STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505099	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spokane Valley Health and Rehabilitation of Cascad	East 17121 Eighth Avenue Spokane Valley, WA 99016

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (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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(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 - Few	Based on observation, interview, and record review, the facility failed to consistently provide bathing/showers for 3 of 6 sampled residents (4, 68, 88) reviewed for activities of daily living (ADLS). This failure placed the residents at risk for a diminished quality of life and unmet care needs. Findings included .<Resident 4>The 09/19/2025 quarterly assessment documented Resident 4 was cognitively intact to make decisions regarding their care and required assistance from nursing staff to complete activities of daily living (ADLS) such as bathing. On 09/29/2025 at 8:48 AM, Resident 4 was observed in their room. During conversation with the resident, they stated it had been a couple of weeks since they were last bathed, and they did not know why they were not getting bathed. Review of the ADL care plan documented Resident 4 needed assistance to bathe from one nursing staff. Interventions implemented on 03/19/2024 instructed nursing staff to bathe the resident twice a week and as needed, and to provide a bed bath when the resident refused or was unable to tolerate being bathed. Review of the Documentation Summary Reports from 09/01/2025 through 11/18/2025 documented the following: - Resident 4 was bathed on 09/03/2025, and was not bathed until a week later on 09/10/2025. Bathing occurred again on 09/13/2025 and 09/17/2025, but the next bath was not provided until 10 days later on 09/27/2025. - Resident 4 was next bathed 28 days later on 10/25/2025. The only other documented bath occurred on 10/29/2025. Documentation showed the resident had been bathed twice for the month of October.- Resident 4 was bathed 11/05/2025, a period of seven days from their last bath on 10/29/2025. Review of the progress notes from the same time period found no documentation that Resident 4 had refused to bathe, nor was there documentation that stated the resident was not being bathed or reasons provided for the lack of bathing. <Resident 68>The 10/03/2025 quarterly assessment documented Resident 68 was cognitively intact to make decisions regarding their care and required assistance from nursing staff to complete activities of daily living (ADLS) such as bathing. In addition, the assessment documented Resident 68 was not bathed during the seven-day time frame of the assessment. On 09/25/2025 at 1:30 PM, Resident 68 was observed sitting at the edge of their bed. When asked if they had any concerns about their care, Resident 68 stated they were supposed to be bathed twice a week, and it wasn't happening because there wasn't enough staff. A review on 11/18/2025 of the ADL care plan documented interventions were implemented on 03/27/2025 which informed nursing staff Resident 68 needed assistance from one nursing staff to bathe, was to be bathed on Wednesdays and Saturdays, and when the resident refused or was unable to tolerate being bathed, a bed bath was to be provided. A review of the Documentation Summary Reports from 09/01/2025 through 11/18/2025 documented the following: - Resident 68 was bathed on 09/08/2025 and 09/11/2025, and was not bathed again until 09/25/2025, a period of 14 days. For the month of September 2025, Resident 68 was bathed a total of four times. - Resident 68 was bathed on 10/25/2025, a period of 30 days from the last documented shower on 09/25/2025 and had refused to be bathed on 10/29/2025. No other documentation was found that showed Resident 68 had been offered a bed bath after refusing to be bathed as instructed in the care plan. - Resident 68 was bathed on 11/05/2025, 10 days from the last shower on 10/25/2025. Documentation showed the resident refused to be bathed on 11/08/2025, however, no documentation was found that showed Resident 68 had been offered a bed bath. <Resident 88>The 09/23/2025 quarterly assessment documented Resident 88 was cognitively intact to make decisions regarding their care, and needed assistance from one nursing staff for bathing. In addition, the assessment documented the resident had not been bathed during the seven days of the assessment period. During a resident interview on 09/25/2025 at 3:17 PM, Resident 88 stated he wanted to stay clean, was scheduled to be bathed on Tuesdays and Fridays, but was not getting showered regularly. Resident 88 further stated they were bathed Friday (09/19/2025), and the last shower prior to that had been three weeks ago. Review of the ADL care plan documented interventions related to bathing were implemented on 03/17/2025 and informed nursing staff that Resident 88 preferred to be bathed twice a week, needed assistance from one nursing staff, and a bed bath was to be provided if bathing was refused or Resident 88 was unable to tolerate being bathed.Review of the Documentation Summary Report from 09/01/2025 through 11/18/2025 documented the following:- Resident 88 was bathed on 09/02/2025, and was not bathed again until 09/16/2025, 14 days later. Bathing occurred on 09/19/2025 and 09/23/2025, but the next bath did not occur until a week later on 09/30/2025.- No documentation was found that showed Resident 88 had been bathed in October 2025.- Resident 88 was bathed 11/04/2025, a period of 34 days after last being bathed, and at the time of the review, the last documented bath occurred on 11/11/2025

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to fully assess and implement orders and interventions, monitored a change in condition for 4 of 9 sampled residents (Residents 7, 24, 6 and 51) whose records were reviewed for quality of care. This failure placed residents at risk of medical complications, discomfort and a decreased quality of life. Findings included . <Resident 51> Review of Resident 51's medical record showed the resident had a bowel movement (BM) on [DATE], and not again until [DATE], a span of six days with no BM. Review of Resident 51's medical record showed the resident had a BM on [DATE] and not again until [DATE], a span of five days with no BM. Review of Resident 51's medical record showed the resident had a BM on [DATE] and not again until [DATE], a span of six days with no BM. Review of a [DATE] progress note showed Resident 51, is complaining of constipation, looked over B&B (bowel and bladder record) and [they have] not had a BM documented since 9-9 2025 [a span of 11 days]. The note showed the nurse asked the aide to take the resident to their room to administer an enema. Review of the [DATE] Medication Administration Record showed no documentation the staff administered the enema on [DATE]. Review of a [DATE] progress note showed Resident 51 experienced a fall on their way to the bathroom. The note showed Resident 51 was found sitting in front of their bathroom and Resident was concern [sic] of being constipated. The note showed the nurse gave the resident MOM (Milk of Magnesia, a laxative) and encouraged fluids. Review of the [DATE] MAR showed the MOM administration was ineffective. Review of a [DATE] Secure Conversations progress note showed the doctor gave an order for the staff to administer, dulcolax [a stool softener] rectally daily as needed for constipation. The progress note showed the staff addressed the provider's order on [DATE], two days later, and informed the provider that Resident 51 was transferred to the hospital on [DATE] (after two falls) and Does not appear these orders were processed prior to resident going OOF [out of facility]. Review of the [DATE] MAR showed no documentation the provider's [DATE] order to administer the Dulcolax suppository was implemented. Review of the [DATE] MAR showed various medications available for administration to relieve constipation or facilitate a BM: - Polyethylene Glycol by mouth if no BM in 24 hours: The MAR showed it was only administered as given on [DATE] and was ineffective. - Milk of Magnesia Suspension orally as needed for no BM for two days. If no results within 24 hours, see Dulcolax Suppository order: The MAR showed no documentation it was administered for the month of [DATE] until [DATE] and it was ineffective. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Dulcolax Suppository rectally as needed if no results from MOM. If no results in 24 hours, see Fleets Enema order: The MAR showed no documentation it was administered for the review period of [DATE] to [DATE]. - Fleet Enema as needed if no results from MOM and subsequent Dulcolax suppository. Complete bowel assessment and notify the doctor if no results: The MAR showed no documentation it was administered for the review period of [DATE] to [DATE]. The above findings were shared with Staff B, Director of Nursing, on [DATE] at 9:22 AM. Staff B acknowledged the staff did not but should have documented the administration of the enema on [DATE] and implemented available as needed orders to address bouts of no documented BM as required. Staff B acknowledged the staff did not implement the provider order to administer the Dulcolax suppository when ordered on [DATE]. When asked why the facility took two days to recognize the [DATE] provider order, Staff B stated, Normally, the nurse managers process the orders. They're not here on the weekends. According to the American Red Cross (a nonprofit humanitarian organization that offers services like domestic disaster relief, blood services, and health/safety training like CPR [Cardiopulmonary Resuscitation, an emergency lifesaving procedure performed when the heart stops beating] and First Aid), a level of less than 85 percent (%) oxygen saturation is considered severe hypoxia. Severe hypoxia is a condition where the body's tissues do not receive enough oxygen and can lead to organ damage and confusion. It is a life-threatening medical emergency that requires immediate attention. Review of a [DATE] at 12:41 PM progress note showed Resident 51 vomited in the dining room at lunch time. The staff obtained vital signs and assessed an oxygen saturation level of 80%. A subsequent note at 2:18 PM showed the nurse called the provider who instructed the nurse to put oxygen on resident to bring up oxygen stats [sic]. Another note showed the resident fell at 2:35 PM and the nurse obtained an oxygen saturation level of 96%. The resident was transferred to the hospital after a second fall on [DATE] at 12:53 AM. Review of an Oxygen Saturation Summary and the remaining medical record showed no documentation the nurse obtained, documented, or monitored Resident 51's oxygen saturation level or their respiratory rate and heart rate on [DATE] from 12:41 PM until 2:35 PM (when the resident fell). Review of the [DATE] MAR showed no orders for the delivery of oxygen as documented in the [DATE] note to put oxygen on resident. Review of the remaining medical record showed no documentation the nurse administered oxygen to Resident 51, how much oxygen was given, and method of delivery. The above findings were shared with Staff B on [DATE] at 9:22 AM. Staff B acknowledged the medical record did not show the nurse frequently monitored Resident 51's oxygen saturation level after identifying it was at a dangerously low level. Staff B stated, Our standing [doctor's] order is to place oxygen with a saturation level below 88%. Staff B acknowledged the medical record showed no documentation the nurse implemented the provider's order to administer oxygen when directed. <Resident 7> (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a comprehensive assessment dated [DATE], Resident 7 had diagnoses of lung disease, pneumonia, and respiratory failure. They were alert and able to make their needs known. Resident 7 was totally dependent on staff for repositioning, toileting, and was always incontinent of their bowels. Review of the bowel task record from [DATE] through [DATE], showed that the resident had a bowel movement (BM) on [DATE]. There were no BM's documented until [DATE], 12 days later. Review of the [DATE] MAR showed the resident had three medications scheduled daily for their bowels. Additionally, the resident had the following medications that could be given PRN (as needed) for constipation: 1) An [DATE] order for Milk of Magnesia (MOM, a liquid laxative), give 1 dose by mouth as needed for No BM for 72 hours. If no results within 24 hours, see Dulcolax suppository order. 2) An [DATE] order for Dulcolax Suppository (a laxative given rectally), insert 1 suppository rectally as needed for bowel care, if no results from MOM. If no results in 24 hours, see Fleets Enema order. 3) An [DATE] order for Fleets Enema (a liquid laxative given rectally) insert 1 unit rectally as needed for bowel care if no results from MOM and subsequent Dulcolax suppository after 24 hours. Complete bowel assessment and notify MD if no results. Per the [DATE] MAR, a dose of MOM was given on [DATE] at 6:42 PM. The follow-up code documented results as unknown. No other doses of any PRN medications were given. Review of progress notes from [DATE] through [DATE] showed no documentation related to Resident 7 lack of BM's, nor any offers or refusals of prn bowel medications. In an interview on [DATE] at 10:14 AM, Staff C, Nursing Assistant (NA) stated that the NA's documented in the computer which residents had BM's. The nurse had a list of residents who did not have a BM to track. In an interview on [DATE] at 10:24 AM, Staff D, Licensed Practical Nurse, stated that the nurse managers run a report every morning that showed who was due for a BM, and gave that list to the floor nurse. In interviews with Staff E, NA on [DATE] at 9:10 AM and Staff F, NA on [DATE] at 9:19 AM, both stated that Resident 7 did not verbalize or indicate any signs of abdominal discomfort when they took care of them recently. In an interview on [DATE] at 12:29 PM, Staff B, Director of Nursing was informed of the documentation of no BM's from [DATE] until [DATE], PRN medications not given and lack of documentation about it. They stated that it was a long span of time and that should have been caught and followed up on. <Failure to Follow a Doctor's Order> <Resident 24> (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a [DATE] quarterly assessment showed Resident 24 re-admitted to the facility on [DATE] with medically complex conditions, including diabetes. The assessment showed Resident 24 was cognitively intact and received insulin and an anticoagulant (blood thinner). Review of a [DATE] Medication Administration Record (MAR) showed an [DATE] physician order that instructed the nurses to check Resident 24's blood sugars at mealtimes and administer insulin based on the blood sugar reading. The orders showed that if the blood sugar reading was between 350 and 399, the nurses must give five units of Novolog (a type of insulin) and call the provider. Review of the MAR showed blood sugar measurements of 394 on [DATE] at 8:00 AM and 355 on [DATE] at 12:00 PM. Review of the medical record showed no documentation the nurse notified the provider of the elevated blood sugars as ordered. Review of a [DATE] MAR showed an [DATE] physician order that instructed the nurses to check Resident 24's blood sugars at mealtimes and administer insulin based on blood sugar reading. The provider orders showed that if the blood sugar reading was between 350 and 399, the nurses must give five units of Novolog and call the provider. Review of the MAR showed blood sugar measurements of 388 on [DATE] at 5:00 PM. Review of the medical record showed no documentation the nurse notified the provider of the elevated blood sugar as ordered. The above findings were shared with Staff B, Director of Nursing, on [DATE] at 10:25 AM. Staff B acknowledged the medical record showed no documentation the nurses notified the provider of Resident 24's elevated blood sugars as ordered. <Resident 6> Review of a [DATE] quarterly assessment showed Resident 6 admitted to the facility on [DATE] with medically complex conditions, including high blood pressure and diabetes. The assessment showed Resident 6 was cognitively intact and received insulin. Review of a [DATE] MAR showed an order that instructed the staff to check Resident 6's blood sugar before meals and at bedtime since [DATE]. The MAR showed the staff obtained the blood sugars at bedtime only. The above findings were shared with Staff O, Resident Care Manager, on [DATE] at 12:32 PM. Staff O acknowledged the staff should have but did not obtain Resident 6's blood sugars as ordered by the provider. Review of a [DATE] MAR showed an order that instructed the nurses to give Resident 6 Lisinopril (a medication for high blood pressure) 2.5 milligrams (a measurement) in the morning. The MAR showed the nurse did not give the Lisinopril on [DATE] due to Vitals out of parameter and documented a blood pressure of 98/58. Review of the medical record showed no provider orders that directed the nurse when to hold the Lisinopril or that the nurse notified the provider of their action and obtained an order to hold the medication. The above findings were shared with Staff O on [DATE] at 12:29 PM. Staff O stated the nurse should have notified the provider of the low blood pressure and obtained an order to hold the Lisinopril or clarify the order to show hold parameters. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 24> Review of the [DATE] American Diabetes Association (ADA, an organization that funds research, advocates policy changes and access to care, and provides education and resources for patients, families, and healthcare professionals) article The Injection Technique Factor: What You Don't Know or Teach Can Make a Difference showed, insulin injections should be rotated to avoid repeat tissue trauma and prevent lipohypertrophy (a condition where fatty tissue develops hard lumps or pits, which impairs insulin absorption and leads to unpredictable blood sugar levels). Rotating sites allowed the fatty tissue to recover, ensured consistent insulin uptake and action, helped maintain stable glucose (sugar) control, and prevented injection site complications like scarring and pain. Review of a [DATE] progress note showed the provider saw Resident 24 for a routinely scheduled visit. The notes showed the provider documented the resident, has been having some bruising to [their] abdomen that is nonpainful, the resident was somewhat concerned about it, and was happening where the resident primarily receives [their] insulin injections. The notes showed the provider Discussed with nursing staff about using an alternative site and they state that they can use [the resident's] arm. Review of the [DATE] MAR showed scheduled insulin orders four times a day at 8:00 AM, 12:00 PM, 5:00 PM and bedtime. The MAR showed the nurses documented they administered the insulin injections to Resident 24's abdomen from [DATE] to [DATE]. Review of the medical record showed no documentation Resident 24 refused to have the insulin administered to other alternative sites. Review of the [DATE] MAR from [DATE] to [DATE] showed scheduled insulin orders four times a day at 8:00 AM, 12:00 PM, 5:00 PM and bedtime. The MAR showed the nurses documented they administered the insulin injections to the Resident 24's abdomen except once (on [DATE] to the right arm). Review of the medical record showed no documentation Resident 24 refused to have the insulin administered to other alternative sites. The above findings were shared with Staff B on [DATE] at 10:39 AM. Staff B acknowledged the medical record showed the nurses continued to use the abdomen as the site for insulin injections despite previous discussion with the provider to rotate or use alternative injection sites to prevent trauma to the abdomen. <Resident 24> Review of a [DATE] progress note showed the nurse trimmed Resident 24's right foot toenails. Review of the physician orders showed an order dated [DATE] that instructed the staff to provide nail and foot care every Saturday. Review of a [DATE] Skin Inspection Note showed, skin assessment head to toe completed upon admission. No skin issues noted. Review of a [DATE], [DATE], and [DATE] Skin Inspection notes showed, no new skin issues. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a [DATE] progress note showed Resident 24, has been complaining about rt [right] big toenail . for 6 weeks. It's in the drs [doctor's] book x3 [three times]. The note showed the nurse assessed, redness is going up from the toenail approx 14 cm [centimeters, a measurement] and blister has developed on front of toe. The note showed the nurse then called the provider who prescribed a topical antibiotic for the diagnosis of paronychia, a nail inflammation that may result from trauma, irritation or infection. Review of the medical record showed no documentation the staff monitored Resident 24's right big toenail, including an initial assessment, preceding the [DATE] progress note. The medical record showed no documentation the staff escalated the persistent concern of the right big toenail when it was not addressed the first time in the provider communication book. The above findings were shared with Staff B on [DATE] at 10:45 AM. Staff B stated, I will find information, when asked if the medical record showed the staff monitored and promptly addressed Resident 24's change in condition preceding [DATE]. No further information was provided. <Failure To Clarify a Physician's Order> A [DATE] facility policy titled Intravenous (IV, by vein) Therapy showed, any IV order was accurately transcribed to the appropriate forms and documented in the resident's medical record. According to a quarterly assessment dated [DATE], Resident 7 had diagnoses of lung disease, diabetes, and hypotension (low blood pressure). They were alert and able to make their needs known. In an interview on [DATE] at 11:34 AM, Resident 7 was observed in their room. They had an IV saline lock (A tube inserted into a vein that does not have fluid running through it. Nurses periodically flushed with saline solution to prevent blockage) in their right wrist. Resident 7 stated that it was placed about a week ago to get IV fluids because they were dehydrated. They further clarified that they only needed fluids one time, and it had not been used since. A review of Resident 7's orders included a [DATE] order to insert an IV catheter to administer fluids, for one time only. This order was signed as completed at [DATE] at 11:03 PM on the [DATE] Treatment Administration Record (TAR). Another [DATE] order instructed the nurses to follow facility IV policy for flushing and site maintenance. This order was not found on the September TAR or MAR. During an interview on [DATE] at 10:24 AM, Staff D, Licensed Practical Nurse, stated that routine care of an IV catheter included flushing it every shift to make sure it did not get clogged. The saline flushes were documented on the MAR. During an interview on [DATE] at 11:31 AM, Staff G, Assistant Director of Nursing, stated that an IV should be flushed every shift if not in use, or the IV line could clog and not be usable. When Staff G reviewed Resident 7's September MAR, they acknowledged there was no order that instructed the staff to document saline flushes every shift and there should have been, and the facility did not follow their policy and the provider order for flushing the IV catheter. Reference WAC 388-97-1060(1)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to ensure sufficient staff were available to meet the care needs for 3 of 6 sampled residents (Residents 4, 68, 88) reviewed for activities of daily living for dependent residents, and 4 of 4 sampled residents (Residents 49, 68, 82, and 88) reviewed for restorative nursing (interventions that promote a resident's ability to adapt and adjust to living as independently and safely as possible). Failure to ensure there was adequate nursing staff available to provide bathing and restorative services placed the residents at risk for unmet care needs, a diminished quality of life. Findings included . <Resident Council>During a Resident Council meeting on 09/30/2025 at 1:28 PM, attendees were asked if care and assistance was provided timely, without having to wait a long time. All residents in attendance (Residents 18, 20, 24, 5, 35, 41, 11, 6, 47, 75, and 91) stated they often had to wait for assistance because there wasn't enough staff. Resident 24 stated they had even used their cell phone to call the facility in an attempt to get care because their call light was not being answered, and even after the call was made, they waited another 10 to 15 minutes longer before assistance was provided. Resident 24 then stated that last weekend they were not bathed because there wasn't enough staff. All residents agreed with Resident 24 that showers were not being provided, sometimes you had to wait days to get bathed, and one resident had not been bathed in two weeks. <Resident Observations and Interviews>On 09/25/2025 at 10:32 AM Resident 32 stated there are many days were the facility was short staffed, and they have had to wait an hour for a bedpan and then 55 minutes to be assisted off of it. Resident 32 stated concern had been expressed to administration, and the response was that the facility was not understaffed, but if they are not understaffed, then they are understaffed for the care we need. On 09/25/2025 at 12:54 PM, Resident 4 stated sometimes they had to wait as long as 45 minutes to get assistance at night to the bathroom. On 09/25/2025 at 1:03 PM, Resident 99 stated it was difficult sometimes at night to be assisted to the bathroom, and they soiled the bed one night because of it. On 09/25/2025 at 1:50 PM, Resident 68 was observed sitting at the edge of their bed, their right hand was visibly contracted, with the resident being unable to open or extend their fingers. When asked if the facility a provided restorative program for their hand, Resident 68 stated no. On 09/25/2025 at 3:21 PM Resident 88 stated they wait a long time for their call light to be answered and they aren't being bathed.<Interviews>In an interview on 11/21/2025 at 11:39 AM, Staff EE, Human Resource Director, stated there were two nursing assistants assigned to both Berryway and Morningside units and the nursing assistants on those units were responsible to provide the bathing for their residents. Staff EE stated when the concern about residents not being bathed was expressed, the decision was made to pull one of the nursing assistants to do the bathing for the residents for both units, and the three remaining nursing assistants would then provide the resident care. This was implemented on 11/05/2025 and the next day it was determined that it was not effective, and each nursing assistant was again responsible for providing the bathing for their assigned residents. Staff EE stated staff were now being written up for not completing showers, and some staff have put in their notice of resignation because of it. Staff EE stated the issue was more a lack of not enough staff to complete the bathing, rather than staff just choosing not to do the care. In an interview on 11/21/2025 at 7:00 AM, Staff P, Licensed Practical Nurse, stated there was not enough nursing assistants to complete showers consistently. In an interview on 11/24/2025 at 11:18 AM, Staff FF, Staffing Coordinator, stated staffing was based on resident census and currently for day and evening shifts, eight nursing assistants were scheduled for each unit, and five nursing assistants were scheduled for the entire building at night. Staff FF stated each resident care manager had a radio and staff were able to call for assistance if needed. At 11:52 AM during the continued interview related to staffing, Staff FF stated Staff Y, restorative aide, would also be pulled to work the floor if needed. When informed there were concerns also with restorative services not being provided, Staff FF stated they were not aware. In an interview on 11/24/2025 from 12:07 PM to 12:25 PM with Staff A, Administrator and Staff B, Director of Nursing, concerns were expressed with the facility not having adequate staff to complete bathing and restorative services. Staff A stated staffing needs were based on resident census and the facility always referred to the State minimum requirements. Both Staff A and Staff B acknowledged there had been issues with residents not being bathed, but believed that there was adequate nursing staff to complete and it was a matter of disciplinary action. When informed that restorative services were not being completed due to the restorative aide being pulled to work the floor, neither Staff A nor Staff B stated they were aware. Please see F677 ADL care for Dependent Residents and F688 Increase/Prevent