STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385189	A. Building B. Wing	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Transitional Care at Sunnyside	4515 Sunnyside Road SE Salem, OR 97302

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 36494 Based on observation, interview, and record review it was determined the facility failed to ensure residents' rights to a dignified existence for 2 of 5 sampled residents (#s 3 and 15) reviewed for dignity and respect. This placed residents at risk for diminished quality of life. Findings include: 1. Resident 3 was admitted to the facility in 2020 with diagnoses including morbid obesity and depression. A care plan dated 2/1/20, revealed Resident 3 was independent with transferring herself/himself in the room, utilized a bed side commode, and required one-person assistance with toileting hygiene. A Grievance Communication Form Dated 9/30/24, revealed the following: - Resident 3 turned on the call light for help at 12:15 PM. At 12:30 PM, Resident 3 placed herself/himself on the beside commode. At 1:15 PM, her/his roommate went out and asked staff for help. At 1:20 PM, almost one hour after the resident turned on the call light, a CNA entered the room and helped Resident 3 off the bedside commode. -Staff 41 (Former CNA) stated Resident 3 indicated her/his call light was on for 45 minutes and Staff 41 told Resident 3 she was the only one answering call lights because the other CNA was providing another resident a shower after lunch. Staff 41 apologized. -Staff 2 (DNS) indicated Resident 3 was independent in her/his room for the most part and Staff 41 intended to assist Resident 3, but another resident was crying in the hall and was distraught. Staff 41 made a judgement call. -Staff 41 apologized to Resident 3 post incident. Resident 3 was upset and crying and stated, It wasn't fair. -Staff 2 indicated the long call light did occur. Staff were not ignoring the call light, or Resident 3's needs, because the CNAs were working the best they could. On 1/2/25 and 1/3/25 attempts to contact Staff 41 were unsuccessful. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/2/25 at 11:20 AM, Resident 3 was observed sitting on the edge of her/his bed. The resident's bedside commode was adjacent to the bed. A call light was attached to the wall next to the bedside commode. Resident 3 stated she/he completed a grievance form regarding the 9/30/24 incident. Resident 3 stated she/he could get onto the bedside commode herself/himself but needed assistance with wiping. Resident 3 stated she/he sat on the bedside commode for almost an hour without assistance and was in tears because her/his bottom hurt from the hard plastic. Resident 3 stated this occurred on more than one occasion and was very frustrating. On 1/6/25 at 2:11 PM, Staff 11 (LPN-Resident Care Manager) stated he spoke with Resident 3 after the incident on 9/30/24, and she/he was upset regarding the incident. On 1/6/25 at 3:39 PM, Staff 2 stated she was aware of the incident on 9/30/24, and Resident 3 was upset from sitting on the bedside commode for an extended period. Staff 2 stated she encouraged the resident to turn her/his call light on sooner when Resident 3 knew when she/he was going to use the commode. 2. Resident 15 was admitted to the facility in 2024 with diagnoses including morbid obesity and anxiety. A care plan dated 8/15/24, and revised on 12/24/24, revealed Resident 15 needed to be supervised when smoking. Resident 15 obtained her/his smoking materials from staff, and returned them when she/he was done smoking. A review of progress notes from 8/30/24 through 9/7/24 revealed Resident 15 was found to have smoking paraphernalia on her/him and was caught smoking while unsupervised. The resident handed over her/his smoking paraphernalia to staff when asked. A Progress Noted dated 9/13/24 at 10:43 AM, revealed the following: -Staff 30 (Former Nursing Student) went into Resident 15's room to provide wound care after the resident returned from visiting with a friend. Therapy was working with the resident. -Staff 30 completed the resident's wound treatment and asked if it was ok if she checked the resident's makeup bag. Staff 30 requested to check due to patient's friend having history of bringing patient paraphernalia. -Resident 15 agreed to have her/his bag searched, and the therapist was present. Staff 30 found a white oval pill with M367 scripted on one side and a lighter. Staff 30 confiscated the pill, took the lighter, and reported the information to Staff 9 (LPN), who then contacted Staff 2 (DNS). The items were given to Staff 2. -Staff 30 spoke with Staff 31 (Former LPN-Resident Care Manager), who requested staff to do a room search immediately and to check Resident 15 when she/he came back downstairs. -Staff 30 indicated two additional nurses went and searched Resident 15's room and belongings, but no smoking paraphernalia was found. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident 15 returned to her/his room and was upset, and yelled at the staff for being in her/his room, saying, You guys need to get the fuck out of my room. You have no right to be in my fucking room. Get the hell out of here. This isn't right, you can't do this, you need to tell [Resident 15] before you search [Resident 15's] room. -Staff 31 informed Resident 15 staff were doing this per administration's direction and needed to complete a full body check on Resident 15. Staff communicated with the resident about which body part needed to be checked prior to touching the resident. The search was completed, and nothing was found on the resident. -Staff 31 let the resident know she/he did not need to yell and indicated to talk nicely to staff. Staff 31 tried to let the resident know staff already searched the room and the resident did not need to leave her/his room. -Resident 15 proceeded to go downstairs and felt she/he was being targeted by staff due to her/his room being searched without permission. On 1/6/25 at 12:10 PM, Resident 15 was observed in her/his room seated in her/his wheelchair. Resident 15 stated she recalled the 9/13/24 incident and stated a staff person sniffed her/his hair upon returning from outside. When the resident returned to her/his room, a staff person approached the resident and asked if she could look into Resident 15's bag, to which the resident agreed. Resident 15 stated they found a Vicodin (pain pill) and a lighter, which the staff member confiscated. Resident 15 stated she/he and the staff person left the room. Resident 15 stated when she/he returned there were multiple staff in her/his room conducting a search. Resident 15 stated W.T.F., you searched [Resident 15's] room without [Resident 15's] permission. Resident 15 stated she/he was flustered, and staff indicated they needed to complete a body search. Resident 15 stated she felt coerced and let Staff 31 complete the body search. Resident 15 stated Staff 31 indicated she was told by Staff 1 (Administrator) and Staff 2 the search needed to be completed. Resident 15 stated the staff found nothing on her/him or in the room. Resident 15 stated she/he felt humiliated, targeted, and angry. On 1/6/25 at 12:54 PM, Staff 9 stated she was aware of the incident on 9/13/24 and was directed by Staff 31 to search Resident 15's room and assist with a body search. Staff 9 stated she could not recall if the resident was in the room during the search or if the staff asked the resident's permission to search the room. Staff 9 stated she was not comfortable with the search but did what was asked of her. Staff 9 stated Resident 15 was extremely upset and angry about what happened and felt her/his rights were violated. On 1/6/25 at 3:05 PM, Staff 31 stated she was not involved with the incident but only heard about Resident 15's room search and body search. Staff 31 stated Staff 1 and Staff 2 were aware and followed up regarding the 9/13/24 incident. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/6/25 at 4:37 PM, Staff 30 stated Resident 15 had a history of being non-compliant with smoking paraphernalia and had items confiscated from her/him before the 9/13/24 incident. Staff 30 stated Staff 1 and Staff 2 told her to an keep an eye on the resident due to non-compliance with smoking. Staff 30 stated she was in Resident 15's room to provide treatment, and the resident had a purse which was unzipped, in which she saw a lighter. Staff 30 stated she asked the resident if she could search her/his purse and the resident agreed. Staff 30 stated she found a pill and lighter in the resident's purse, confiscated them, and informed Staff 31. Staff 30 indicated she and a couple other staff members were told to search the resident's room and had done so without permission. Resident 15 was out of the room during the search, and no one asked permission to search her/his room. Staff 30 stated upon Resident 15's return, she was extremely upset, stating, You should not be going through my stuff without my permission. Staff 30 stated Staff 31 informed the resident a body search needed to be completed and Staff 31 conducted the body search. Staff 30 stated Resident 15 was very upset, cursed, and nothing was found in the resident's room or on her/his body. Staff 30 stated the incident made her very uncomfortable and she never experienced anything else like it. On 1/6/25 at 4:13 PM and 5:37 PM, Staff 1 and Staff 2 were present for an interview. Staff 1 and Staff 2 stated Resident 15 was non-compliant with smoking paraphernalia, and both were aware of the incident that occurred on 9/13/24. However, both staff stated they were unaware Resident 15's room was searched, or a body search was completed without the resident's permission. Staff 1 stated she expected staff to ask permission prior to searching the resident's room or when conducting a body search.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 36494 Based on observation, interview, and record review it was determined the facility failed to accommodate residents with the correct fit of incontinence briefs for 4 of 13 sampled residents (#s 1, 6, 13 and 15) reviewed for dignity and respect and accommodation of need. This placed residents at risk skin breakdown and discomfort. Findings include: 1. Resident 1 was admitted to the facility in 2015 with diagnoses including diabetes and renal disease. A care plan dated 9/5/23, and revised on 12/5/24, revealed Resident 1 was incontinent of bowel and bladder, and used a brief with tabs, size three extra-large. Staff were to ensure the brief tabs were secure, so they did not scratch the skin, and use barrier cream between skin if tab contact was anticipated. Resident 1 required two-person assistance for bed mobility and one or two-person assistance for a brief change. On 12/27/24 at 1:30 PM, Witness 20 (Complainant) stated Resident 1 was recently switched to a different brief size for incontinence care, and the brief was too small, was tight, and caused red marks on the resident's skin. Witness 20 stated the resident reported concerns to staff, but the resident was still in the smaller brief. Interviews were conducted on 12/30/24 from 12:32 PM through 3:35 PM, with Staff 12 (CNA), Staff 43 (CNA), and Staff 13 (CNA). Staff 12, Staff 43, and Staff 13 stated Resident 1 was incontinent of bowel and bladder and required one or two persons to provide incontinence care. Staff 12, Staff 43, and Staff 13 stated residents were changed over to new brief sizes and Resident 1 complained the new brief was too small, cut into her/his skin, and rubbed uncomfortably. Staff 13 stated Resident 1's previous brief went over the top of the resident's pannus area, but the new sized brief went under the pannus, causing the tabs to rub, and resulting in red skin around the area. Staff 12 stated the new briefs were decided based on height and weight only, and nothing else about Resident 1 was considered. On 12/30/24 at 3:53 PM, Resident 1 was observed in bed. Resident 1 stated she/he was provided a new brief size, and the brief was way too small. The resident pulled down her/his blankets, and lifted her/his pannus, and the brief was visible along with where the tabs attached to the brief. Resident 1 stated the brief was too tight around her/his legs, rubbed on her/him, and was very uncomfortable. Resident 1 further stated she/he spoke with Staff 2 (DNS) and Staff 11 (LPN/Resident Care Manager), but both staff indicated the brief was the correct size based off her/his height and weight and did not allow her/him a different size. On 1/6/25 at 1:48 PM, Staff 11 stated Resident 1 was sized for a new brief based off the resident's height and weight. The brief she/he was fitted for did not recommend a larger brief size, according to the chart. Staff 11 stated he was aware Resident 1 was not comfortable in the new brief and the resident preferred a brief that went over the top of her/his pannus. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/6/25 at 3:13 PM, Staff 2 stated all residents were sized for new briefs and she was not sure what size Resident 1 wore prior to the brief change, but the old brief was place over the resident's pannus area. The new sized brief was based on height and weight, and staff were trained on the new brief sizes. Staff 2 stated she was unaware there were concerns regarding Resident 1's new brief size. 2. Resident 13 was admitted to the facility in 2021 with diagnoses including a stroke and anxiety. A care plan dated 3/10/21, and revised on 12/5/24, revealed Resident 13 was frequently incontinent of urine, and used a brief with tabs, size three extra-large. Staff were to assist Resident 13 with incontinent care after each episode. Resident 13 required substantial/maximum to dependent assistance with toileting hygiene. On 12/30/24 at 10:57 AM, Resident 13 stated she/he was very upset due to being placed in a new brief size. Resident 13 stated the brief she/he was fitted for was too small, and was tight around the thighs, and crotch area. Resident 13 stated CNAs could not supply her/him with a bigger brief size because of what her/his care plan indicated. Resident 13 stated, This is just not right. On 12/31/24 at 9:35 AM Witness 23 (Complainant) stated Resident 13 was recently switched to a different brief size for incontinence care and the brief was too small, tight, and uncomfortable for Resident 13. Witness 23 stated the resident was very upset regarding the new brief and asked for a different size brief but was told the brief fit her/him appropriately and was based off her/his height and weight. Witness 23 stated upper management did not consider Resident 13's waist size or lower body size. Witness 23 further stated upper management told residents they needed to buy their own briefs if the residents were unhappy with the size of brief provided. On 12/31/24 at 2:13 PM, Staff 16 (CNA), and on 1/3/25 at 2:13 PM, Staff 28 (CNA) stated Resident 13 was frequently incontinent of bladder, and required one staff person to assist with her/his incontinent care needs. Staff 16 and Staff 28 stated Resident 13 was extremely upset about the new brief sizes because the new brief was tight around her thighs, and crotch area. Staff 16 and Staff 28 stated to their knowledge, Resident 13 did not have redness or skin breakdown. On 1/2/25 at 2:35 PM, Staff 7 (LPN) stated Resident 13 was very upset regarding her/his brief size change and felt the brief was too small. Staff 7 stated a brief specialist was in the building and assisted with determining the correct brief size for each resident, which was based off height and weight. On 1/6/25 at 3:57 PM Staff 2 (DNS) stated she was aware Resident 13 was upset about the new brief sizing and was focused on the color of the brief. Staff 2 stated the new briefs were determined by height and weight for each resident. Staff 2 stated she was unaware Resident 13 had concerns regarding the brief being too small and uncomfortable. 3. Resident 15 was admitted to the facility in 2024 with diagnoses including morbid obesity and anxiety. A care plan dated 8/15/24, and revised on 12/4/24, revealed Resident 15 required one-person assistance with toileting, and used size two extra large briefs without tabs. Staff were to ensure the brief was securely fastened. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/31/24 at 9:35 AM Witness 23 (Complainant) stated Resident 15 was recently switched to a different brief size for incontinence care and the brief was too small, tight, and uncomfortable for Resident 15. Witness 23 stated the resident was very upset regarding the new brief and asked for a different size brief but was told the brief fit her/him appropriately and was based off her/his height and weight. Witness 23 stated upper management did not consider Resident 15's waist size or lower body size. Witness 23 further stated upper management told residents they needed to buy their own briefs if the residents were unhappy with the size of brief provided. On 1/3/25 at 10:50 AM, Resident 15 was observed sitting in her/his wheelchair, well groomed with no odors. Resident 15 stated she/he required one staff person to assist with toileting and pulling up her/his clothing. Resident 15 stated she/he was switched to a smaller brief than her/his prior size and the new brief was way too small. Resident 15 stated it was tight and rubbed on her/his thighs. Resident 15 stated she/he reported concerns to upper management, and was told to buy her/his own briefs and would not be supplied with a larger brief size. Resident 15 stated it was very upsetting. On 1/3/25 at 11:30 AM, Staff 16 (CNA) and at 11:57 AM, Staff 29 (CNA) stated Resident 15 was a one-person assist with toileting but was known to self-transfer. Staff 16 and Staff 29 stated the resident complained of the new brief size change and indicated the briefs were too tight, pinching her/him and the tabs that attach to the brief do not stay adhered. Staff 16 and Staff 29 stated the resident was informed to buy her/his own supplies from upper management because Staff 2 (DNS) would not supply the resident with a larger brief. On 1/6/25 at 4:13 PM, Staff 2 and at 5:37 PM, Staff 1 (Administrator) stated all residents were sized for new briefs and was not sure what size Resident 15 wore prior to the brief change. Staff 1 and Staff 2 stated the new sized brief was based on height and weight, and staff were trained on the new brief sizes. Staff 1 and Staff 2 stated they were unaware Resident 15 was uncomfortable in her/his brief and did not know the resident was buying her/his own supply. 42270 4. Resident 6 admitted to the facility in 5/2019 with diagnoses including Guillain-Barre Syndrome (a neurological disorder which causes muscle weakness, tingling, and paralysis). A 7/23/24 Wound Evaluation revealed Resident 6 had a Stage 4 pressure wound (a wound that extends completely through all layers of the skin, exposing muscle, tendon, or bone) on her/his coccyx (tailbone). An 8/2/24 Progress Note revealed Resident 6 complained to staff about facility staff using face towels to do wound care and the Resident Care Manager requested an order for wet wipes due to Resident 6's skin breakdown. A review of Resident 6's orders revealed no orders for staff to use wet wipes instead of washcloths for incontinence care and wound care on the coccyx. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/31/24 at 1:50 PM and on 1/2/25 at 12:58 PM Resident 6 stated the facility staff used washcloths to clean the area around her/his coccyx wound. Resident 6 stated Staff 2 (DNS) had the facility staff use washcloths instead of wet wipes. Resident 6 stated the facility staff used the washcloths for incontinence care currently when the facility ran out of wet wipes and it was painful due to the wound on her/his coccyx area. On 1/2/25 at 2:12 PM Staff 46 (CNA) stated the staff did not have access to enough wet wipes for all the personal care provided daily and the staff were to fill out a slip to request wipes to be delivered by Staff 2 once a day. Staff 46 stated the staff were to use washcloths to do incontinence care for Resident 6 and she/he complained about it being very rough because her/his skin was delicate. On 1/2/25 at 3:49 PM Staff 37 (CNA) stated the facility staff were required to use washcloths for incontinence care and on resident wounds. Staff 37 stated Resident 6 complained about the washcloths being uncomfortable. On 1/6/25 at 12:54 PM Staff 2 stated the facility moved to using washcloths for residents rather than wet wipes for all residents except those with skin breakdown; and those with skin breakdown were added to a list and approved for use of wet wipes. On 1/6/25 at 2:30 PM Staff 2 provided an undated Resident Approved for Wet Wipes List of residents who were approved for wet wipes for incontinence care and stated the facility moved to washcloths on 7/16/24. The Resident Approved for Wet Wipes List revealed Resident 6 was not approved to receive incontinence care with wet wipes until 8/2/24. Staff 2 confirmed Resident 6 should have always been on the list of residents to use wet wipes instead of wash cloths but there was a time staff used wash cloths for incontinence care. Staff 2 reviewed the orders for residents with approval for wet wipes and confirmed Resident 6 did not have an order for the staff to use wet wipes instead of wash cloths.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 50926 Based on interview and record review it was determined the facility failed to notify the physician regarding a change in condition for 1 of 4 sampled residents (#5) reviewed for change of condition. This placed residents at risk for lack of physician involvement. Findings include: The facility's Change in a Resident's Condition or Status Policy Statement dated 2/2021 directed the nurse to notify the resident's attending physician or the on-call physician of a significant change in the resident's physical condition. Resident 5 was admitted to the facility in 10/2023 with diagnoses including Congestive Heart Failure (a chronic condition in which the heart does not pump blood as well as it should) and a below the knee amputation. Review of Resident 5's clinical record revealed the following: - On 10/27/24 Resident 5 had a 4.9 pound weight gain in 24 hours. No evidence was found to indicate the physician was notified. - On 10/29/24 Resident 5 had a 10.2 pound weight gain in the past seven days. No evidence was found to indicate the physician was notified. - On 11/1 Resident 5 had a 4 pound weight gain in 24 hours. No evidence was found to indicate the physician was notified. - On 11/3 Resident 5's had a 3.2 pound weight gain in 24 hours. No evidence was found to indicate the physician was notified. A Nursing Care Note dated 11/10/24 revealed the provider was notified of Resident 5's weight gain - to188.2 pounds [8.4-pound gain in one week]. Resident 5 was sent to the hospital and admitted for evaluation of lower extremity swelling. On 1/2/25 at 2:50 PM Staff 32 (LPN-Resident Care Manager) stated when daily weights were ordered for patients with CHF the nurse was expected to report a weight gain of two pounds in 24 hours or five pounds in a week. Staff 32 stated she did not notify the provider of any weight changes. On 1/2/25 at 3:56 PM Staff 34 (LPN) stated she recalled Resident 5 being upset about her/his weight gain but could not recall the exact date. Staff 34 stated she did not notify the provider of any weight gains. On 1/6/25 at 11:18 AM Staff 2 (DNS) confirmed the physician was not notified for dates identified. Staff 2 stated she expected nursing staff to notify the physician when a resident had weight gain of two or three pounds within a 24-hour period, or if a resident had a five-pound increase within a week. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/6/25 at 3:10 PM Staff 42 (Medical Director) stated staff should follow the American Heart Association recommendations and notify the provider regarding a resident who had weight gain of two or three pounds within a 24-hour period, or if a resident had a five-pound increase within a week, which could be a potential sign of worsening heart failure.

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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. 36494 Based on observation, interview and record review the facility failed to provide sufficient nursing staff to ensure residents attained or maintained their highest practicable mental, physical, and psychosocial well-being for 4 of 7 sampled residents (#s 1, 2, 3, and 13) and 2 of 2 floors reviewed for call light wait times and staffing. This placed residents at risk for lack of ADL care needs. Findings include: 1. Resident 1 was admitted to the facility in 2015 with diagnoses including diabetes, and renal disease. A care plan dated 9/5/23, and revised on 12/5/24, revealed Resident 1 was incontinent of bowel and bladder. Resident 1 required one or two-person assistance for all ADL care needs and required a mechanical lift for transfers. On 12/27/24 at 1:30 PM, Witness 20 (Complainant) stated Resident 1 had concerns regarding long call light response times, which were 30 minutes or longer. Witness 20 stated the resident called him on multiple occasions when she/he was sitting in a wet and soiled brief. Witness 20 stated ongoing concerns with staffing and long call light response times dated back to July 2024. On 12/30/24 at 12:32 PM, Staff 12 (CNA) and at 3:35 PM, Staff 13 (CNA) stated the resident was dependent on ADL care needs and had concerns with not enough staff to answer call lights. Staff 12 stated Resident 1 sat in wet and soiled briefs for 20 minutes or longer on more than one occasion. On 12/30/24 at 3:53 PM, Resident 1 was observed in bed. Resident 1 stated the facility did not have enough CNAs, which was a concern since the beginning of summer and continued to be an issue. Resident 1 stated call lights were long, at times up to 30 plus minutes. Resident 1 further stated she/he sat in a wet and soiled brief on multiple occasions. On 1/6/25 at 1:48 PM, Staff 11 (LPN-Resident Care Manager) stated Resident 1 had concerns of long call light wait times, since the summer months and was due to being short staffed. On 1/6/25 at 5:22 PM, Staff 1 (Administrator) and Staff 2 (DNS) stated they were aware of call lights being a concern and it was an ongoing issue. Staff 1 and Staff 2 stated all staff were responsible for answering call lights in a timely manner. Staff 1 and Staff 2 acknowledged the facility struggled with appropriate CNA staffing ratios. 2. Resident 2 was admitted to the facility in 2024 with diagnoses including a stroke and depression. A care plan dated 6/28/24, and revised on 7/13/24, revealed Resident 2 was on a toileting program due to mixed bowel and bladder incontinence. Resident 2 required one-person assistance for all ADL care needs. (continued on next page)

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	385189	A. Building B. Wing	01/06/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/27/24 at 12:30 PM, Resident 2 indicated she/he needed assistance with toileting due to her/his left sided weakness. Resident 2 stated there were concerns with long call light response times and she/he had sat in a wet and soiled brief for 20 plus minutes once when she/he was first admitted and another episode towards the beginning of December 2024. Resident 2 stated long call light wait times were 20 to 30 plus minutes and was an ongoing concern. On 12/30/24 at 12:32 PM, Staff 12 (CNA) and on 12/31/24 at 2:13 PM, Staff 16 (CNA) stated Resident 2 required assistance with toileting but at times soiled herself/himself because of long call light response times. Staff 12 and Staff 16 stated long call light response times and being short staffed were an ongoing concern. On 12/31/24 at 9:45 AM, Staff 9 (LPN) stated Resident 2 concerns regarding long call light response times and had wet herself/himself on more than one occasion. Staff 9 stated the long call light response times were due to lack of staff which was an ongoing concern. On 1/6/25 at 5:22 PM Staff 1 (Administrator) and Staff 2 (DNS) stated they were aware of call lights being a concern and it was an ongoing issue. Staff 1 and Staff 2 stated all staff were responsible for answering call lights in a timely manner. Staff 1 and Staff 2 acknowledged the facility struggled with appropriate CNA staffing ratios. 3. Resident 3 was admitted to the facility in 2020 with diagnoses including morbid obesity and depression. A care plan dated 2/1/20, revealed Resident 3 was independent with transferring herself/himself in the room, utilized a bed side commode, and required one-person assistance with toileting hygiene. On 12/27/24 at 10:44 AM, and 1/2/25 at 11:20 AM, Resident 3 was observed sitting on the edge of her/his bed, well groomed. Resident 3 stated there were ongoing concerns with long call light wait times and the facility was short staffed from July 2024 to present. Resident 3 stated she/he could get onto the bedside commode herself/himself but needed assistance with wiping. Resident 3 stated she/he sat on the bedside commode for greater than 20 minutes to almost an hour without assistance, which occurred on more than one occasion and was very frustrating. On 12/30/24 from 11:00 AM, through 3:01 PM, Staff 22 (CNA), Staff 12 (CNA), and Staff 43 (CNA) were interviewed and stated Resident 3 needed assistance with wiping after she/he was on the bedside commode. Staff 22, Staff 12, and Staff 43 stated the resident sat on her/he bedside commode on multiple occasions for greater than 30 minutes. Staff 43 stated Resident 3 was frustrated and upset on those occasions because the bedside commode was uncomfortable. On 1/6/25 at 2:11 PM, Staff 11 (LPN-Resident Care Manager) stated he was aware Resident 3 had concerns with long call light wait times and sat on her/his bedside commode for extended periods of time due to being short staffed. Staff 11 stated call lights and staffing was an ongoing issue. On 1/6/25 at 5:22 PM, Staff 1 (Administrator) and Staff 2 (DNS) stated they were aware of call lights being a concern and it was an ongoing issue. Staff 1 and Staff 2 stated all staff were responsible for answering call lights in a timely manner. Staff 1 and Staff 2 acknowledged the facility struggled with appropriate CNA staffing ratios. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. Resident 13 was admitted to the facility in 2021 with diagnoses including a stroke and anxiety. A care plan dated 3/10/21, and revised on 12/5/24, revealed Resident 13 was frequently incontinent of urine. Staff were to assist Resident 13 with incontinent care after each episode. Resident 13 required substantial/maximum to dependent assistance with toileting hygiene. On 12/30/24 at 10:57 AM, and 1/2/25 at 12:30 PM, Resident 13 stated call light response times were terrible, CNAs passed by her/his room without answering the call lights, and took upwards of 40 minutes or longer. Resident 13 stated she/he sat in a wet brief on more than one occasion. Resident 13 stated every shift was terrible, but weekends were the worst. On 12/31/24 at 2:13 PM, Staff 16 (CNA) and on 1/3/25 at 2:13 PM, Staff 28 (CNA) were interviewed. Staff 16 and Staff 28 stated Resident 13 reported concerns with sitting in wet briefs on multiple occasions due to long call light response times of 20 to 30 minutes. Staff 16 and Staff 28 stated the resident was upset because it occurred on all shifts, but especially on the weekends. On 1/6/25 at 5:22 PM Staff 1 (Administrator) and Staff 2 (DNS) stated they were aware of call lights being a concern and it was an ongoing issue. Staff 1 and Staff 2 stated all staff were responsible for answering call lights in a timely manner. Staff 1 and Staff 2 acknowledged the facility struggled with appropriate CNA staffing ratios. 5. A review of the Direct Care Staff Daily Reports from 7/4/24 through 1/1/25 revealed state minimum bariatric CNA staffing requirements were not maintained for 74 of 90 days reviewed for staffing. On 12/27/24 the facility provided lists of residents who: -Required assistance with eating and were considered an aspiration risk: 13 -Required two-person assistance with transfers or mechanical lift: 35 -Required assistance with toileting: 41 -Residents who were incontinent: 52 -Residents who required behavioral healthcare needs: 9 -Residents who required bariatric healthcare needs: 10 Review of Resident Council Notes revealed the following concerns from 6/2024 through 12/2024: June 2024: Call lights were too long on evening shift. July 2024: Call lights response times were horrible especially on weekends. August 2024: Not enough staff on the weekends so terrible. Call light response times up to an hour wait. September 2024: Call light response time on swing shift were on average 30 to 45 minutes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	October 2024: Call light response time on evening shift were 40 plus minutes. Resident 3 utilized call light for assistance off her/his bedside commode and just waits because no CNAs come to assist her/him. November 2024: Long call light response times on evening and swing shift. Residents called out for CNAs and they walked by the room and ignored the residents' call lights. December 2024: Long call lights on evening shift and a resident waited 80 minutes for assistance. CNAs made excuses as to why they were unable to answer call lights timely. Showers were not completed at the scheduled time. Interviews with staff revealed the following: On 12/27/24 at 9:41 AM, Staff 23 (CNA) and at 11:00 AM, Staff 22 (CNA) both stated staffing was terrible. The facility was short staffed all the time since 7/2024 and continued to be a struggle. Staff 22 and Staff 23 stated call lights could be 45 minutes or longer, and residents sat in wet and soiled briefs on multiple occasions. Staff 22 and Staff 23 further stated there was high acuity residents, including bariatric residents, which took more time. Staff 23 and Staff 22 stated wet wipe and briefs were difficult to access, because those supplies were no longer stored in the linen closets and had to be requested and turned into Staff 2 (DNS), which took time away from resident care. On 12/30/24 at 12:32 PM, Staff 12 (CNA) and at 2:20 PM, Staff 21 (CNA), and at 3:35 PM, Staff 48 (CNA) were interviewed. Staff stated they worked on both floors and staffing was not great. Staff 12, Staff 21 and Staff 48 stated the facility was short staffed constantly, as far back as 7/2024 and continued to be short staffed. Both floors had high acuity residents, as well as bariatric residents. Staff 12, Staff 21 and Staff 48 stated residents complained constantly regarding long call light response times, which ranged from 30 to 40 minutes, and residents sat in wet and soiled briefs due to lack of staffing. Staff 12, Staff 21 and Staff 48 stated the linen closets no longer had wet wipes or briefs and they had to request for additional wet wipes when running low or out and request more briefs, which at times made it difficult to provide timely care because CNAs had to turn in a form to Staff 2 (DNS) to receive the supplies, which resulted in longer call light wait times. Staff 12, Staff 21, and Staff 48 stated at times it was difficult to assist with getting residents up timely for meals and showers. Staff 12, Staff 21 and Staff 48 stated the facility was constantly short staffed, management was aware, and weekends were awful. On 12/31/24 at 9:45 AM Witness 23 (Complainant) stated the facility was constantly short staff dating back to 7/2024 and continued struggling to meet the acuity of residents in the building. Witness 23 stated call lights were greater than 25 to 30 minutes at times, depending on how short staffed the facility was. Witness 23 stated residents were very upset regarding lack of care and sitting in soiled briefs. Staff 23 further stated CNAs had to request wet wipes and brief supplies which slowed staff down because CNAs were to turn in a form to Staff 2 before acquiring more wet wipes or briefs. If Staff 2 was not available, the nursing staff had to access the supply room to retrieve more briefs for residents which took away from resident care. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/31/24 at 2:13 PM, Staff 16 (CNA) stated he worked on both floors and the lack of staffing went back to during the summer months, and was ongoing. Staff 16 stated the facility was constantly short staffed and call light response times were 15 minutes on a good day. Staff 16 stated residents complained of sitting in wet and soiled briefs and were very upset about lack of staff. Staff 16 stated the summer months were worse. On 1/2/25 at 10:00 AM, Staff 6 (RN) stated the facility struggled with staffing since 7/2024 and it was an ongoing concern. Staff 6 stated call light response times were long, and residents were very upset regarding call light response times. Staff 6 indicated it was difficult for her at times with CNAs not having access to wet wipes or briefs. If a CNA ran out of wet wipes and briefs, they completed a form and turned the form into Staff 2, to receive more supplies. If Staff 2 was not available, she would be responsible to retrieve more briefs from central supply for CNAs, which took time away from her resident care. Staff 6 stated she had never experienced anything like this. On 1/2/25 at 2:03 PM, Staff 19 (CNA) stated being short staffed and long call light response times were an ongoing issue as far back as 7/2024. Staff 19 stated residents sat in wet and soiled briefs for 30 minutes or longer due to being short staffed. Staff 19 stated many residents required two-person assistance or were dependent on ADL care. Staff 19 further stated residents were very upset regarding lack of care being provided. Staff 19 stated management was aware but it continued to be an issue. On 1/6/25 at 5:22 PM, Staff 1 (Administrator) and Staff 2 (DNS) stated they were aware CNA staffing shortages dating back to 7/2024 and they continued to work on hiring more CNAs and meeting the appropriate ratios. Staff 1 and Staff 2 acknowledged there were concerns regarding call light response times. Staff 1 and Staff 2 stated all staff were responsible for answering call lights in a timely manner.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 36494 Based on observation, interview, and record review it was determined the facility failed to ensure residents food preferences were honored for 1 of 3 sampled resident (#3) reviewed for food. This placed residents at risk for food lessened quality of life. Findings include: Resident 3 was admitted to the facility in 2020 with diagnoses including morbid obesity and diabetes. A 12/27/24 meal ticket revealed Resident 3 ordered barbecue country ribs, scalloped potatoes, mixed vegetables, fruit salad, two strawberry kiwi juices and two diet lemon sodas. On 12/27/24 at 12:21 PM, Resident 3 was observed eating lunch in her/his room and the meal consisted of barbecue country ribs, scalloped potatoes, and mixed vegetables. The resident received one strawberry kiwi juice and one diet lemon lime soda. There was only one beverage each and no fruit salad delivered with the meal. On 12/27/24 at 12:25 PM, Resident 3 stated she/he did not receive what she/he requested which occurred often. Staff 12 (CNA) was present and acknowledged the resident did not receive what she/he requested, and which was a common occurrence. On 12/31/24 at 8:14 AM, Staff 12 (CNA) delivered Resident 3's breakfast which included a Belgian waffle with syrup, oatmeal, Canadian bacon, scrambled eggs, coffee and one milk. Nothing on the meal ticket was circled and Resident 3 stated she/he did not order any of the breakfast items because the resident was never given the menu on 12/30/24 to be completed. Staff 12 confirmed this happened often because residents were not always given menus the day before. On 12/31/24 at 8:25 AM, Staff 12 stated Resident 3's preferences were often not honored. The resident liked to receive two bowls of Cheerios, a yogurt, and a cup of hot chocolate. On 12/21/24 at 1:26 PM, Staff 25 (Dietary Manager) stated CNAs were responsible to ensure residents completed menus for the next day's meal and turn the menu selection in the day before to ensure residents' preferences were honored. Staff 25 stated she was not aware Resident 3 did not receive what she/he ordered on 12/27/24. Staff 25 stated when a menu selection was not submitted, residents received whatever printed out on the meal ticket. Staff 25 acknowledged she was unaware of Resident 3's preference because she was new to the position and was learning the dietary meal ticket system on the computer.