STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105376	A. BUILDING _____ B. WING _____	09/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WEST MELBOURNE HEALTH & REHABILITATION CENTER	2125 WEST NEW HAVEN AVE WEST MELBOURNE, FL 32904

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 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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 10 rooms on 2 of 4 units (Unit A: A123, A126, A127, A128, A105, A107, A108, A110; and Unit C: C309 & C315) for a total of 95 rooms in use; for 3 of 4 nurses' stations on 3 of 4 units (Unit A, Unit B, and Unit C); and for 1 of 4 medication rooms, (Unit A). Findings: 1. On 09/15/2020 at 11 AM, room A123 was observed to have privacy curtains between bed A and bed B. The privacy curtain was missing two hooks that attached to the ceilings metal curtain partition track. On 09/15/2020 at 11:10 AM, room A126 was observed to have multiple 1-2 feet gouges into the white painted drywall located behind the headboard of bed A. The wall located to the right of the window was painted a brown color and had multiple white paint scuff marks on it, about 6 to 12 long. The lighter brown colored wall located at the end of the beds with the dressers also had multiple white paint scuff marks on them, approximately 4 to 8 in length. The scuffed paint marks were on the wall at approximately the height of a wheelchair. On 9/15/2020 at 11:40 A, room A127 was observed to have multiple gouge marks in the white painted drywall located on the wall past the door entrance to the right, on the bathroom door, and throughout the room. The gouge marks were between 6 to 2 feet long at the height of a wheelchair. On 9/15/2020 at 12 PM, room A128's bathroom was observed to have a speckled brown and gray residue on the base of the toilet. On 9/16/2020 at 3:15 PM, continued observation of room A128's bathroom toilet revealed that the same speckled brown and gray residue remained on the base of the toilet. This was validated by housekeeping supervisor on 9/19/2020 at 9:45 AM. On 9/16/20 at 3:15 PM, room A128's flooring that was located directly beneath the air conditioning (AC) wall unit by bed B had a rusty colored residue on it. Upon closer inspection, there was a metal trim around the AC unit that was flush to the wall. The right and left lower corners of the metal trim were rusted directly above where the colored residue was found. On 9/17/2020 at 5:50 PM, observation of rooms A123, A126, and A127 were conducted with the maintenance director and housekeeping director. Both validated the above maintenance and housekeeping concerns. Room A128's housekeeping and maintenance concerns were validated on 9/19/2020 at 11:35 AM. On 9/19/2020 at 10 AM, observation of the facility's 3 nurses' stations and their attached bathrooms were observed with the maintenance director and executive director. Unit A's nurses' station revealed multiple black spots on the floor beneath the rolling chairs. The nurses' station counter tops where nurses sat to answer phones, conduct paperwork, and use a computer was made of a purplish colored laminate. The approximate one inch edge of the counter was intermittently broken off in jagged shaped edges. The administrator validated the broken laminate edges. The floors underneath the counter tops where the nurses sat had a gray and black residue on them that extended the back wall underneath the countertop. The return air conditioning ventilation grate located on the ceiling above the nurses' station was metal. It was rusty gray and black in color. The administrator and maintenance director said it was old and validated that it needed to be replaced. Observation of unit A's medication room revealed a double door cabinet located beneath the sink. The left cabinet door was hanging down about two to three inches. The left side hinge was not stable and both cabinet door handles were held together with rubber bands for closure. The wall where the medication/treatment cart was parked had a gouge in the white paint at the height of the cart that was approximately 3 feet long and 1/2 deep in the middle of the gouge line. The administrator and maintenance director validated the broken cabinet doors and gouged wall. The administrator said that cabinet doors below these sinks were supposed to be screwed shut and the screws must have come loose. Observation of the B unit nurses' station revealed that it had the same purplish color laminate on the desk and countertops as unit A. The edges of the counter top where the nurses sat also had broken pieces of laminate interspersed throughout the edge of the countertop. Both B and C unit nurses' stations revealed gray and black residue underneath the counter and desk area. The residue extended the back of the wall about 6-12 inches. The floor corners underneath the nurses' station desk also had large amounts of gray and black residue. The B and C unit nurses' station bathroom toilets both had dark brown and black residue at their base. The administrator stated the nurses' stations and bathrooms could be cleaner and the broken laminate edges of the nurses' desk area could potentially be repaired as not to be a hazard. 2. On 9/15/20 at 2:10 PM, water was observed dripping from the air conditioning (AC) vent in the ceiling on the front hallway of the C Wing. A black substance and water marks were noted on the ceiling tiles around the vent. Water marks were also observed on 2 ceiling tiles above the C Wing unit manager's office doorway and on 2 ceiling tiles above the television in the hallway. There were broken and missing ceramic tiles on the front and side walls of the nurses' station facing 2 hallways. On 9/16/20 at 11:01 AM, the black substance and watermarked tiles around the AC vent in the ceiling were unchanged. Another vent above the C Wing nurses' station had a black substance on the surrounding ceiling tiles and there was evidence of moisture on the ceiling tiles. The white metal vent had scattered black and rusted areas. Water was observed dripping from the AC vent onto Licensed Practical Nurse (LPN) P who sat at a computer at the desk. On 9/17/20 at 7:37 AM, damaged walls about 6 inches above floor level, were observed in room [ROOM NUMBER]'s bathroom. A deep horizontal gouge, approximately 12 inches long, was noted under a toilet paper holder. There was a scratched and scuffed area approximately 24 inches long, parallel to the floor, on the opposite wall under the grab bar beside the toilet. On 9/17/20 at 7:41 AM, approximately 8 vertical scratches and gouges of different depths, between 12 and 24 inches long, were observed on the wall behind bed A's headboard in room [ROOM NUMBER]. On 9/17/20 at 8:41 AM, the C Wing UM stated she was aware there were wet areas on the ceiling tiles in the hallways and above the nurses' station, and that water dripped from the AC vents to the floor. She explained the situation had existed for at least the last 2 weeks since she assumed the position of UM. The C Wing UM recalled water from the AC vent dripped on her on one occasion when she was seated at the nurses' station. She explained maintenance staff knew about the dripping from the AC vents and the wet, stained ceiling tiles as these issues were discussed regularly in daily meetings with all managers. She stated managers were assigned specific areas on every unit and they should report concerns such as safety issues, broken items and damaged walls and ceilings. The C Wing UM stated maintenance staff replaced some ceiling tiles on 9/15/20 in the afternoon, after the survey team initially toured the C Wing. She said, They attempt to stay on top of replacing wet tiles, but they are usually showing watermarks within 24 hours. Observation of the front wall of the nurses' station with the C Wing UM revealed a long strip of duct tape had been placed to secure a previously missing wall tile. She described the broken tiles and duct tape as not appealing. The C Wing UM stated she did not want the residents' home to have this appearance, and acknowledged it was not a homelike environment. On 9/18/20 at 10:13 AM, during a tour of the C Wing with the Maintenance Director, he validated the condition of the damaged walls in rooms [ROOM NUMBERS]. He stated these areas needed to be repaired but were currently not on his schedule. The Maintenance Director verified the damaged walls were easily visible to anyone who walked into the rooms. He stated he

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

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.

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F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) was also aware of the AC vents sweating and water damaged ceiling tiles. He stated it was not a homelike environment for residents. He stated the facility had a guardian angel program through which assigned staff monitored the facility's environment. The Maintenance Director stated the administrator would be able to answer questions about the program. 3. Observations conducted in room [ROOM NUMBER] on 09/15/20 at 1:30 PM, 3:07 PM and on 09/17/20 at 9:55 AM, 12 PM and 4:40 PM revealed a resident privacy curtain with multiple brown stains, the base of the bathroom sink faucet with a buildup of a hard white substance, brown stains at the base of the toilet and the safety handrail in the bathroom was covered with black stains. Observations conducted in room [ROOM NUMBER] on 09/15/20 at 2:20 PM and on 09/16/20 at 9:55 AM revealed the base of the bathroom sink faucet with a buildup of a hard white substance, brown stains at the base of the toilet, the safety hand rail in the bathroom was covered with black stains and a disposable razor with cover was on top of the paper towel dispenser. Observations conducted in room [ROOM NUMBER] on 09/15/20 at 3 PM, on 09/16/20 at 10:25 AM, 1:55 PM and on 09/17/20 at 5:05 PM revealed resident privacy curtain with multiple brown stains. Observations conducted in room [ROOM NUMBER] on 09/15/20 at 2:40 PM and on 09/17/20 at 11:15 AM and 4:40 PM showed the wall behind the head of the bed was gouged out and was missing paint. The toilet paper dispenser in the bathroom was hanging off the wall and there was a square cut out hole in the wall between the dressers which contained electrical wires and a light bulb. On 09/17/20 at 5:20 PM, observations of rooms 105, 107, 108 and 110 were conducted with the A wing unit manager (UM). She confirmed the finding and stated, The rooms do not look home-like, they need to be cleaned and fixed and razors are never to be kept in a resident's room for safety reasons. The UM explained that as part of her role as the unit manager she conducted resident room observations and the facility also had a program (guardian angel) where management staff were assigned to observe several resident rooms. The staff were required to meet with the residents and to observe the room and bathroom for any issues that needed to be fixed. We have a TELs maintenance system to document and notify the Maintenance Director or Housekeeping Manager of any issues requiring attention. On 09/17/20 at 5:20 PM, the Director of Nursing (DON) stated that any type of sharp such as a razor was not to be stored in a resident's room. If a resident needs a razor the Certified Nursing Assistant (CNA) would obtain the razor for the resident and then remove and discard the razor in the sharps container for safety reasons. On 09/17/20 at 5:35 PM, observations of rooms 105, 107, 108 and 110 were conducted with the Maintenance Director and the Housekeeping Manager. They confirmed the findings of soiled privacy curtains with brown stains in rooms [ROOM NUMBERS], the hard white build up on the base of the bathroom sink faucets in rooms [ROOM NUMBERS], brown stains at the base of the toilets in rooms [ROOM NUMBERS], black stains on the bathroom safety hand rails in rooms [ROOM NUMBERS] and in room [ROOM NUMBER] the gouges and missing paint on the wall, a hole in the wall with exposed wires and light bulb and the toilet paper dispenser hanging off the wall in the bathroom. The Housekeeping Manager stated it was the responsibility of the housekeeping staff to notify him with issues in resident rooms and bathrooms, soiled privacy curtains and broken items so they could be replaced. The Maintenance Director and Housekeeping Manager both stated the bathrooms were not home-like and needed to be cleaned and repaired. On 09/17/20 at 6:30 PM, the Administrator stated the facility had stopped the resident Guardian Angel program six months ago when the Coronavirus Disease 2019 (COVID-19) started. We are more focused on the COVID-19 care right now. Review of the policy, Personnel Qualifications and Delegation of Maintenance Duties, dated August 1, 2002, read, The facility's maintenance department is organized for the purpose of maintaining the facility, to protect the health and safety of residents, personnel and public
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessments accurately reflected prescribed medications for 17 of a total sample of 58 residents, (#15, 20, 23, 25, 32, 33, 34, 37, 46, 47, 53, 58, 66, 94, 133, 139, 441). Findings: 1. Resident #139's MDS quarterly assessment with assessment reference date (ARD) of 8/13/20, indicated she received anticoagulant medication on 7 of 7 days during the look back period. Review of resident #139's medical record revealed a physician's orders [REDACTED]. Drugs classified as anticoagulants or blood thinners are medications that hinder the clotting time of blood. Antiplatelet agents such as Aspirin and [MEDICATION NAME] prevent blood clots by inhibiting platelets from adhering to each other (Retrieved from www.merriam-webster.com on 9/25/20). On 9/18/20 at 11:02 AM, the MDS Licensed Practical Nurse (LPN) stated she completed Section N Medications on resident #139's quarterly assessment. She explained she reviewed the physician's orders [REDACTED]. On 9/18/20 at 11:10 AM, review of the RAI Version 3.0 Manual with the MDS Coordinator revealed instructions for section N0410E. Anticoagulant. It read, Do not code antiplatelet medications such as aspirin/extended release, [MEDICATION NAME], or [MEDICATION NAME] here. The manual revealed medications should be coded according to the medication's pharmacological classification, and not for how it is used. The MDS Coordinator stated Aspirin was not an anticoagulant, therefore resident #139's assessment was inaccurate. On 9/18/20 at 11:16 AM, the MDS LPN was asked to pull a report of all residents in the facility who had physicians' orders for Aspirin and/or [MEDICATION NAME]. Review of the report and comparison of physicians' orders with current MDS assessments revealed inaccuracies. 17 of the 55 residents with orders for antiplatelet agents had MDS assessments that indicated they received anticoagulant medications. 2. Resident #58 had a physician's orders [REDACTED]. 3. Resident #94 had a physician's orders [REDACTED]. 4. Resident #66 had a physician's orders [REDACTED]. 5. Resident #34 had a physician's orders [REDACTED]. 6. Resident #133 had a physician's orders [REDACTED]. 7. Resident #20 had a physician's orders [REDACTED]. 8. Resident #32 had a physician's orders [REDACTED]. 9. Resident #46 had a physician's orders [REDACTED]. 10. Resident #46 had a physician's orders [REDACTED]. 11. Resident #15 had a physician's orders [REDACTED]. 12. Resident #33 had a physician's orders [REDACTED]. 13. Resident #23 had a physician's orders [REDACTED]. 14. Resident #441 had a physician's orders [REDACTED]. 15. Resident #47 had a physician's orders [REDACTED]. 16. Resident #53 had a physician's orders [REDACTED]. 17. Resident #37 had a physician's orders [REDACTED]. On 9/19/20 at 11:52 AM, the MDS Coordinator validated the inaccuracies of the assessments reviewed. She explained the MDS assessment was the base of the care plan and an inaccurate assessment could cause an inaccurate care plan that did not meet residents' needs. The policy and procedure Resident Assessment Instrument (RAI) effective 10/29/15 revealed residents would be assessed to identify care needs and to develop an appropriate plan of care.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide nail care, dental care, hair care and showers for 3 of 8 sampled residents who required staff assistance with activities of daily living, of a total sample of 58 residents, (#69, #121, & #31). Findings: 1. Long term care resident #69 was admitted to the facility on [DATE]. She had [DIAGNOSES REDACTED]. Her 7/9/2020 quarterly Minimum Data Set (MDS) assessment included a Brief Interview Mental Status (BIMS) score of 9, which indicated moderately impaired cognition. She required supervision from staff for eating and required extensive assistance from one staff person for bathing, toileting, and personal hygiene. On Tuesday 9/15/2020 at 11:40 AM, resident #69 was observed to have both long, jagged nails and some short uneven nails on both hands. The long nails were jagged on the ends and had dark colored residue underneath them. The resident said she wore adult briefs and preferred a bed bath to a shower at this time. On Wednesday 09/16/2020 at 11:15 AM, resident #69's hands were observed to have some long jagged nails and some short uneven nails on both hands. The fingernails had dark and cream colored residue underneath them. The resident said she was looking for something with which to clean them. On Thursday 9/17/2020 at 3:15 PM, observation of resident #69's nails revealed they continued to be jagged and uneven with dark residue underneath them. Two of her fingernails on her left hand had broken down into the top of the nail bed. The resident said she had caught them on something and that it hurt when that happened. She said she wanted them trimmed but could not find her scissors. At 3:20 PM the resident's Certified Nursing Assistant (CNA)-A validated that the resident's fingernails needed to be trimmed and cleaned. She stated that her shower days were Wednesdays and Saturdays, on the 3-11 shift. She said that it was expected that nails be cleaned and trimmed during her shower time which was yesterday, (Wednesday). She said the resident preferred a bed bath to a shower but that she had not been assigned to care for the resident yesterday. At 3:30 PM, during an observation of resident #69's nails with the resident's nurse, licensed practical nurse (LPN)-E, and the resident's unit manager (UM), both validated that her nails needed to be trimmed and cleaned, and the physician would be notified for a treatment of [REDACTED]. At this time, review of Unit A's shower sheet with the UM and LPN-C validated that resident #69's

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F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) shower days were on Wednesdays and Saturdays in accordance with her room number. The bottom of the unit's shower schedule read, Shaving and Nail care should be done with shower and as needed (PRN). On 9/18/2020 at 12 PM, the Director of Nursing (DON) said that CNAs were expected to perform nail care during scheduled shower times and as needed. Review of resident #69's Activities of Daily Living (ADL) care plan, dated 3/10/17-11/28/2020, noted that she required staff assistance with bathing 2 times per week and as needed (PRN). Interventions included providing nail care with showers, as needed, and during activities as accepted by resident. 2. Long term care resident #121 was admitted to the facility on [DATE]. She went on hospice services on 8/29/2020. Her [DIAGNOSES REDACTED]. Her most recent MDS assessment dated [DATE] noted that she required extensive assistance from one staff person for eating, bathing, and personal hygiene which included oral care. Her BIMS score was noted as 0 which indicated severe cognitive impairment. On 09/15/20 at 10:15 AM , resident #121 was observed in bed with her eyes closed and mouth open. Her bottom teeth had a large amount of creamy whitish residue between them. On 9/16/2020 at 11:15 AM, resident #121 was observed in bed with her eyes closed. The left side of her lips were stuck together with a sticky residue. Her bottom teeth had a creamy whitish residue between them. On 9/17/2020 at about 3:45 PM, observation of resident #121's lips and mouth revealed that her bottom teeth continued to have the same type of sticky creamy whitish residue between them. At 3:50 PM, CNA-B said the resident's mouth and teeth needed to be cleaned. She added that she did not know the resident well as she worked on various units in the facility. At 3:55 PM, the Unit Manager validated the condition of the residents' mouth and teeth and said they needed to be cleaned. On 9/18/2020 at 12 PM, the Director of Nursing (DON) said that CNAs were expected to perform mouth care or teeth care at least twice a day, morning and evening. Review of resident # 121's ADL care plan dated 5/12/2017 to 10/30/20 included that staff need to assist resident with brushing her teeth and provide oral care. Review of the facility's undated policy, Brushing the Resident's Teeth included the following: Oral hygiene is provided to clean and freshen the resident's mouth ad teeth, lessen the potential for infections of the mouth or gums and to stimulate the gums and remove food particles from between the teeth .Oral hygiene is provided twice daily .or unless the resident desires more frequent hygiene. 3. Resident #31 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS significant change assessment with assessment reference date of 6/21/20 revealed resident #31 had clear speech, clear comprehension and made herself understood. The MDS assessment showed she could .express ideas and wants . and did not exhibit physical, verbal or other behavioral symptoms. The document revealed she did not .reject evaluation or care . that is necessary to achieve the resident's goals for health and well-being. Resident #31 required extensive assistance with bed mobility, transfers and personal hygiene, and physical help in part of bathing. She had limitation in range of motion on one side, in her upper and lower extremities. Review of resident #31's medical record revealed a care plan, initiated on 9/13/19, for assistance to complete activities of care safely. The interventions directed nursing staff to help resident #31 gather necessary items, take her to the bathing area and assist with her hair. The care plan indicated resident #31 should be bathed according to the schedule, twice weekly and as needed. Review of the C-Wing Showers schedule revealed resident #31 was to receive showers on Mondays and Thursdays during the 3:00 PM to 11:00 PM shift. On 9/16/20 at 10:47 AM, resident #31 had a large number of white flakes in her hair and on her scalp around the hairline. Resident #31 stated she used to be on the A wing where she received showers and had her hair washed regularly. She explained A Wing CNAs used to wash and comb her hair, then style it in a ponytail. Resident #31 stated she had been on the C Wing for over a month and had not yet received a shower or had her hair washed. She stated C Wing CNAs gave her sponge baths only, not full bed baths, that included only incontinence care and washing her face and underarms. Later that afternoon at 3:22 PM, resident #31 still had large white flakes visible in her hair and on her scalp. A white build-up was noted along her hairline above her face, and large white flakes had fallen to her forehead. On 9/17/20 at 7:36 AM, resident #31 stated she still had not received a shower or had her hair washed and reiterated the last time she had this care was on the A Wing. The condition of her hair remained the same. Resident #31 demonstrated how she scratched her scalp to get rid of the crusted build-up. As she scratched the top of her head and hairline vigorously, large white flakes fell to her forehead and onto her clothing. On 9/17/20 at 7:49 AM, the C Wing UM explained each resident received a minimum of 2 assigned showers every week, but they could have showers as often as they wanted. She pointed to the C-Wing Shower List 9/17/20 . Monday & Thursday 3-11 Shift form posted near the nurses' station. She explained CNAs were to sign the form after performing the task and nurses should also initial the form to verify. The form indicated resident #31 was scheduled to have a shower that afternoon. The following day, Friday 9/18/20 at 10:21 AM, the C Wing UM reviewed the shower list for the previous afternoon and confirmed there was no documentation of a shower for resident #31. She reviewed the assigned CNA's documentation in the electronic medical record and provided conflicting documentation that resident #31 received a Bath per schedule on 9/17/20. On 9/18/20 at 10:26 AM, resident #31 informed the C Wing UM she did not receive her scheduled shower or have her hair washed the previous afternoon. The C Wing UM validated there were crusted areas along resident #31's hairline and a significant number of flakes visible in her hair. Resident #31 informed the C Wing UM she wanted to have a shower and get her hair washed, but no one offered. She told the C Wing UM she had not received any showers or had her hair washed since she arrived on the C Wing. Resident #31 said, They took good care of me on A Wing. I got showers and they washed my hair over there. A few minutes later at 10:29 AM, the C Wing UM said, It made me feel sad. She stated her expectation was staff would follow the shower schedule, and if residents preferred, they could provide a full bed bath and wash their hair in bed. The C Wing UM was unable to provide any C-Wing Shower List forms completed by nursing staff to show showers were attempted or provided during the 6 week period resident #31 had been on the unit. On 9/18/20 at 11:39 AM, the DON stated CNAs were to provide showers according to the schedule. The DON said, If resident wants her hair to be washed, staff should be doing it. Review of nursing progress notes from August to September 2020 revealed resident #31 did not refuse showers or to have her hair washed. Review of the policy and procedure Bath - Shower or Tub effective 10/01/10 revealed the purpose Shower and tub baths promote cleanliness and comfort for the resident. The job description for Certified Nursing Assistant reviewed on 9/01/09 revealed a CNA was . continuously responsible for providing quality nursing care to residents. Essential job functions included providing individualized attention and personal care such as showers, shampoos and combing hair.