated Resident #39 had not been given a bath today at this point because there was no time this morning to give baths. b.) Resident #53 was admitted to the facility on [DATE] with diagnoses including dementia. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan dated 11/25/24 revealed Resident #53 had an ADL self-care deficit related to dementia. Interventions included assistance by staff with bathing and showering. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #53 had severely impaired cognition. She required extensive assistance by staff with activities of daily living. During an interview on 02/16/25 at 5:00 PM Nurse #5 stated Resident #53 did not receive her scheduled shower last night (Saturday 2/15/25). She stated that was reported to her this morning when she came on duty by the night nurse. She stated Resident #53 still had not had a shower as of now. She stated she did not know why the showers weren't done by the Nurse Aides. She stated Resident #53 was scheduled for showers to be given on night shift on Wednesday and Saturday nights. During a phone interview on 3/4/25 at 8:30 PM Nurse Aide #9 stated he was the assigned Nurse Aide on 2/15/25 from 7:00 AM until 7:00 PM. He stated baths were not given to any residents during his shift on 2/15/25 because he was the only Nurse Aide assigned on the locked unit that day and there was no time to give baths. During an interview on 2/18/24 at 3:00 PM Nurse Aide #7 stated he worked Saturday night 2/15/25 on the locked unit from 7:00 PM until 7:00 AM. He stated he was an agency nurse aide and stated he was made aware of who needed showers when he came on shift. He stated he was busy during the shift and just didn't get the showers done on any of the three residents who were scheduled which included Resident #53. During an interview on 2/16/25 at 2:51 PM Nurse Aide #5 stated she was the assigned Nurse Aide on the locked unit today and was scheduled to work from 7:00 AM until 7:00 PM. She stated Resident #53 had not been given a bath today at this point because there was no time this morning to give baths. c.) Resident #60 was admitted to the facility on [DATE] with diagnoses including dementia. A care plan revised 11/25/24 revealed Resident #60 had an ADL self-care deficit related to dementia with agitation. Interventions included to encourage resident to participate to the fullest extent. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #60 had moderately impaired cognition. She required extensive assistance by staff with activities of daily living. She had no rejection of care. During an interview on 02/16/25 at 5:00 PM Nurse #5 stated Resident #60 did not receive her scheduled shower last night (Saturday 2/15/25). She stated Resident #60 still had not had a shower as of now. She stated she did not know why the showers weren't done by the Nurse Aides. She stated Resident #60 was scheduled for showers to be given on night shift on Wednesday and Saturday nights. During a phone interview on 3/4/25 at 8:30 PM Nurse Aide #9 stated he was the assigned Nurse Aide on 2/15/25 from 7:00 AM until 7:00 PM. He stated baths were not given to any residents during his shift on 2/15/25 because he was the only Nurse Aide assigned on the locked unit that day and there was no time to give baths. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/18/24 at 3:00 PM Nurse Aide #7 stated he worked Saturday night 2/15/25 on the locked unit from 7:00 PM until 7:00 AM. He stated he was an agency nurse aide and stated he was made aware of who needed showers when he came on shift. He stated he was busy during the shift and just didn't get the showers done on either of the three residents who were scheduled which included Resident #60. During an interview on 2/16/25 at 2:51 PM Nurse Aide #5 stated she was the assigned Nurse Aide on the locked unit today and was scheduled to work from 7:00 AM until 7:00 PM. She stated Resident #60 had not been given a bath today at this point because there was no time this morning to give baths. During a phone interview on 2/18/24 at 4:00 PM Nurse #7 stated she was the assigned nurse on the locked unit on Saturday night 2/15/25. She stated she was an agency nurse, and it was her very first night working in the facility. She indicated she was aware showers were scheduled on night shift but did not know why the nurse aides on duty Saturday night didn't do them. She indicated she reported this to the oncoming nurse the next morning. During the survey three attempts were made to contact Nurse Aide #8 who was on duty in the locked unit from 7:00 PM until 7:00 AM on Saturday night 2/15/25. There was no response. During an interview on 02/19/25 at 11:24 AM the Director of Nursing (DON) stated she was made aware of the three residents who did not get showered on their scheduled shower day on Saturday night 2/15/25. She stated she did confirm after talking with Nurse Aide #7 and Nurse Aide #8 who were the nurse aides on duty that showers weren't given. She stated they chose not to do the showers, and they received disciplinary action and were pulled from the locked unit. She stated they typically had two nurse aides assigned to each shift on the locked unit and there were two nurse aides on duty from 7:00 AM until 7:00 PM. She stated the showers should have been given. 35173 2) Resident #7 was admitted to the facility on [DATE]. Diagnoses included history of urinary tract infections, muscle wasting and atrophy, and need for assistance with personal care. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #7 was cognitively intact and was coded for impairments to both sides of upper and lower extremities and dependent with one staff physical assistance for ADL care. Resident #7 was always incontinent of bowel and bladder. A care plan updated on 02/11/25 for Resident #7 revealed a plan of care was in place for incontinent care and required staff assistance with toileting and bowel and bladder incontinence. The goal of care was to receive the appropriate level of staff assistance for toileting and incontinence care. Interventions included providing one person assistance with toileting and incontinence care. A plan of care was in place for limited physical mobility related to weakness, impaired mobility and incontinence with a goal that resident would be free of complications related to immobility to include skin breakdown. Interventions included observing for any signs or symptoms of skin breakdown. A plan of care updated on 02/13/25 revealed the resident had a Stage IV pressure ulcer to her coccyx (a small bone at the base of the spinal column above the buttocks) related to immobility and incontinence with a goal that the pressure ulcer would show signs of healing and remain free from infection. Interventions included observing any changes in skin status. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview with Resident #7 on 02/16/25 at 10:30 AM revealed an alert and oriented resident lying in bed on her back. Resident #7 reported that her brief had not been changed since early this morning and stated it was well before breakfast. Resident #7 stated she was wet with urine at this time and wanted to be changed. Resident #7 stated she would ring her call bell to get assistance. A follow up observation and interview was conducted with Resident #7 on 02/16/25 at 1:15 PM. Resident #7 stated she rang her call bell and told the Nurse Aide (NA) #2 that she needed her brief to be changed. The call light was not sounding upon entry to Resident #7's room. Resident #7 reported NA #2 stated she would be right back but she did not come back. Resident #7 stated she believed it was about 10:30 AM or so when she pressed her call bell, but she could not remember the actual time. Resident #7 stated she wanted her brief to be changed, but she did not want to keep bothering the nurse aide. An interview was conducted with Nurse Aide (NA) #2 on 02/16/25 at 1:15 PM. NA #2 was asked when the last time was that she checked on and changed Resident #7's brief. NA #2 responded I don't know, I don't keep track of that. I am so busy with the 18 residents on my hall. NA #2 stated she did not recall Resident #7 ringing her call bell to ask for assistance or telling Resident #7 she would be back. NA #2 stated she would check Resident #7 at this time. An observation of NA #2 was conducted on 02/16/25 at 1:15 PM. NA #2 was noted to have checked Resident #7's brief and it was noted to be saturated with a significant amount urine. NA #2 was observed changing Resident #7's brief at this time. Resident #7's dressing to her coccyx was noted to be intact. A follow up interview was conducted with NA #2 on 02/16/25 at 1:45 PM. NA #2 stated she was doing the best the could with keeping up with changing her residents. NA #2 stated she tried to check her residents every 2 - 3 hours per the facility protocol to see if the residents needed to be changed, but that Resident #7 had gone over 4 hours before she was changed again. NA #2 stated she did not remember when she first changed Resident #7 but she thought it was at the start of her shift around 7:30 AM. NA #2 stated she should have checked her for incontinence again after 2-3 hours since she was one of her residents known to urinate a lot. An interview was conducted with the Administrator on 02/21/25 via phone at 1:35 PM. The Administrator stated he would have expected the nurse aides to check and change all residents on their assignment every 2 - 3 hours to ensure they were kept dry and clean to maintain the resident's skin integrity.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40044 Based on record review, and staff, Registered Dietician and Physician interviews, the facility failed to provide a nutritional supplement ordered twice a day for 30 days for wound healing to a resident who was at risk for malnutrition and had a facility acquired unstageable deep tissue injury of the right heel and a deep tissue injury to the left heel that developed into a Stage IV pressure wound. This occurred to 1 of 10 residents (Resident #60) reviewed for nutrition. Findings included. Resident #60 was admitted to the facility on [DATE] with diagnoses including muscle wasting with atrophy, dysphagia, and dementia. A wound physician's report dated 11/20/24 revealed Resident #60 had bilateral deep tissue injuries to her left and right heels. A care plan revised 11/25/24 revealed Resident #60 was at nutritional risk due to cognitive decline associated with dementia, dysphagia with a modified diet order, age-related physiological decline and debility, skin breakdown, diabetes, and aphasia. She was at risk for malnutrition, and for hydration alterations and weight fluctuations secondary to diuretic use. Interventions included in part: to observe for signs of malnutrition and provide and serve supplements as ordered. The Registered Dietician will evaluate and make diet change recommendations as needed. The Registered Dietician review note dated 12/17/24 revealed that she evaluated Resident #60. The head-to-toe skin review indicated that Resident #60 had a suspected deep tissue injury on the right and left heel. The current weight on 12/4/24 was 111 pounds, which was up over the past month. The Registered Dietician recommended for wound healing Arginaid twice a day for 30 days. (Arginaid is a nutritional supplement in a powder or drink mix that contains arginine. Arginine is an amino acid that's essential for wound healing. It stimulates the release of growth hormone and insulin-like growth factor, which can improve wound healing.) Review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) dated December 2024 revealed no documentation that Arginaid nutritional supplement was administered to Resident #60. Review of Resident #60's progress notes from 12/17/24 through 12/31/24 revealed no documentation as to why Arginaid was not administered. Review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) dated January 2025 revealed no documentation that Arginaid nutritional supplement was administered to Resident #60. Review of Resident #60's progress notes from 1/1/25 through 1/17/25 revealed no documentation as to why Arginaid was not administered. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #60 had moderately impaired cognition. She had two deep tissue injuries. She had no rejection of care. A wound physician's report dated 2/12/25 for Resident #60 revealed the deep tissue injury to the left heel had now revealed itself to be a Stage IV pressure injury. The right heel wound remained unstageable due to necrosis. The Registered Dietician review note dated 2/13/25 revealed that she evaluated Resident #60 for pressure areas and weight loss. The wound report indicated Resident #60 had wounds to the left and right heel. The Registered Dietician recommended for wound healing and weight stability Arginaid twice a day for 90 days. Review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) dated February 2025 revealed no documentation that Arginaid was administered to Resident #60. Review of Resident #60's progress notes from 2/1/25 through 2/28/25 revealed no documentation as to why Arginaid was not administered. Review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) dated March 2025 revealed no documentation that Arginaid was administered to Resident #60 as of 3/5/25. During an interview on 2/17/25 at 2:30 PM Nurse #8 stated she was consistently assigned to care for Resident #60. She stated Resident #60 had pressure wounds, but she did not recall Resident #60 receiving Arginaid at any time since December 2024. She stated she did not see the order on the MAR or the TAR for Arginaid for Resident #60 in December 2024, or January 2025 or through today 2/17/25. During an interview on 02/18/25 at 2:44 PM the Registered Dietician stated she last evaluated Resident #60 on 2/13/25. The progress notes indicated Resident #60 continued with deep tissue injuries and Stage III and Stage IV pressure wounds. She stated she was not aware that the Arginaid recommendation for wound healing was not implemented in December 2024, but a new recommendation was made for Arginaid on 2/13/25. She stated she did not enter her recommendations as orders. She stated when she wrote the recommendations, she emailed them to the Director of Nursing, then the physician would sign off on the order then the nursing staff would enter it into the resident's electronic medical record to be implemented. During an interview on 02/20/25 at 1:04 PM the Director of Nursing (DON) stated that when the Registered Dietician made recommendations following her evaluations, she emailed the recommendations to her. She stated she would then forward the email to the Unit Manager to complete the order process. She indicated that she gave the recommendations made by the Registered Dietician to Unit Manager #1 following the December 2024 evaluation of Resident #60. During a phone interview on 02/21/25 at 2:05 PM Unit Manager #1 stated she gets the Registered Dietician recommendations from the DON. She stated once she gets the recommendation, she sends it to the Nurse Practitioner or the Physician to be signed off, then she would enter the order into the electronic medical record, and it would flow to the Medication Administration Record. She stated she looked back for the recommendation for Resident #60 from December 2024 for Arginaid and she could not find where the recommendation was sent to her. She indicated it was missed and was never implemented. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 3/4/25 at 2:00 PM the Physician stated Resident #60 had an unstageable deep tissue injury on her right heel and a Stage IV pressure wound on her left heel. She stated Resident #60 had multiple comorbidities that contributed to her wound development and the wounds were unavoidable. She stated she was made aware of the Arginaid order not getting entered for Resident #60 following the onsite survey period. She stated Arginaid had not been used in the facility for several years, however if it was recommended by the Registered Dietician then she would have signed off on the recommendation and expected the order to be entered and administered to the resident. A phone interview was conducted on 3/5/25 at 2:00 PM with the Registered Dietician, along with the Administrator and the Corporate Nurse. The Registered Dietician stated her recommendations had to have approval by the Physician before they were entered as an order. She stated she made another recommendation for Arginaid for Resident #60 during her last evaluation on 2/13/25 to aid in wound healing. The Corporate Nurse stated there had been an issue with the Registered Dieticians emails getting transmitted to the DON. The Administrator stated they just ordered the Arginaid for Resident #60, and it arrived at the facility on Monday 3/3/25. He stated Resident #60 would get the Argnaid by tomorrow 3/6/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Rehabilitation and Healthcare Center	1070 Old Ocean Highway Bolivia, NC 28422

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 - Few	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** 35173 Based on observations, record review, staff, and resident interviews the facility failed to provide sufficient nursing staff to provide incontinence care to a dependent resident (Resident #7). Nurse Aide #2 reported she changed Resident #7's brief at approximately at 7:30 AM and had not checked the resident for incontinence needs again until 1:15 PM. This occurred for 1 of 24 residents reviewed for sufficient staffing. Findings included: Resident #7 was admitted to the facility on [DATE]. Diagnoses included history of urinary tract infections, muscle wasting and atrophy, and need for assistance with personal care. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #7 was cognitively intact and was coded for impairments to both sides of upper and lower extremities and dependent with one staff physical assistance for ADL care. Resident #7 was always incontinent of bowel and bladder. A review of the staffing assignment sheet on 02/16/25 revealed there was one nurse aide assigned to each of the 100 hall, 200 hall, 300, and 400 hall from 7:00 AM to 7:00 PM, one nurse aide on the 500 hall (locked unit) due to a call out, and 2 nurse aides from 10:00 AM until 7:00 PM. The facility census (number of residents residing in the facility) posting on 02/16/25 was 81 residents. The staffing assignment sheets on 02/16/25 revealed the following: Nurse Aide #2 assigned to the 100 Hall with 16 residents Nurse Aide #3 assigned to the 200 Hall with 15 residents Nurse Aide #4 assigned to the 300 Hall with 17 residents Nurse Aide #1 assigned to the 400 Hall with 17 residents Nurse Aide #5 and Nurse Aide #6 assigned to the 500 hall with 16 residents The total number of nurse aides working on 02/16/25 during the 7:00 AM to 7:00 PM was 6. There was a medication aide who was not working as a nurse aide who was administering medications on the 200 hall. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview with Resident #7 on 02/16/25 at 10:30 AM revealed an alert and oriented resident lying in bed on her back. Resident #7 reported that her brief had not been changed since early this morning and stated it was well before breakfast. Resident #7 stated she was wet with urine at this time and wanted to be changed. Resident #7 stated she would ring her call bell to get assistance. A follow up observation and interview was conducted with Resident #7 on 02/16/25 at 1:15 PM. Resident #7 stated she rang her call bell and told Nurse Aide (NA) #2 that she needed her brief to be changed. The call light was not sounding upon entry to Resident #7's room. Resident #7 reported NA #2 stated she would be right back but she did not come back. Resident #7 stated she believed it was about 10:30 AM or so when she pressed her call bell, but she could not remember the actual time. Resident #7 stated she wanted her brief to be changed, but she did not want to keep bothering the nurse aide. An observation of NA #2 was conducted on 02/16/25 at 1:15 PM. NA #2 was noted to have checked Resident #7's brief and it was noted to be saturated with a significant amount urine. NA #2 was observed changing Resident #7's brief at this time. An interview was conducted with NA #2 on 02/16/25 at 1:15 PM. NA #2 was asked when she last checked and changed Resident #7's brief. NA #2 responded I don't know, I don't keep track of that. I am so busy with the 18 residents on my hall. NA #2 stated she did not recall Resident #7 ringing her call bell to ask for assistance or telling Resident #7 she would be back. NA #2 stated she had 18 residents and it was very difficult to meet all the needs of the residents, and she was not always able to meet their needs during her shift. NA #2 stated she was working from 7:00 AM to 7:00 PM on this hall. She stated she could not always find a staff member to assist her because the other aides were busy too. She stated 18 residents on the 100 hall were a lot of residents to care for during the day and evening shift and it was difficult to do it alone and provide the care needed. A follow up interview was conducted with NA #2 on 02/16/25 at 1:45 PM. NA #2 stated she was doing the best she could with keeping up with changing her residents. NA #2 stated she tried to check her residents every 2 - 3 hours per the facility protocol to see if the residents needed to be changed, but that Resident #7 had gone over 4 hours before she was changed again. NA #2 stated she did not remember when she first changed Resident #7 but she thought it was at the start of her shift around 7:30 AM. NA #2 stated she should have checked her for incontinence again after 2-3 hours since she was one of her residents known to urinate a lot. At this time, the actual number of residents she was assigned was confirmed by Nurse Aide to be 16 residents on 02/16/25. NA #2 stated 16 residents on day shift was a lot of care to provide with one nurse aide. An interview with the Scheduler on 02/18/25 at 1:30 PM revealed on day shift (7:00 AM until 7:00 PM) she was allocated to have 7 nurse aides. The scheduler stated if a staff member called off, they had to try and replace the call out. She stated normal scheduling was based on the facility census and with the census being 81, she would schedule 7 nurse aides but someone almost always called out. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/18/25 at 11:55 AM Nurse Aide #1 stated it was difficult for her to get all of her care done for the residents when she worked the 400 hall by herself. Nurse Aide #1 stated she usually had at least 17 residents on day shift on her assignment. Nurse Aide #1 stated a lot of her residents on the 400 hall required two person assistance or the need for a mechanical lift and it was not easy to find the second person to help. Nurse Aide #1 stated she would ask the upper management staff to assist, but they were not always available to assist. Nurse Aide #1 stated she would then not be able to get the residents out of bed until she found help. During a phone interview on 03/04/25 at 8:00 PM Nurse Aide #14 stated they needed more Nurse Aides assigned to all the halls. NA #14 stated care to the residents was not always getting done such as incontinence care when there was not enough staff. NA #14 stated he had worked each hall and it was always staffed with the bare minimum (1 nurse aide per hall) and it was hard to get care done for the residents. A phone interview was conducted with the Administrator on 02/21/25 at 1:35 PM. The Administrator stated the census on 02/16/25 was 81 and he had scheduled 7 Nurse Aides. He stated they were allocated 7 Nurse Aides on day shift, and they scheduled seven but that included a Medication Aide as well. He stated the 7th person was a Nurse Aide/Medication Aide and was assigned to a medication cart on the 02/16/25 which left only 6 Nurse Aides for 81 residents. The Administrator stated he did not feel it was a concern and that one Nurse Aide to 16 - 17 residents was a manageable assignment. The Administrator stated the assignment was tough but doable.