STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146052	A. BUILDING _____ B. WING _____	**07/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALHAMBRA REHAB & HEALTHCARE	**417 EAST MAIN STREET, BOX 310 ALHAMBRA, IL 62001**

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 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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, the Facility failed to turn and reposition dependent residents in a timely manner to prevent pressure ulcers for 3 of 5 residents (R3, R8 and R11) reviewed for pressure ulcer prevention in the sample of 14. Findings include: 1. On 7/10/20 at 8:50 AM, R3 was lying in bed and stated she was waiting for the aides to come and change her, and she had been wet for some time. R3 stated V2, Director of Nursing (DON), told her the staff had documented they last changed her around 4:00 AM this morning, but that she did not remember them coming in since last night at around 10:00 PM. R3 stated she would have had to have woken up because she has to have assistance with turning herself on to her side. R3 stated she has waited over an hour for staff to answer her call light. R3 stated she has asked staff to get her out of bed, but they inform her they do not have enough staff to get her up. She stated she has not been out of bed for three days, since she received her shower on 7/7/20. R3 stated she is unable to move herself in bed to get off her backside, and staff do not come in every two hours like they are supposed to turn and reposition her. On 7/10/20 at 8:52 AM V7 and V8, Nurse's Assistants (NAs), removed R3's gown, which was wet with urine at the bottom, and her adult diaper, which was also saturated with urine. R3 had dark red wrinkles on her buttocks and backs of her legs from laying in same position for so long. After completing R3's incontinent care, V7 and V8 positioned R3 onto her back in the same position she was in when they entered her room. On 7/10/20 at 9:00 AM, V7 and V8 stated they did not know anything about R3 being on a turning and repositioning program. R3's Minimum Data Set (MDS), dated [DATE], documents she is alert and oriented and is dependent on staff for bed mobility, transfers, toileting, and personal care. R3's Care Plan, dated 3/10/20, documents a problem, (R3) is at risk of abuse and/or neglect related to: she needs assist with ADLs (Activities of Daily Living). 2. On 7/10/20 at 1:30 PM, V7 and V8 transferred R8 into her bed with the mechanical lift. V8 removed R8's gown and R8's urine saturated adult diaper, which was bunched up into her perineal area. V8 stated R8 had been up in her chair since around 6:30 AM, when she and another nurse aide had gotten R8 up for breakfast. After V7 removed R8's wet diaper, deep red wrinkles were observed on R8's bilateral buttocks and thighs. On 7/10/20 at 1:45 PM, V2, Director of Nursing, observed the deep, red wrinkles in R8s buttocks and thighs. V2 stated, I know we have some issues with turning and repositioning and incontinence care are some of them. I am having a meeting this afternoon, and these are some of the things we will be discussing. R8's MDS, dated [DATE], documents she is severely cognitively impaired, and she is dependent on staff for all ADLs. R8's Care Plan, edited 6/30/20, documents: (R8) is at risk for pressure ulcers development related to impaired mobility-dependent on staff for position changes and transfers. Is incontinent of bladder. 6/30/20 has open area left palm; 6/29/20 has open area on left bunion. Interventions for this care plan include: Follow facility policies/protocols for the prevention/treatment of [REDACTED]. Hospice was notified and skin prep applied. On 7/10/20 at 1:50 PM, V7 and V8 stated no one had educated them that residents should be checked for incontinence except when they go to bed or how often they should be turned and repositioned while they are up in their chairs. V8 stated, We toilet the residents who let us know when they need to go to the bathroom, but don't do anything with the residents in the geri (geriatric) chairs. 3. On 7/10/20 at 1:25 PM, V5, Nurse Aide, pushed R11, in her high-backed reclining wheelchair, down to her room after lunch. She left R11 in her chair and walked out of the room. V5 stated R11 was gotten up that morning at 8:30 AM, and she had been up all day. V5 stated R11 did not receive turning and repositioning or incontinent care since being transferred to her chair at 8:30 AM. V5 stated the evening shift will come on at 2:00 PM and will transfer R11 to her bed and will clean her up then. V5 stated this is the usual routine, stating R11 does not lay down after meals. R11's MDS, dated [DATE], documents she is severely cognitively impaired and is dependent on staff for all ADLs. R11's Care Plan, dated 7/14/20, documents, (R11) is dependent on staff for all care due to [MEDICAL CONDITION]. She has impaired cognitive and communication skills. Staff to perform all ADLs. Assess resident for incontinent episodes and provide care as needed. Reposition resident every two hours and as needed to prevent skin breakdown. On 7/14/20 at 8:50 AM, V1, Administrator, stated the angel aides are not doing anything they are not supposed to be doing. V1 stated the Angel Aides (Nurse Aides) can do anything a Certified Nursing Assistant can do. The Facility's undated policy, Pressure Ulcer Prevention, documents, Purpose: To prevent and treat further breakdown of pressure ulcers. Procedure: Turn resident every two hours and position with pads or pillows to protect boney prominences.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide safe transfer technique and adequate supervision during ambulation to prevent accidents for 4 of 4 residents (R1, R8, R9, and R10) reviewed for falls/accidents in the sample of 14. Findings include: 1. R1's Face Sheet documents she was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. R1's Minimum Data Set (MDS), dated [DATE], documents R1 requires extensive assist of 2 staff with transfers. R1's Care Plan, dated 4/10/20, documents R1 has an Activity of Daily Living (ADL) self-care deficit and is at risk for falls, and R1 requires assistance of 2 staff, using a sit to stand mechanical lift for transfers. The Facility's Resident Fall Log, dated June 2020, documents R1 had a fall on 6/3/20 at 5:23 PM, when her right leg gave out. On 7/10/20 at 9:27AM, V7 and V8, Nurse's Assistants (NAs), performed a transfer for R1 using a sit-to-stand mechanical lift. V7 and V8 pulled on R1's arms to sit her up from a lying position to sitting on the side of her bed. After R1 was in a sitting position, a sit-to-stand belt was placed on R1 and her feet were placed on the foot board. The strap to the secure her legs was not placed on R1. R1 was holding onto the grab bars and V7 andV8 began to lift R1 up with the lift and pulled up R1's pants. R1 did not have a gait belt on. R1 then began to yell, I need to go down. The sit to stand malfunctioned and would not go down, leaving R1 in the upright position for approximately 30 seconds. At that time, the lift began to work and V7 and V8 placed R1 on the edge of the bed. After 3-4 minutes, V7 and V8 then lifted R1 using the same sit to stand to lift R1 and transfer her into her wheelchair. 2. On 7/10/20 at 1:30 PM V7, NA, and V8, NA, attached the straps of the mechanical lift sling that was under R8 to the mechanical lift, and raised R8 until she was a couple of inches over her chair. Then V7 stated, Stop, we are at the wrong end of the bed, and they lowered R8 back into her chair, and moved the chair to the middle of the bed, and then raised R8 again, using the mechanical lift. V7 stopped again, after R8 was raised out of her chair, and stated, We have to move her up to the head of the bed, so R8 was lowered back into her wheelchair, and wheeled to the head of her bed, and then was transferred into her bed with the lift. R8's MDS, dated [DATE], documents she is severely cognitively impaired, and she is dependent on staff for all ADLs. On 7/10/20 at 1:40 PM, V7 stated, I'm not even sure we should be doing some of this stuff. 3. On 7/10/20 at 12:41 PM, R9 was sitting on her roommate's bed and V5, NA, and V8 pulled her up to standing by holding on to her arms. They did not use a gait belt. V5 tried to pull R9 towards the bathroom, but R9 resisted and her gait became very unsteady as she tried to pull away, so V5 and V8 held onto her arms and walked her over to her bed and sat her down. After sitting her down on the bed, V8 stated, We don't use a gait belt with

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 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) her because sometimes she gets up and walks on her own. We only use a gait belt if a resident needs assist. I just put my hand on (R9's) back to guide her. We only need gait belts for transfers. V8 then walked R9 up B-hall to the small dining room, holding R9's hands while standing in front of her, with V8 walking backwards. V8 did not use a gait belt while walking R9 to the dining room. V8 stated she does have a gait belt, but forgot it at home. R9's MDS, dated [DATE], documents R9 is severely cognitively impaired and requires extensive assist with transfers and limited assist with ambulation. 4. On 7/10/20 at 1:20 PM, V5 assisted R10 to ambulate from the small dining room, down B-hall and part of C-hall. R10 was resisting going to her room and was pulling away from V5. V5 did not put a gait belt on R10 and held on to the back of R10's pants while walking with her. R10 walked, leaning forward, slightly bent over. The Facility's Fall Logs, dated April 2020 and June 2020, document R10 has had falls on 4/21/20, 6/12/20, and 6/25/20. R10's MDS, dated [DATE], documents she is severely cognitively impaired and requires extensive assist of two staff for transfers and ambulation. R10's Care Plan, dated 4/22/20, documents the problem: Restorative Ambulation Program (R10) has unsteady gait and balance issues while standing. The interventions for this care plan include: If very unsteady-use two staff assistance when ambulated or w/c. On 7/14/20 at 8:50 AM, V1, Administrator, stated the angel aides are not doing anything they are not supposed to be doing. She stated they only do what is included in the guidance provided by the governor in response to COVID. V1 stated the Angel Aides (Nurse Aides) can do anything a Certified Nursing Assistant can do. The Facility's undated policy, Safety (General Guidelines for Resident Safety) documents,7. Support the resident's body well during all positioning, transferring and ambulation. Avoid pulling on the resident's extremities. Provide two or more persons to assist when necessary for resident and staff safety. 13. Use assistive devices as necessary.
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 provide thorough and timely incontinence care to prevent urinary tract infections for 4 of 4 residents (R1, R2, R3 and R8) reviewed for incontinence care in the sample of 14. Findings include: 1. R1's Face Sheet documents she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R1's Minimum Data Set (MDS), dated [DATE], documents R1 requires extensive assist of 2 staff with transfers and is dependent upon staff for her toileting needs. R1's Care Plan, dated 4/10/20, documents R1 has Activities of Daily Living (ADL) self-care deficit requires assist of 2 staff for her toileting needs. The Facility's Infection Control Line Listing, dated April 2020, documents R1 was diagnosed with [REDACTED]. On 7/10/20 at 9:27AM, V7, Nurse Aide (NA) and V8, NA, performed peri-care for R1. V7 and V8 pulled on R1's arms to sit her up from a lying position to sitting on the side of her bed. R1 was visibly wet with urine. After R1 was in a sitting position, V7 then put on gloves and used a tissue to wipe R1's perineal area. No other perineal care was provided. V7 and V8 then lifted R1 using the mechanical lift and transferred her into her wheelchair. There was a strong urine odor noted and the bed pad was wet with urine. On 7/14/20, at 8:05 AM, R1's call light was going off. V10, Housekeeper, stated she had already told a nurse's aide a while ago that R1 need to use the bedpan. V10 stated she had informed V5, Nurse's Aide (NA), that R1 needed the bed pan, and no one had come to help R1 yet. V10 answered R1's call and let R1 know that she would go let the nurse's aides know she was still waiting. On 7/14/20, at 8:07 AM, V5 and V7 came and assisted R1 onto the bed pan and told her they would be right back to check on her. R1 put her call on at 8:15 AM to be removed from the bed pan. V5 came into R1's room at 8:35 AM to take R1 off the bed pan. On 7/14/20 at 8:30AM, R1 stated that she waited over an hour over the weekend (7/11/20 & 7/12/20) to use the bedpan and she had to go bad. 2. R2's Face Sheet documents she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R2's MDS, dated [DATE], documents she is cognitively intact and requires assistance with transfers, bed mobility, toileting, dressing and hygiene. On 7/10/20 at 8:05AM, R2 stated, There are usually on 2 aides in the building and sometimes only 1. They have some good aides, but they have some [AGE] year-olds who think they know it all. R2 stated she must wait a long time, sometimes hours, for her call light to be answered and for staff to assist her. R2 stated, It's worse on the weekends. On 7/14/20 at 7:50AM, R2 stated the weekend (7/11/20 & 7/12/20) was horrible and she had long wait times for call lights to be answered, and for care. R2 stated the lady down the hall (later identified as R1) had to wait over two hours. R2 stated on 7/12/20 she slept in a wet bed all night. She stated, No one would come and change me, they came in and shut off my light and never came back. R2's Progress Note, dated 7/4/2020 at 6:58 PM, documents, Resident having increased incontinence and R (right) flank pain. Resident has low back pain already from spinal issues. MD (Medical Doctor) notified of s/s of a UTI. Nurse to obtain a urine specimen tonight. Will send to ER if symptoms worsen. R2's Progress Note, dated 7/4/2020 at 7:22 PM, documents MD (Medical Doctor) ordered urine specimen with culture-start on Bactrim DS (an antibiotic) BID (twice daily) x 7 days. Resident and family informed. 3. R3's MDS, dated [DATE], documents she is alert and oriented and is dependent on staff for bed mobility, transfers, toileting and personal care. R3's Care Plan, dated 3/10/20, documents a problem, (R3) is at risk of abuse and/or neglect related to: she needs assist with ADLs. On 7/10/20 at 8:50 AM, R3 was lying in bed and stated she was waiting for the aides to come and change her, and that she had been wet for some time. R3 stated V2, Director of Nursing (DON), told her the staff had documented they last changed her around 4:00 AM this morning, but that she did not remember them coming in since last night at around 10:00 PM. R3 stated she would have had to have woken up because she has to assist with turning herself on to her side. R3 stated she has waited over an hour for staff to answer her call light, and if they would come when she first calls, she could use the bed pan and not be incontinent. R3 stated she wishes staff would change her more often because she keeps getting UTIs and she never used to get them so often. On 7/10/20 at 8:52 AM, V7 and V8 removed R3's gown, which was wet with urine at the bottom, and her adult diaper, which was also saturated with urine. V7 used a wet washcloth and peri-wash to cleanse R3's groin and perineal area, wiping back and forth without changing washcloths or going to a clean section of the washcloth. V7 did not spread R3's labia to cleanse her inner folds and did not cleanse all areas that were wet with urine, including her inner thighs and lower abdomen. V7 and V8 turned R3 side to side to cleanse both buttocks but did not cleanse her rectum. V7 did not dry R3's skin after cleansing. On 7/10/20 at 9:00 AM, V7 and V8 stated they did not know anything about how often R3 should be toileted. The Facility's Infection Control Line Listing, dated April 2020, documents R3 was treated for [REDACTED]. 4. R8's MDS, dated [DATE], documents she is severely cognitively impaired, and she is dependent on staff for all ADLs. On 7/10/20 at 1:30 PM, V8 removed R8's gown and her saturated adult diaper, which was bunched up into her perineal area. V8 stated R8 had been up in her chair since around 6:30 AM, when she and another nurse aide had gotten her up for breakfast. After V7 removed R8's wet diaper, deep red wrinkles were observed on R8's bilateral buttocks and thighs. V7 used wet washcloths that were sitting on R8's dresser and cleansed R8's peri area, wiping with a back and forth motion, without using a clean section of the washcloth for each area. V7 did not spread R8's labia to cleanse her inner folds and did not cleanse her lower abdomen and inner thighs, which were visibly wet with urine. V7 and V8 rolled R8 to her right side and cleansed her left buttock, then without drying her, put barrier cream on her left buttock. They did not turn R8 onto her left side to clean her right buttock. On 7/10/20 at 1:50 PM, V7 and V8 stated no one had ever educated them that residents should be checked for incontinence. V8 stated, We toilet the residents who let us know when they need to go to the bathroom. On 7/10/20 at 1:45 PM V2 stated, I know we have some issues with turning and repositioning and incontinence care are some of them. I am having a meeting this afternoon, and these are some of the things we will be discussing. The Facility's undated policy, Incontinent Care documents Purpose: 1. To keep skin clean, dry, free of irritation and odor. 2. To identify skin problems as soon as possible so treatment can be started. The Policy documents 3. To prevent skin breakdown. 4. To prevent infection. Note: Take all incontinent residents to the bathroom or put on the bedpan before and after meals and at least every two hours between meals. The bed pan should be offered at regular intervals during the night.
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** Based on observation, interview, and record review, the Facility failed to ensure qualified staff are available to meet residents' needs timely, including turning and positioning, incontinent care and safe transfer/ambulation assistance. This has the potential to affect all 36 the residents in the facility. Findings include: On 7/10/20 at 7:50 AM, there were 3 Nurse Aides, the Director of Nursing (DON), and one LPN to provide care for 36 residents. There were no Certified Nurse's

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F 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 2) Assistants on duty in the facility at that time. On 7/10/20 at 10:20 AM, V2, Director of Nursing (DON), stated none of the aides taking care of the residents today were Certified Nurse Assistants (CNA). V2 stated V5, V7 and V8 were angel aides who went through a nurse aide course online, took a test and then were shown demonstrations by the previous DON. V2 stated this was done before she came to work at the facility. V2 stated she is trying to hire Certified Nurse's Aides to work at the facility. 1. On 7/14/20, at 8:05 AM, R1's call light was going off. V10, Housekeeper, stated she had already told a nurse's aide a while ago that R1 need to use the be pan. V10 stated she had informed V5, Nurse's Aide (NA), that R1 needed the bed pan, and no one had come to help R1 yet. V10 answered R1's call and let R1 know that she would go let the nurse's aides know she was still waiting. At 8:07 AM, V5 and V7, NA, came and assisted R1 onto the bed pan and told her they would be right back to check on her. R1 put her call on at 8:15 AM to be removed from the bed pan. V5 came into R1's room at 8:35 AM to take R1 off the bed pan. On 7/14/20 at 8:30AM, R1 stated that she waited over an hour over the weekend (7/11/20 & 7/12/20) to use the bedpan and she had to go bad. 2. On 7/10/20 at 8:05 AM, R2 stated the facility had staffing issues and she has difficulty getting staff to answer her call lights. She stated, There are usually on 2 aides in the building and sometimes only 1. They have some good aides, but they have some 16- year-olds who think they know it all. R2 stated she must wait a long time, sometimes hours, for her call light to be answered and for staff to assist her, and it's worse on the weekends. On 7/14/20 at 7:50 AM, R2 stated the weekend (7/11/20 & 7/12/20) was horrible and she had long wait times for call lights to be answered and for care. R2 stated the lady down the hall (later identified as R1) had to wait over two hours. R2 stated on 7/12/20 she slept in a wet bed all night. She stated, No one would come and change me, they came in and shut off my light and never came back. 3. On 7/10/20 at 8:50 AM, R3 stated she has asked staff to get her out of bed, but they informed her they do not have enough staff. She stated she has not been out of bed for three days, since she received her shower on 7/7/20. R3 stated she is unable to move herself in bed to get off her backside, and staff do not come in every two hours like they are supposed to turn and reposition her. 4. On 7/10/20 at 1:30 PM, V7 and V8, Nurse's Aides, transferred R8 into her bed with the mechanical lift. V8 removed R8's gown and her saturated adult diaper, which was bunched up into her perineal area. V8 stated R8 had been up in her chair since around 6:30 AM, when she and another nurse aide had gotten her up for breakfast. After V7 removed R8's wet diaper, deep red wrinkles were observed on R8's bilateral buttocks and thighs. 5. On 7/10/20 at 1:20 PM, V5 assisted R10 to ambulate from the small dining room, down B-hall and part of C-hall. R10 was resisting going to her room and was pulling away from V5. V5 did not put a gait belt on R10 and held on to the back of R10's pants while walking with her. R10 walked, leaning forward, slightly bent over. 6. On 7/10/20 at 1:25 PM, V5, Nurse Aide, pushed R11, in her high-backed reclining wheelchair, down to her room after lunch. She left R11 in her chair and walked out of the room. V5 stated R11 was gotten up that morning at 8:30 AM, and she had been up all day. V5 stated R11 did not receive turning and repositioning or incontinent care after being transferred to her chair at 8:30 AM. V5 stated the evening shift will come on at 2:00 PM, and will transfer R11 to her bed and will clean her up then. V5 stated this is the usual routine, stating R11 does not lay down after meals. On 7/10/20 at 1:50 PM, V7 and V8 stated no one had educated them that residents should be checked for incontinence except when they go to bed, or how often they should be turned and repositioned while they are up in their chairs. V8 stated, We toilet the residents who let us know when they need to go to the bathroom, but don't do anything with the residents in the geri (geriatric) chairs. 7. On 7/10/20 at 8:45AM in the dining room, V5, Nurse Aide, was assisting a resident with eating breakfast. As V5 was assisting the resident, V5 began to fall asleep and dropped the spoon full of food in her lap. V5 woke up and began feeding this resident again. On 7/10/20 at 9:15 AM, V5, Nurse's Aide, stated the staff don't show up and if they do, it's hours after the start of their shift. V5 stated most weekends V5 is the only aide in the mornings. V5 stated she doesn't feel the facility is addressing the staffing concerns. V5 stated she was exhausted. 8. On 7/10/20, at 9:40 AM, V7, Nurse's Aide, stated staffing issues are horrible, the worse. Picture the worse you've seen, and it is worse here. V7 stated the staff do not show up for their schedule shifts. V7 stated she had not received any training on how to use the mechanical lifts. V7 stated, We taught ourselves. On 7/10/20 at 9:42 AM, V8, Nurse's Aide, stated, Staffing is horrible. V8 states she was given one day training with a CNA and then was on her own. V8 states her training for the Angel Aide consisted of classroom training with the previous DON, we watched slide shows, did an online test and got a certificate. We didn't get much training. They learned how to make beds, use the Hoyer lift, and sit to stand lift and how to wash their hands. The DON would show us then we would have to do it, not much on the checklist. On 7/14/20 at 7:35 AM, V2 stated there were no Certified Nurse's Aides on the day shift on the previous weekend (7/11/20 and 7/12/20) and only nurse aides worked on those shifts. On 7/14/20 at 8:50 AM, V1, Administrator, stated the angel aides are not doing anything they are not supposed to be doing. She stated they only do what is included in the guidance provided by the governor in response to COVID-19. V1 stated the Angel Aides (Nurse Aides) can do anything a Certified Nursing Assistant can do. 9.On 7/10/20 at 10:30 AM, V1, Administrator, stated the current census in the facility was 36 residents.