STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145420	A. BUILDING _____ B. WING _____	08/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRIDGEWAY SENIOR LIVING	111 EAST WASHINGTON BENSENVILLE, IL 60106

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** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide assistance with bathing, grooming and toileting for residents requiring extensive assistance with ADLs (Activities of Daily Living). This applies to 7 of 13 residents (R2, R3, R5, R8, R9, R10, R12) reviewed for the need for ADL assistance. The findings include: The following MDS (Minimum Data Sets) all show the following residents all require extensive assistance with bathing, dressing, personal hygiene and toilet use: R2 (MDS dated [DATE]) R3 (MDS dated [DATE]) R5 (MDS dated [DATE]) R8 (MDS dated [DATE]) R9 (MDS dated [DATE]) R10 (MDS dated [DATE] , 2020) R12 (MDS dated [DATE]). 1. On 8/12/20 at 9:10am, during initial tour of the facility, R8 and R10 were noted with visible, unshaven facial hair. On 8/12/20 at 9:15am, R2, R9, R10, R12 all had long fingernails with brown/black underneath their nail. 2. On 8/12/20 at 9:45am, R2 was taken from the dining area to her room for wound care. R2 was noted to have soiled her incontinence brief with bowel movement and urine. After V6 (Wound Care Nurse) performed the wound care dressing change, V6 was in the process of closing off R2's incontinence brief when V6 was prompted to R2's soiled incontinence brief and the need for incontinence care. 3. On 8/12/20 at 1:35pm, R3 was in bed. R3 was alert and oriented. R3 stated she was changed last at around 5:30am. R3 further stated the guy-referring to V16 (Certified Nursing Assistant, CNA) came to check around 10am but did not do anything. On 8/12/20 at 1:37pm, V16 was asked if he had changed R3's incontinence brief this shift, V16 stated no but that he checked on R3 around 10am. On opening R3's incontinence brief, R3 was noted with small bowel movement with lots of black/brown drainage from R3's excruciated buttocks. Review of R3's shower sheet showed R3 was not given bed bath on 8/12/20 and 8/15/20 as scheduled. R3's shower sheet showed R3 was given bed bath last on 8/8/20. On 8/16/20 at 12:50pm, V2 (Director of Nursing, DON) stated she was not sure why R3 did not receive bed baths as scheduled. 4. On 8/12/20 at 11am, R5 was seen in her recliner high chair in the dining area. R5's red sweat pant was noted to be bulged up in between her legs. At 11:02am, V7 (CNA) stated he was taking care of R5 and had just changed R5 at around 10am. R5 was wheeled back to her room. V7 put R5 on her right side to change her incontinence brief, R5 was noted to have two soiled incontinence briefs. When V7 was asked why R5 had two incontinence briefs on, V7 stated he has not changed R5 since the beginning of his shift (7am). V7 stated earlier he was not telling the truth about the time he changed R5. Review of facility's policy titled Shaving the Resident" with a revised date of March 2004 showed The purpose of this procedure is to promote cleanliness and to provide skin care. Review of facility's policy titled Giving a Bedbath with a revised date April 2007 showed The purpose of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review facility failed to follow physician order [REDACTED]. This applies to 4 of 5 residents (R2, R3, R6 and R7) reviewed for pressure ulcer in the sample of 13. The findings include: 1. R2's EHR showed R2 was originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R2's MDS (Minimum Data Set) dated 6/30/20 showed R2 with BIMS (brief interview for mental status) score of 3, which meant R2's cognition was severely impaired. R2's MDS showed R2 requires extensive assistance of one or two staff for bed mobility, transfer, dressing, toilet use and personal hygiene. R2's MDS showed R2 is always incontinent of bowel and bladder. R2's wound evaluation and management summary dated 8/7/20 showed R2 with Stage 3 pressure wound for at least 101 days duration. The summary also showed R2's wound size of 0.9 x 0.5 x 0.1 cm (centimeter) with moderate serous exudates, and 100% granulation tissue. R2's latest wound evaluation and management summary dated 8/14/20 showed R2 with stage 3 pressure wound for over 107 days duration. The summary also showed R2's wound size 0.8 x 0.4 x 0.1 cm, moderate serous exudates, 100% granulation tissue. R2's care plan with no initiation date showed R2 has stage 3 pressure ulcer to the sacrum and the interventions were to follow physician's orders [REDACTED]. R2's Treatment Administration Record (TAR) dated August 2020 showed to cleanse Right buttock with normal saline, and apply letospermum honey and cover with dry dressing On 8/12/20 at 9:45am, R2 was taken by V8 (Physical therapy assistant) from the unit dining area to her room for exercise. V6 (Wound Care Nurse) went into R2's room to perform the wound care dressing change. R2 was assisted from her wheelchair to bed. V6 removed R2's soiled incontinence brief sideways to expose R2's sacral wound. There was no dressing covering R2's wound. On 8/12/20 at 9:55am, V6 stated the dressing probably came off during incontinence care by nursing staff and should have been replaced. 2. R3's EHR showed R3 was originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R3's MDS dated [DATE] showed R3 with BIMS score of 15 which meant R3 was cognitively intact. R3's MDS showed R3 requires extensive assistance of one or two staff with bed mobility, dressing, and personal hygiene. The MDS showed R3 requires total dependence of two persons physical assist with transfer and toilet use. R3's MDS showed R3 with impairment on both sides of lower extremities. R3's record showed R3 with a indwelling catheter and was always incontinent of bowel. Review of R3's TAR dated 8/10/20 showed the following order: a) Left and right buttocks - clean with normal saline, apply [MEDICATION NAME] to both wound areas, cover with dry dressing every day shift for excoriation. R3's wound evaluation and management summary dated 8/14/20 showed R3 with stage 3 pressure wound for at least 3 days duration. The summary showed R2's wound size was 5.7 x 3.2 x 0.1 cm, moderate serosanguineous exudates. With new order to apply Leptospermum honey daily with gauze island dressing. On 8/12/20 at 1:35pm, R3 was in bed. R3 was alert and oriented. R3 stated she has not seen the wound care nurse for two weeks. On 8/12/20 at 1:37pm, V16 (CNA) came in to R3's room to perform incontinence care on R3. R3's buttocks was noted with excoriated skin. R3's incontinence brief was noted with brown/black drainage from the wound. There was no dressing on R3's sacral wounds as ordered. On 8/13/20 at 11:10am, V6 stated he was notified by V26 (Nurse) on 8/12/20 to take a look at R3's buttocks. There was no order for wound care after V6 was notified until 8/14/20 when R3 was seen by the wound physician. R3's progress note dated 8/13/20 at 10:24pm, showed V6 was again notified of R3's wound condition. 3. R6's EHR showed R6 was originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R6's MDS dated [DATE] showed R6's BIMS score of 3, which meant R6's cognition was severely impaired. R6's MDS showed R6 requires extensive assistance of one or two staff with bed mobility, transfer, dressing, and toilet use. R6's MDS showed R2 was always incontinent of bowel and bladder. R6's TAR showed the following orders: (a). right dorsal first toe - cleanse with normal saline, apply hydrogel and cover with dry dressing daily. (b). right heel - cleanse with normal saline, apply alginate with silver and cover with dry dressing daily. A review of R6's TAR showed both orders were not done on 8/9/20. R6's wound evaluation and management summary dated 8/7/20 showed R6 with unstageable necrosis wound for over 10 days duration. The summary also showed R2's wound size was 4.9 x 6.2 x 0.1 cm, heavy serous exudates, thick adherent devitalized necrotic tissue 40%, slough 20 % and 40% granulation tissue. R6's latest wound evaluation and management summary dated 8/14/20 showed R6 with unstageable necrosis for over 16 days duration. The summary also showed R6's wound size was 4.9 x 6.2 x 0.1 cm, heavy serous exudates, thick adherent devitalized necrotic

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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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) tissue 40%, slough 20% and 40% granulation tissue. There was also an order [REDACTED]. On 8/12/20 at 11:17am, V6 performed dressing change on R6's wounds. The dressing on R6's right heel was almost black with a foul smell. The old dressing had no date or initial on it. V6 stated he was not doing wound care on 8/11/20 and could not say whether R6's heel wound dressing was done. V6 further stated R6 was just transferred to this unit from another unit on 8/11/20. V6 stated there are five residents on this unit that requires wound care. After the completion of the wound care on R6, R6's foot was not offloaded as ordered and it was not placed in the sponge boot. On 8/12/20 at 12:28pm, V9 (Wound care nurse 2) stated she was on the unit with V17 (Wound care nurse 3) on 8/11/20 but performed dressing change on only 4 residents. 4. R7's EHR showed R7 was originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R7's MDS dated [DATE] showed R7 with BIMS of 15 which meant R7 was cognitively intact. R7's MDS showed R7 requires extensive assistance of one or two staff with bed mobility, dressing, and personal hygiene. The MDS also showed R7 with total dependence on two staff for transfer and toilet use. The MDS showed R7 with impairment on both sides of side of upper extremities. R7's MDS showed R7 has bowel and bladder incontinence. R7's TAR dated August 2020 showed the following orders: (a). right groin - cleanse with normal saline solution, apply [MEDICATION NAME] and cover with dry dressing daily. R7's latest wound evaluation and management summary dated 8/14/20 showed R7 with right groin wound. The summary showed R7's wound size was 0.1 x 0.7 x 0.5 cm, moderate serosanguinous exudates, slough 10%, and 90% granulation tissue. On 8/12/20 at 1pm, V14 was providing incontinence care for R7. There was no dressing to R7's right groin area. R7's buttocks was noted with redness. V14 placed a separate pad underneath R7's right thigh, V14 stated R7 is a heavy wetter. On 8/13/20 at 11:10am, V6 stated he expects CNAs to report to nurses if wound dressings are off. V6 stated he expects wound dressings to be dated and initialed. On 8/13/20 at 1pm, V2 (Director of Nursing, DON) stated CNAs should notify nurses if there are no dressings on the wound or if the dressing falls off during care. V2 stated the wound care team must have missed R6 due to the room change a day before. V2 further stated nurses should follow physician order [REDACTED].
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to clean resident's perineal area after incontinence episode in a manner that would prevent the potential development of infection and maintain hygiene. This applies to 6 of 6 residents (R2, R3, R4, R5, R7 and R12) reviewed for incontinence care in the sample of 13 residents. The findings include: 1. R2's EHR showed R2 was originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R2's MDS (Minimum data Set) dated 6/30/20 showed R2 with BIMS (brief interview for mental status) score of 03, which meant R2 had severely impaired cognition. R2's MDS showed R2 requires extensive assistance of one or two staff with bed mobility, transfer, dressing, toilet use and personal hygiene. R2's MDS showed R2 was always incontinent of bowel and bladder. On 8/12/20 at 9:45am, R2 was taken from the unit dining area to her room for wound care. R2 was noted to have soiled her incontinence brief with bowel movement and urine. After V6 (Wound Care Nurse) performed the wound care dressing change, V6 was in the process of closing R2's incontinence brief when V6 was prompted to R2's soiled incontinence brief and need for incontinence care. V6 put R2 on her right side, removed the soiled incontinence brief and used a wet wash cloth to wipe R2's perineal area. V6 failed to separate and clean R2's labia prior to applying a clean incontinence brief on R2. 2. R3's EHR showed R3 was originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R3's MDS dated [DATE] showed R3 with BIMS score of 15 which meant R3 was cognitively intact. R3's MDS showed R3 requires extensive assistance of one or two staff with bed mobility, dressing, and personal hygiene. The MDS showed R3 requires total dependence of two persons physical assist with transfer and toilet use. R3's MDS showed R3 with impairment on both sides of lower extremities. R3's record showed R3 with a indwelling catheter and was always incontinent of bowel. On 8/12/20 at 1:35pm, R3 was observed in bed. R3 was alert and oriented. R3 stated she was changed last at around 5:30am. On 8/12/20 at 1:37pm, V16 (Certified Nursing Assistant, CNA) was notified of R3's statement. V16 removed R3's soiled incontinence brief that was noted with small bowel movement and lots of black/brown drainage from R3's excoriated buttocks. V16 failed to clean around R3's urethra and the juncture of R3's indwelling urinary catheter and down at least three inches of the catheter. V16 also failed to separate R3's labia area. V16 turned R3 only to her right side and never put R3 on her back so he could adequately clean R3's perineal area. 3. R4's EHR showed R4 was originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R4's MDS dated [DATE] showed R4 with BIMS score of 1 which meant R4 had severely impaired cognition. R4's MDS showed R4 requires extensive assistance of one or two staff with bed mobility, transfer, dressing, toilet use and personal hygiene. R4's MDS showed R4 was always incontinent of bowel and bladder. On 8/12/20 at 10:26am, V5 (CNA) was to perform incontinence care on R4. V5 turned R5 to her right side. R4 was noted with small bowel movement. V5 wiped R4's perineal area without separating and cleaning R4's labia area. V5 also was wiping the perineal area back and forth instead of using downward [MEDICAL CONDITION]. 4. R5's EHR showed R5 was originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R5's MDS dated [DATE] showed R5 with BIMS score of 03 which meant R5's cognition was severely impaired. R5's MDS showed R5 requires extensive assistance of one or two staff with bed mobility, transfer, dressing, toilet use and personal hygiene. The MDS showed R5 with impairment on one side of upper extremity and impairment on both sides of lower extremities. R5's MDS showed R5 was always incontinent bowel and bladder. On 8/12/20 at 11am, R5 was seen in her recliner high chair in the dining area. R5's red sweat pant was noted to be bulged up in between her legs. At 11:02am, V7 stated he takes care of R5 and had just changed R5 at around 10am. R5 was wheeled back to her room. V7 put R5 on her right side to change R5 and was noted with two soiled incontinence briefs. V7 was observed using wipes around R5's perineal area. V7 failed to separate and clean R5's labia before applying a clean incontinence brief on R5. 5. R7's EHR showed R7 was originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R7's MDS dated [DATE] showed R7 with BIMS score of 15, which meant R7 was cognitively intact. R7's MDS showed R7 requires extensive assistance of one or two staff with bed mobility, dressing, and personal hygiene. The MDS also showed R7 with total dependence on two staff for transfer and toilet use. The MDS showed R7 with impairment on both sides of side of upper extremities. R7's MDS showed R7 always was incontinent of bowel and bladder. On 8/12/20 at 1:09pm, R7 was in bed. V14 (CNA) stated she would leave the floor at 1:30pm today. V14 removed R7's soiled incontinence brief. V14 failed to retract R7's skin and clean the entire penis shaft. V14 placed a clean incontinence brief under R7 and put extra pad underneath R7's right thigh. V14 further stated she placed the extra pad because R7 is a heavy wetter. 6. R12's EHR showed R12 was originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R12's MDS dated [DATE] showed R12 with BIMS score of 4, which meant R12's cognition was severely impaired. R12's MDS showed R12 requires extensive assistance of one or two staff with bed mobility, transfer, dressing, toilet use and personal hygiene. R12's MDS showed R12 was always incontinent of bowel and bladder. On 8/12/20 at 12:19pm, V7 (CNA) stated he has not changed R12 this shift. R12's soiled incontinent brief had small bowel movement. V7 failed to open and clean R12's labia before applying clean incontinent brief. On 8/13/19 at 1pm, V2 (Director of Nursing, DON) stated nursing staff are expected to gather materials, wipe from front to back while opening and cleaning the labia area for female and cleaning the urethra for male. V2 stated nursing staff should provide incontinence care by also cleaning the groin areas. Review of facility's policy titled, Perineal Care with revised date August 2008 showed, For a female resident, b. wash perineal area wiping from front to back. (1). Separate labia and wash area downward from front to back. (2). Continue to wash the perineum moving from inside outward to and including thighs, alternating from side to side, and using downward [MEDICAL CONDITION]. (3). Rinse thoroughly in same direction. For a male resident, . (b). wash perineal area starting with urethra and working outward. (Note: If the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about 3 inches. Gently rinse and dry the area). (1). retract foreskin of the uncircumcised male. (2). Wash and rinse urethra area using a circular motion. (3). continue to wash the perineal area including the penis, scrotum and inner thighs.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide adequate staffing to meet the need of residents requiring extensive assistance with supervision and ADLs (Activities of daily living - grooming, bathing,

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F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) toileting). This applies to 10 of 13 residents (R2, R3, R4, R5, R7 through R12) reviewed for ADLs and supervision in the sample. The findings include: The following MDS (Minimum Data Sets) all show the following residents all require extensive assistance with dressing, personal hygiene and toilet use: R2 (MDS dated [DATE]) R3 (MDS dated [DATE]) R5 (MDS dated [DATE]) R8 (MDS dated [DATE]) R9 (MDS dated [DATE]) R10 (MDS dated [DATE]) R11 (MDS dated [DATE]) R12 (MDS dated [DATE]). Grooming 1. On 8/12/20 at 9:10am, during initial tour of the facility, R8 and R10 were noted with visible, unshaven facial hair. On 8/12/20 at 9:15am, R2, R9, R10, R12 all had long fingernails with brown/black underneath their nails. Incontinence care 2. On 8/12/20 at 9:45am, R2 was taken from the dining area to her room for wound care. R2 was noted to have soiled her incontinence brief with bowel movement and urine. After V6 (Wound Care Nurse) performed the wound care dressing change, V6 was in the process of closing R2's incontinence brief before when he was prompted to R2's soiled incontinence brief and need for incontinence care. On 8/12/20 at 1:35pm, R3 was observed in bed. R3 was alert and oriented. R3 stated she was changed last around 5:30am. R3 further stated the guy-referring to V16 (Certified Nursing Assistant) came to check around 10am but did not do anything. On 8/12/20 at 1:37pm, V16 was asked if he had changed R3's incontinence brief this shift, V16 stated no but that he checked on R3 around 10am. On opening R3's incontinence brief, R3 was noted with small bowel movement with lots of black/brown drainage from R3's excruciated buttocks. Review of R3's shower sheet showed R3 was not given bed bath on 8/12/20 and 8/15/20 as scheduled. R3's shower sheet showed R3 was given bed bath last on 8/8/20. On 8/16/20 at 12:50pm, V2 (Director of Nursing, DON) stated she was not sure why R3 did not receive bed baths as scheduled. On 8/12/20 at 9:10am, R5 was seen in her recliner high chair in the dining area. R5's red sweat pant was noted to be bulged up in between her legs. At 11am, R5 was still in her recliner high chair in the dining area. At 11:02am, V7 stated he had just changed R5 at around 10am. R5 was wheeled back to her room. V7 put R5 on her right side to change her incontinence brief, R5 was noted with two soiled incontinence briefs. When V7 was asked why R5 had two incontinence briefs on, V7 stated he has not changed R5 since the beginning of his shift (7am). V7 stated earlier he was not telling the truth about the time he changed R5. On 8/12/20 at 12:19pm, V7 CNA stated he has not changed R12 this shift. R12's soiled incontinent brief has small bowel movement. On 8/12/20 at 1:09pm, R7 was in bed. V14 (CNA) stated she would leave the floor at 1:30pm today because she had to go somewhere. V14 removed R7's soiled incontinence brief. V14 placed a clean incontinence brief under R7 and put extra pad underneath R7's right thigh. V14 further stated she placed the extra pad because R7 is a heavy wetter. On 8/12/20 at 10:26am, V5 (CNA) was to perform incontinence care on R4. V5 turned R4 to her right side. R4 was noted with small bowel movement. Supervision 3. On 8/12/20 at 12:09pm, R11 was noted to be in the corner of the dining area with one table against her chair. R11 was noted to push on the table several times. V25 (Activity Aide) was the only staff in the dining area with 15 other residents that required adequate attention. On 8/12/20 at 12:10pm, V25 stated she put the table against R11's chair because R11 stands up and fall off the chair. Staffing observation on all units on 8/12/20 On 8/12/20 at 12:28pm, Unit A had a census of 47 residents, 2 nurses, 2 CNAs and 1 restorative aide. On 8/12/20 at 2pm Unit B had a census of 16 residents, 1 nurse, 1 CNA and 1 transportation coordinator/CNA. On 8/12/20 at 1:15pm Unit C had a census of 33 residents, 2 nurses and 2 CNAs. On 8/12/20 at 12:50pm Unit D had a census of 43 residents, 2 nurses and 3 CNAs On 8/12/20 at 9:10am Unit E had a census of 36 residents had 1 nurse and 2 CNAs. On 8/13/20 at 10:05am, V23 (Staffing coordinator) stated staffing is usually ok with the nurses but not with CNAs due to a lot of call offs. V23 stated currently there 4 CNAs on vacation which makes replacement harder when staff calls off. V23 stated there were call offs on 8/12/20. V23 stated often times the facility uses restorative aides to assist with care. V23 stated ideally, the facility should have 13 CNAs on the day and evening shifts and 10 CNAs on the night shift but it does not happen. CNAs call offs, take time off and are on vacation. V23 further stated there should be 10 nurses on day and evening shifts and 5 nurses on the night shift. On 8/13/20 at 1pm, V2 (Director of Nursing) stated staffing has been a challenge in the facility and that the facility is actively hiring. V2 stated she hired 5 CNAs between May 2020 and August 2020 and they are no longer working at the facility. V2 stated it is hard to fill last minute call offs but incentives/bonuses are usually offered. On 8/12/20 at 9:20am, V4 (Nurse) stated today is a bad staffing day because of the call offs. On 8/12/20 at 12:38pm, V11 (Restorative aide) working was CNA today. V11 stated staff struggles to have important care done. V11 stated it is hard when you are pulled to work the floor, there is shortage on all the units. On 8/12/20 at 12:35pm, V10 (CNA) stated you just do the best you can. V10 stated sometimes the CNAs are two instead of 4 that are expected to work. V10 stated she was the only CNA on unit B on 8/9/20 with 15 residents who are persons under investigation (PUI) for Covid-19. PUI residents are placed on contact and droplet isolation precautions in the facility. On 8/12/20 at 12:48pm, V13 (CNA) stated staffing is often worst on weekends. On 8/12/20 at 12:52pm, V15 (Nurse) stated it is tough to provide care when sometimes you have 2 CNAs to work the floor. V15 stated D unit usually only have 3 CNAs instead of 4 CNAs.