STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275103	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CONTINENTAL CARE AND REHABILITATION	2400 CONTINENTAL DR BUTTE, MT 59701

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F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** Based on observation, interview, and record review, the facility failed to treat three (#s 10, 11, and 12) of 17 sampled residents, who were unable to feed themselves independently, with respect and dignity, by standing while assisting with eating during mealtimes. Findings include: During an observation on 3/2/20 at 5:30 p.m. in the dining room during dinner, staff member F was standing while helping resident #10 eat. Staff member F proceeded to assist two other residents (#s 11 and 12) with eating, in addition to resident #10, all while standing. During an interview on 3/2/20 at 6:15 p.m., staff member H stated, I know we're supposed to sit (when we help residents eat), but we don't have enough time to sit down. Staff member H stated there had been an influx of new admissions who required 1:1 feeding assistance. During an interview on 3/2/20 at 6:45 p.m., staff member F stated she felt horrible for standing over the residents when helping them eat. Staff member F explained there were too many people in the dining room for her to sit down. During an observation on 3/4/20 at 8:30 a.m. of the dining room during breakfast, staff member P was feeding pancakes to resident #10, who was on her left side. Using her right hand, while standing to resident #10's right side, she continued to stand as she helped him drink a cup of coffee. Staff member P rested her left hand on the back of resident #10's geri-chair during this time. Staff member P then gave resident #12, who was sitting in a wheelchair to staff member P's right, a bite of pancakes, while continuing to stand. During an interview on 3/4/20 at 9:10 a.m., staff member P stated she was trained on how to assist residents during mealtime to maintain dignity. Staff member P stated she was unable to sit down due to lack of available seating. During an interview on 3/4/20 at 11:35 a.m. staff member A stated, Standing is not okay, referring to staff members standing while feeding residents. During an interview on 3/5/20 at 10:15 a.m., resident #10 stated he would rather have staff sit down next to him when they help him eat. Review of resident #10's MDS, with an ARD of 2/19/20, showed a BI[CONDITION] of 15, showing he was cognitively intact. Resident #10's MDS also showed he required a 1-person assist with eating. Review of resident #11's MDS, with an ARD of 1/20/20, showed a BI[CONDITION] of 3, showing a severe cognitive impairment. Resident #11's MDS also showed she required a 1-person assist with eating. Review of resident #12's MDS, with an ARD of 2/10/20, showed a BI[CONDITION] of 3, showing a severe cognitive impairment. Resident #12's MDS also showed she required a 1-person assist with eating. Review of the facility's policy, Assistance with Meals, revised 7/2017, showed: Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: not standing over residents while assisting them with meals.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** Based on observation, interview, and record review, the facility failed to update care plans and information on the Kardex program for 2 (#s 6 and 10) of 17 sampled residents, which had the potential to contribute to skin breakdown by not informing CNAs of repositioning tasks. Findings include: During an observation on 3/5/20 at 9:10 a.m. staff members C and S helped resident #10 turn on his side in his bed so staff member C could visualize an area of skin breakdown on resident #10's coccyx. During an interview on 3/5/20 at 9:30 a.m. staff members C and S stated staff turn resident #10 every two hours to prevent skin breakdown from occurring; however, staff member S stated, Turning and repositioning was not included on resident #10's Kardex. Staff member S explained the Kardex showed which residents require certain CNA interventions. Residents who were reliant on staff for mobility should have turning and repositioning as an intervention on the Kardex. Staff member S stated CNAs were unable to document when they were turning and repositioning resident #10. Staff member S was unable to verify if staff were indeed turning and repositioning resident #10 every two hours. During an interview on 3/5/20 at 9:35 a.m., staff member S stated resident #6 also did not have Turning and repositioning as one of his interventions on the Kardex for CNAs to implement. Staff member S stated she was concerned about resident #6's skin integrity due to his constant mobility and reliance on a wheelchair. Staff member S stated the facility provided a Roho cushion to help ease the pressure exerted on his skin, but that was just recently. Review of resident #10's care plan, dated 2/12/20, showed: Risk for impaired skin integrity related to limited mobility, and, Turn and reposition every 3-4 hours and weekly skin check. Review of resident #6's most recent care plan did not show he required repositioning, although it did show he was at risk for skin breakdown. Review of resident #6's MDS, with an ARD of 2/20/20, showed he was a two-person physical assist and dependent on staff for transferring.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility staff failed to accurately and quickly assess a [MEDICAL CONDITION], resulting in delayed treatment; and failed to prevent a medication that was not included on the medication orders from being administered, to 1 (#7) of 17 sampled residents. Findings include: During an interview on 3/3/20 at 5:25 a.m., staff member I stated resident #7 had fallen in December of 2019, and it was later determined at the hospital that he had sustained a [MEDICAL CONDITION]. Staff member I explained resident #7 fell around 11:30 p.m., and was transported to the hospital around 7:30 a.m., 8 hours later. Staff member I stated the nurse who was responsible for resident #7 did not assess him following the fall. During an interview on 3/3/20 at 8:15 a.m., staff member B stated she did not think staff member M intervened appropriately because she had not transported resident #7 to the hospital immediately. Staff member B stated staff member M had also administered [MED], which was not included on resident #7's medication orders. During an interview on 3/4/20 at 11:21 a.m., staff member A stated staff who started their shift the morning after resident #7's fall were upset with how the situation was handled. Staff member A stated management had provided education for staff member M. During an interview on 3/4/20 at 6:45 p.m., staff member M stated when resident #7 fell , she had been unfamiliar with the resident's care because she usually did not work on the memory care unit. Staff member M stated she relied on the CNA's interpretation of resident #7's fall, which was that it was a behavior, and something resident #7 did frequently. Staff member M stated resident #7 would not allow her to assess him, but she was able to give him two [MED] tablets. Review of resident #7's MAR indicated [REDACTED]. Staff member M's employee file included an Employee Warning notices for two items, dated 12/6/19. The first showed: (Staff member M) should obtain an order for [REDACTED].: As a nursing professional, you are required. to assess and/or monitor residents' conditions and provide professional nursing services. as identified during nursing rounds. The document was signed by staff member M on [DATE]9/19. Refer to F689-Accidents for more information related to resident #7's fall with injury.

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

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F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1)
F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** Based on observation, interview, and record review, the facility failed to prevent one Stage 4 pressure ulcer for 1 (# 2); one Stage 2 pressure ulcer for 1 (#6); and one Stage 2 pressure ulcer for 1 (#10), of 17 sampled residents. All of these pressure ulcers, which may have been avoidable, developed during the residents' stays in the facility. Findings include: A. During an interview on 3/2/20 at 4:15 p.m., resident #2 stated she developed a Stage 4 pressure ulcer in the facility a few months ago. Resident #2 stated staff had not been turning and repositioning her prior to the development of the ulcer, and she felt the ulcer could have been avoided if she had been turned and repositioned appropriately. During an interview on 3/3/20 at 2:42 p.m., staff member B stated she was not working in the facility when resident #2 first developed the pressure ulcer in October of 2019. Staff member B stated staff had started turning and repositioning in December of 2019. During an interview on 3/4/20 at 9:28 a.m., staff member P stated she thought resident #2's pressure ulcer developed in the facility because she would sit in her wheelchair for several hours at a time. Staff member P said staff had been much better about turning and repositioning resident #2 recently. During an interview on 3/4/20 at 10:15 a.m., resident #2 stated her pressure ulcer had caused her to stay in bed more often. Resident #2 stated she could only be up out of bed and in her chair for one hour at a time, and her mood had been bad because of that. During an interview on 3/4/20 at 6:45 p.m., staff member M stated she was concerned about resident #2's skin integrity. Staff member M stated she had asked the CNAs to put her to bed first after dinner, so she did not have to stay in her chair for more than an hour at a time (to prevent skin breakdown). Staff member M stated CNAs have been too busy to put her to bed right away, and so resident #2 has had to sit in her wheelchair for hours after dinner. During an interview on 3/5/20 at 12:55 p.m., staff member T stated pressure ulcers were a common issue in nursing homes, especially for residents who rely on staff for mobility, such as resident #2. Review of the CNA Kardex, under Turning and Repositioning, which showed how frequently resident #2 was turned and repositioned, which reflected resident #2 was turned and repositioned every 2 hours for the following: -65% of the time in March of 2020; -48% of the time in February of 2020; and -60% of the time in January of 2020. There was no documentation in the Kardex showing resident #2 had refused care. Review of Nursing Progress Notes, for resident #2, from October-November of 2019 showed the resident's wound developed sometime between late October and early November of 2019. The wound continued to deteriorate throughout November and December of 2019. One Nursing Note, dated 12/8/19, showed, Resident's wound on right gluteal fold continues to deteriorate. Noted that a second tunnel is in wound bed .(medical provider) ordered her to be sent to the Wound Clinic. B. During an interview on 3/4/20 at 8:45 a.m., resident #6 stated he had to wait thirty minutes to one hour to be assisted into or out of bed, or to the restroom. During an interview on 3/4/20 at 9:12 a.m., staff member P stated she had observed resident #6 scooting around in his wheelchair, which she thought may have contributed to his recent skin breakdown. During an interview on 3/5/20 at 9:30 a.m., staff member S stated she had concerns about residents who rely on staff for positioning and mobility because the facility did not have sufficient staffing to get (residents) up and down so they end up in the same positions for long periods of time, which can negatively affect skin integrity. Review of resident #6's care plan, dated 1/3/20, showed resident #6 relied on his wheelchair for locomotion, and was at a risk for skin breakdown related to incontinence. The intervention for this goal was turning/repositioning every 2-3 hours. Review of resident #6's skin assessment, dated 2/28/20, showed: new buttock abrasion on the upper right side, in addition to coccyx area red with a 0.5 cm diameter superficial open area. The assessment also noted a superficial open area (on the left buttock) 1.3 cm x 0.6 cm which is surrounded by a 6.2 x 4.5 cm red area that blanches to touch. C. During an interview on 3/5/20 at 7:35 a.m. resident #10 stated he thought he had a sore on his buttocks because it felt painful. During an observation on 3/5/20 at 9:10 a.m., staff members S and C provided skin care for resident #10. As resident #10 rolled over to his left side, staff member S noted a 1 cm circular opening on his coccyx. Staff member S provided A&D ointment to the area. During an interview on 3/5/20 at 9:15 a.m., staff member C stated she would notify the medical provider about the new skin breakdown, and for the meantime, would continue to apply A&D ointment to the area. Review of resident #10's care plan, dated 2/12/20, showed: risk for impaired skin integrity related to limited mobility. Refer to 725-Sufficient Staffing
F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**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 interview and record review, the facility failed to prevent an elopement for 1 (#13) and the resident had a [DIAGNOSES REDACTED].#7) of 17 sampled residents. Findings include: A. During an interview on 3/3/20 at 7:45 a.m., staff member L stated resident #13 had been discharged from the facility and had eloped during her stay in January of 2020. Staff member L stated resident #13 had a Wanderguard on her wrist when she eloped, and was residing on hall A (not the memory care unit) when she walked out the front doors with her walker. Staff member L explained staff had found resident #13 on the other side of the building, which was concerning to her, because resident #13 had a dementia diagnosis. Staff member L stated resident #13 was likely outside for 20-30 minutes in below freezing temperatures. Staff member L stated the facility decided to move resident #13 to the memory care unit two or three days following the incident. During an interview on 3/3/20 at 8:00 a.m., staff member B stated resident #13's elopement occurred during the night shift, and she was missing for about 15 minutes before staff found her in the courtyard towards the back of the building. Staff member B stated a Wanderguard had been placed on resident #13 the morning of the elopement. Staff member B explained staff determined resident #13 had walked out of the building into the courtyard from a side door, not the front doors; however, the Wanderguard alarm went off at the front doors only. Staff member B explained there was not a Wanderguard alarm system on the side door that led out to the courtyard. During an interview on 3/3/20 at 9:00 a.m., staff member B stated resident #13 had admitted to the facility on [DATE], and eloped on 1/29/20 during the night shift. Staff member B stated resident #13 was not mobile her first few days in the facility; however, she became progressively more mobile throughout her first week and would wander the halls with her walker. Staff member B stated resident #13 had not triggered for a elopement risk evaluation when she first admitted to the facility. Staff member B stated resident #13 did not seem to be exit seeking, but she was confused and did have a dementia diagnosis. Staff member B stated a Wanderguard was placed on resident #13 on 1/29/20 in the morning. Staff member B added that resident #13 did not appear to be anxious or angry, But she did find a door and go out. During an interview on 3/4/20 at 11:26 a.m., staff member A stated resident #13 had not been exhibiting any concerning behaviors that would have led staff to believe she was an elopement risk. Staff member A then remembered a Wanderguard had been placed the morning of the elopement, 1/29/20, and stated, (Resident #13) must have had wandering behaviors before that (day) then. Staff member A stated staff had met to discuss the incident and determined that, because the alarm went off at the front doors (instead of the side door where the elopement happened), and staff did not see anyone at the front doors, they turned off the alarm, instead of looking for the resident. Staff member A stated staff confirmed the Wanderguard system was functioning the next day. To summarize, the facility failed to complete an elopement risk assessment prior to resident #13's elopement; failed to supervise a resident with a dementia [DIAGNOSES REDACTED]. Review of the facility's policy, Elopements, revised 12/2007, showed: If an employee discovers that a resident is missing from the facility, he/she shall: .initiate a search of the building(s) and premises. Review of a Nursing Progress Note, dated 1/29/20, showed, Unable to locate resident while doing room to room search. Last seen by staff at (9:45 p.m.). Nurse looked out into the A-wing patio area and heard resident outside of the wooden gate. Nurse opened gate and assisted resident with her rolling walker which has a seat on it back into the facility. Resident's clothes were dry and no dampness noted. After vital signs taken and resident warmed up we took her to the door and her wandergard set off alarm - unable to locate which door she went out of due to no alarms going off. Review of a Nursing Progress Note, dated 1/30/20, showed, Was transferred to (memory care unit) this afternoon for closer supervision. no ill effects of elopement of yesterday. Review of the facility's Unsafe Wandering Risk Evaluation, dated 1/29/20, and completed following resident #13's elopement, showed, Resident had wandergard (sic) placed on her wrist today 1/29/20. she is constantly wandering all over the building and looking for her husband. B. During an interview on 3/3/20 at 5:25 a.m., staff member I stated resident #7 had fallen in December of 2019, and it was later determined at the hospital that he had sustained a [MEDICAL CONDITION]. Staff member I explained resident #7 fell around 11:30 p.m., and was transported to the hospital around 7:30 a.m., eight hours later. Staff member I stated the nurse who was responsible for resident #7 did not assess him following the fall, and assumed the fall was a behavior. Staff member I explained resident #7 had a history of [REDACTED]. During an interview on 3/3/20 at 6:10 a.m., staff member K stated she took shift report the morning after resident #7 fell and immediately assessed him.

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F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) Staff member K suspected he had sustained a [MEDICAL CONDITION], and sent him to the hospital, where the fracture was confirmed. During an interview on 3/3/20 at 8:15 a.m., staff member B stated she recalled staff member K was quite upset that staff member M did not send resident #7 to the hospital immediately. Staff member B stated she did not think staff member M intervened appropriately because she had not transported resident #7 to the hospital immediately. During an interview on 3/3/20 at 9:10 a.m., NF1 stated resident #7 was not in a wheelchair prior to the [MEDICAL CONDITION]. She clarified that resident #7 had been wheelchair bound since the incident. During an interview on 3/4/20 at 6:45 p.m., staff member M stated when resident #7 fell , she had been unfamiliar with the resident's care because she usually did not work on the memory care unit. Staff member M stated she relied on the CNA's interpretation of resident #7's fall, which was that it was a behavior, and something resident #7 did frequently. Staff member M stated resident #7 would not allow her to assess him. Review of resident #7's incident report, dated 12/3/20, showed he had fallen that evening and was transported to the hospital the morning of 12/4/20. Review of a Nursing Note, dated 12/[DATE]9, showed, at 8:30 p.m.: Female staff member was leading resident to his room and upon entering his room and explaining to him that this was his room - resident intentionly (sic) slid to the floor acting like he fell according to staff member and started yelling loudly call the ambulance. This nurse notified by staff member and attempted to assess resident but he refused to allow this nurse to assess him. Assisted x 2 to his bed due to resident would not get up off floor after being asked numerous times. Resident refused to get up off the floor. He complained of his right leg hurting and I could not get him to straighten his leg. When another staff member came into his room he complained of his left hip and side hurting. Unsure if he is truly hurt (due to) he would not allow this nurse to perform active or passive (range of motion). But according to staff he has done this before dramatically lying on the floor as though hurt. Notified (medical provider) of situation via answering service . Review of Nursing Notes, dated 12/[DATE]9, showed, at 2:09 a.m., Resident has been lying in bed and refused to place weight on either of his legs so staff could assist him to toilet. Resident confused at this time as is his normal baseline. Review of Nursing Notes, dated 12/[DATE]9, showed, at 7:05 a.m., This writer came on shift at (6:00 a.m.), report given to this nurse, assessed resident, left leg shorter than right and it is externally rotated. Call to (Director of Nursing) and also (Medical Provider). Review of resident #7's care plan, dated 2/29/20, showed resident #7 .is at a high risk for falls and injuries. Review of resident #7's MDS, with an ARD of 12/19/19, showed a BI[CONDITION] of 0, showing the resident had severely impaired cognition.
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 sufficient nursing staff, which had the potential to negatively affect the physical and the psychosocial well-being of residents. Specifically, the facility failed to prevent incontinence episodes for 1 (#1) by not responding to her call light in a timely manner; failed to respond to the call light of 2 (#s 6 and 9) in a timely manner so that they could receive ADL assistance; failed to prevent a fall and timely transfer to the hospital due to low staffing for 1 (#7); failed to provide timely turning and repositioning for 1 (#2), which contributed to the development of a Stage 4 pressure ulcer; and failed to maintain the dignity of 4 (#s 10, 11, 12, and 17) of 17 sampled residents, by standing while providing assistance with eating due to low staffing levels. Findings include: Residents' Perspective During an interview on 3/2/20 at 5:10 p.m., resident #9 stated there was only one CNA working on the A and C halls. Resident #9 stated she felt disappointed and physically uncomfortable when she had to wait 30-45 minutes for staff to help her to the restroom. During an interview on 3/3/20 at 12:10 p.m., resident #1 stated her call lights had been ignored for up to 30 minutes. Resident #1 stated, I don't like to do that, referring to having incontinent episodes. Resident #1 stated she could usually hold it, but not when she had to wait for 30 minutes. During an interview on 3/4/20 at 8:45 a.m., resident #6 stated staff response time to call lights was awfully slow, and he had to wait usually 30-60 minutes to be assisted into or out of bed, or to the restroom. During an interview on 3/4/20 at 10:05 a.m., resident #15 stated, There are not enough staff to get my needs met. Resident #15 explained staff had told him they do not have the time to get him out of bed and put him to bed when he wants. Staff's Perspective During an interview on 3/2/20 at 4:00 p.m., staff member D stated she had to stay and work one night recently as a CNA; otherwise, there would have been only one CNA for A and C wings. Staff member D stated residents were not put to bed until 8:00 p.m. that same evening she worked as a CNA. During an interview on 3/2/20 at 4:35 p.m., staff member C stated she felt the facility did not have enough staff to accommodate the needs of the residents. Staff member C stated there were usually two nurses and three CNAs for the A and C halls, which housed all residents except for residents on the memory care unit, which was staffed with one nurse and one CNA. Staff member C explained the facility had several new admissions in the past week or two. During an interview on 3/2/20 at 5:40 p.m., staff member G stated she would often pick up CNA responsibilities because, recently, there had been only one CNA for halls A and C. Staff member G stated the facility would ask her to come in early and stay late often. During an interview on 3/3/20 at 5:05 a.m., staff member G stated there were usually one or two CNAs for the A and C halls (about 45 residents), and one CNA for the memory care unit (about 14 residents). Staff member G felt staffing ratios were not determined based on residents' acuity; more on sheer numbers. Staff member G added that CNAs tend to call off work last minute. During an interview on 3/3/20 at 5:25 a.m., staff member I stated the facility did not have enough CNAs. Staff member I stated the facility did not have any CNAs on night shifts last week, and that negatively affected residents as staff took much longer to respond to call lights. Staff member I stated he had been pulled from his nursing duties to work as a CNA. Staff member I added the facility had admitted several residents recently who required more nursing care; for example, residents with dementia [DIAGNOSES REDACTED]. During an interview on 3/3/20 at 5:40 a.m., staff member J stated he had been scheduled as the only CNA for halls A and C on several occasions, which was especially difficult because many residents required a Hoyer (mechanical) lift or two-staff assistance. During an interview on 3/4/20 at 10:20 a.m., staff member N stated she was scheduled yesterday from 6:00 a.m. until 6:00 p.m. At 6:00 p.m., she left the facility, which meant only one CNA was working halls A and C. During an interview on 3/4/20 at 10:22 a.m., staff member Q stated she was the only CNA working last night from 6:00-6:30 p.m. She stated she was again the only CNA for about one hour between 3:00 and 4:00 a.m. During an interview on 3/4/20 at 11:32 a.m., staff member A stated the facility had a lot of new staff and he did not feel they were working together as a team as efficiently as possible. Staff member A explained he had purchased radios to improve team efficiency. Staff member A stated the Facility Assessment was updated annually, and took residents' acuity into consideration; although, staff did not have an opportunity to express their input as of this year. Staff member A stated they could do that at their next QAPI meeting. Staff A stated the facility had several new admits recently, and staff had been struggling to manage the workload. Staff member A stated the facility has had to call nurses who were not scheduled to work and/or utilize management to help offset the workload. During an interview on 3/4/20 at 6:45 p.m., staff member M stated, We're lucky if we have three CNA's at night for the whole facility. Sometimes we only have two, and it does make it hard-there's just not enough assistance. Staff member M stated the night when resident #7 fell (see F684), We just didn't have enough staff. Skin integrity During an interview on 3/2/20 at 4:00 p.m., staff member D said resident #2 should be sitting in her wheelchair only for one hour at a time due to skin integrity issues, but she has had to sit in her wheelchair for up to three hours because of the lack of staff. During an interview on 3/2/20 at 4:10 p.m., resident #2 stated there were two CNAs working last night and one left early. Resident #2 stated she has had to wait for three hours for staff to move her from her wheelchair to her bed, which was problematic because she was supposed to be in her wheelchair for only one hour at a time. Resident #2 expressed she felt frustrated when she had to wait for staff to move her from her wheelchair to her bed. During an interview on 3/3/20 at 5:05 a.m., staff member G stated, I don't know if we're able to give quality care (to the residents) with the staffing we have .to make sure residents are turned every two hours, checked, and changed. It has affected (residents') skin integrity. During an interview on 3/5/20 at 9:30 a.m., staff member S stated she had concerns about residents who rely on staff for positioning and mobility because the facility did not have sufficient staffing to get (residents) up and down so they end up in the same positions for long periods of time, which can negatively affect skin integrity. During an intervew on 3/5/20 at 12:55 p.m., staff member T stated pressure ulcers were a common isssue in nursing homes, especially for residents who rely on staff for mobility. Staff member T stated there was high staff turnover in the facility and that was part of the difficulty of providing consistent care to residents; so, for resident #2, for example, as soon as a staff member learned about her wound and how to care for it, they would leave. Mealtimes During an interview on 3/2/20 at 5:15 p.m., staff

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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 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) member C stated managers had been helping during mealtimes because the facility did not have enough CNAs. During an observation on 3/2/20 at 5:25 p.m. in the dining room, staff member E was serving dinner plates to residents. During an interview on 3/2/20 at 5:27 p.m., staff member E stated the facility had implemented a new plan during mealtimes, which involved having one manager assist throughout a meal. The managers would alternate daily. During an observation on 3/2/20 at 5:30 p.m., staff member F was standing while feeding resident #10. Staff member F proceeded to help feed two other residents (#s 11 and 12), in addition to resident #10, all while standing. During an interview on 3/2/20 at 5:40 p.m., staff member D stated she felt staff did not have enough time to sit down with residents 1:1 and help them eat. During an interview on 3/2/20 at 6:00 p.m., staff member H stated, I know we're supposed to sit (when we help residents eat), but we don't have enough time (to sit with everyone). Staff member H stated there had been an influx of new admissions in the past few weeks who required 1:1 feeding assistance. During an interview on 3/2/20 at 6:45 p.m., staff member F stated there were currently six residents in wheelchairs or geri-chairs who required assistance during eating. Staff member F explained the facility usually had only two or three residents who required assistance during meals. Staff member F stated staff tried to sit next to those residents who required assistance; however, there were too many people in the dining room to do so. During an observation on 3/4/20 at 8:30 a.m., in the dining room during breakfast, staff member P was feeding pancakes to resident #10. Throughout breakfast, staff member P went back and forth between three residents (#s 10, 12, and 17) to assist them with eating. During an interview on 3/4/20 at 9:10 a.m., staff member P stated she was responsible for assisting two or three residents during mealtimes. Staff member P stated there was no chair available for her to sit, and, if she only had one resident to assist, she would be able to sit down next to them. Staff member P stated, It does not feel like we have enough staff to accommodate (the residents). Documentation The facility provided a list of residents who required feeding assistance and those residents who required a Hoyer lift and/or two-person transfer assistance. The list showed 12 residents required some form of assistance during meals, and 13 residents required a Hoyer lift for transfers. Facility staffing documentation showed staffing for the entire facility, including the memory care unity. For February of 2020, 2-4 CNAs were scheduled for each 12-hour shift. On 2/5/20, for example, one nurse was scheduled from 6:00 a.m.-6:00 p.m.; another nurse came on at 2:00 p.m. and worked until 10:00 p.m. Two CNAs were scheduled from 6:00 a.m.-2:00 p.m. for the entire facility. From 2:00-4:00 p.m., there were three CNAs; and from 4:00-10:00 p.m., there were, again, two CNAs. The same document showed the total number of worked hours for both nurses and CNAs on 2/5/20 was 132.5 hours. Between 2/1/20 and 2/21/20, there were another eight days in which the total number of worked hours for nurses and CNAs was less than 132.5 hours. Approximately 40% of the time, there were 2-3 CNAs providing care for more than 50 residents. For comparison, between 1/1/20 and 1/22/20, the lowest number of hours worked for nursing staff was 141.3. Review of the facility's Calloff Report, between 1/1/20 and 3/3/20, showed there were a total of 69 call-offs. 14 CNAs and 10 nurses called-off during in February of 2020; in January of 2020, 32 CNAs and 10 nurses called-off work.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to appropriately notify and educate their staff as to appropriate PPE for 1 (#8), of 17 sampled residents, who was on contact precautions; failed to follow contact precaution standards; and failed to perform appropriate hand sanitization in between feeding 2 (#s 10 and 12) residents, which had the potential to place residents at risk of infection. Findings include: A. During an observation on 3/3/20 at 11:55 a.m., resident #8 did not have a sign on the door that showed the resident was on transmission precautions. There was a 3-drawer plastic cart outside of the resident's door, but no information as to which PPE to don prior to entering. During an interview on 3/3/20 at 12:00 p.m. staff member N stated resident #8 was on contact precautions due to a [DIAGNOSES REDACTED]icile. (C. difficile is a bacterial infection in the gut that requires contact precautions, i.e. staff to don a gown and gloves prior to providing direct care). Staff member N, however, stated she would don a gown, gloves, and mask prior to providing direct care. During an observation on 3/4/20 at 11:50 a.m., there was no sign on resident #8's door that stated the resident was on transmission precautions. There was a 3 -drawer plastic cart outside of the resident's door, but no information as to which PPE to don prior to entering. The cart contained red biohazard bags, gloves, gowns, masks, and booties. During an interview on 3/4/20 at 12:05 p.m. with staff members D and O, staff member O stated she had forgotten to put on a gown before entering resident #8's room. Staff members D and O stated they were not sure how someone would know which PPE to don if they were a visitor or a new employee and were unfamiliar with resident #8's diagnoses. During an interview on 3/4/20 at 12:15 p.m. staff member B stated if the facility had a policy and procedure on transmission precautions, she did not know about it. During an interview on 3/4/20 at 1:30 p.m., staff member R stated for someone on contact precautions, she would don a mask and gloves before entering the room. Staff member R did not mention donning a gown. Review of residents residing in the facility showed four cases of [DIAGNOSES REDACTED]icile between 1/20/20 and [DATE], among three residents. The other two residents (not resident #8) had both discharged from the facility by 2/3/2020. Review of resident #8's care plan, dated [DATE], showed, under Risk for Infection [MEDICAL CONDITION] (infection of the bloodstream) and Cdiff (C. difficile). Educate resident/representative on infection control practices, and, Educate resident/representative on techniques to prevent infection, such as handwashing adequate rest, nutrition, and avoidance of crowds. There was no mention of PPE in the resident's care plan. Review of the facility's policy, [MEDICAL CONDITION], showed: Residents with [DIAGNOSES REDACTED]icile will be placed on Contact Precautions .healthcare workers will wear gloves and gowns upon entering the room of a resident with [DIAGNOSES REDACTED]icile infection, and will remove gowns and gloves prior to exiting the room. Visitors will be encouraged to wear gowns and gloves, and instructed on proper hand hygiene. B. During an observation on 3/4/20 at 8:30 a.m., in the dining room during breakfast time, staff member P was feeding resident #10 pancakes with a spoon using her right hand. Her left hand was positioned on the back of resident #10's wheelchair. Staff member P then moved to resident #12 and gave her a bite of pancakes without sanitizing her hands. While staff member P was assisting resident #12, resident #10 coughed without covering his mouth in the general direction of staff member P and resident #12. Staff member P then used resident #10's clothing protector to wipe his mouth. Staff member P did not sanitize her hands between assisting resident #12 and resident #10. Staff member P continued to assist both residents throughout breakfast without sanitizing her hands. During an interview on 3/4/20 at 9:10 a.m., staff member P stated she was not sure when she was supposed to sanitize her hands when assisting residents. She stated she tried to do it as soon as she remembered. Review of the facility's policy, Assistance with Meals, updated 7/2017, showed: All employees who provide resident assistance with meals will be trained and shall demonstrate competency in the prevention of foodborne illness, including personal hygiene practices and safe food handling.