STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055292	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHIELDS RICHMOND NURSING CENTER	1919 CUTTING BLVD RICHMOND, CA 94804

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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 ensure four of 27 sampled residents (Resident 36, Resident 37, Resident 30, and Resident 19) were treated with dignity and respect during meal assistance when: 1. In the dining room, a staff member served and uncovered the food tray in front of Resident 36 and was not assisted with feeding, making her wait at the table. 2. In the dining room, Resident 37 was not served her tray the same time as the other two residents in the same table. 3. In the residents' room, a staff member fed both Resident 30 and Resident 19 simultaneously, while standing over residents. These deficient practices resulted in residents receiving undignified dining assistance. Findings: 1. During a review of Resident 36's Minimum Data Set (MDS, an assessment tool used to direct care) Quarterly Assessment, dated December 29, 2019, the MDS Assessment indicated, Resident 36 required extensive assist with one person physical assistance in eating. During an observation on 3/9/20 at 12:45 p.m., in the dining room, a staff member served and uncovered the food tray in front of Resident 36. Resident 36 was not assisted with feeding, making her wait at the table while her food was getting cold. It was only after all the other residents in the dining room were served their food, when a staff member sat next to Resident 36 and began assisting her with feeding. During an interview on 3/9/20 at 12:50 p.m., with the Director of Staff Development (DSD), the DSD stated, Resident 36 required assistance and cueing when eating. The DSD acknowledged Resident 36's food was uncovered and was getting cold while waiting for a staff member to feed the resident. The DSD stated, once trays are passed, staff needs to assist resident with feeding. 2. During a review of Resident 37's MDS Quarterly Assessment, dated December 30, 2019, the MDS Assessment indicated, Resident 37 had severe cognition impairment, and required limited assist with one person physical assistance in eating. During an observation on 3/9/20 at 12:45 p.m., in the dining room, Resident 37 was seated in a wheelchair, positioned at a table with two other residents. The two residents from the same table were served their food and started eating, while Resident 37 patiently waited for a staff member to deliver her food tray. Resident 37 was holding an empty sippy cup and repeatedly brought the sippy cup to her mouth as if she was drinking something, while waiting for her food tray. During an interview on 3/9/20 at 12:50 p.m., with the DSD, the DSD stated, trays are supposed to come out together by tables. 3. During a review of Resident 30's MDS Quarterly Assessment, dated December 25, 2019, the MDS Assessment indicated, Resident 30 has severe cognition impairment, and required extensive assist with one person physical assistance in eating. During a review of Resident 19's MDS Quarterly Assessment, dated February 3, 2020, the MDS Assessment indicated, Resident 19 has severe cognition impairment, and required limited assistance with one person physical assistance in eating. During an observation on 3/9/20 at 9:10 a.m., inside the residents' room, Resident 30 and Resident 19 were each seated upright in their beds, food served on top of their over bed tables in front of them, and were ready for breakfast. The Certified Nursing Assistant (CNA) 1 started to feed Resident 30, then walked towards Resident 19 to feed the resident. CNA 1 did this repeatedly during feedings, while standing over residents. CNA 1 stated, this was what she did, she fed the residents simultaneously. During an interview on 3/10/20 at 1:06 p.m., with the Director of Nursing (DON), the DON stated, it is not dignified to feed two residents at the same time. During an interview on 3/11/20 at 8:30 a.m., with the DSD, the DSD stated, staff members should feed residents one at a time and with staff sitting at the level of the resident. During a review of the facility's policy and procedure (P&P) titled, Quality of Life Dignity, dated August 2009, the P&P indicated, .Residents shall be treated with dignity and respect at all times. ' Treated with dignity ' means the resident will be assisted in maintaining and enhancing his or her self esteem and self worth . Staff shall treat cognitively impaired residents with dignity and sensitivity . Review of the facility's P&P titled, Assistance with Meals, dated July 2017, indicated, Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Dining Room Residents .Facility Staff will serve resident trays and will help residents who require assistance with eating. 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 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to address and manage complaints of pain for one (Residents 172) of 27 sampled residents when pain medication for mild pain was given for complaints of moderate pain. This failure resulted in unnecessary pain and suffering which affected Resident's 172's ability to maintain their highest practicable physical, mental, and psychosocial well-being. Findings: Review of the Face Sheet indicated that Resident 172 was admitted on [DATE] with multiple [DIAGNOSES REDACTED]. In an observation and concurrent interview on 3/9/20 at 9:00 a.m., Resident 172 complained that the facility did not have his pain medication to manage his post-op pain until mid-day the next day. Resident 172 stated the staff told him the medications was not available. In an interview with the family member (FM 1) on 3/9/20 at 9:00 a.m., FM 1 stated the staff gave Resident 172 Tylenol (pain medication) which does not help for his post-surgical amputation of his leg. FM 1 stated the staff informed them that they were waiting for pharmacy delivery in the morning. Review of the Physician's (MD) order dated 3/2/20 indicated, Assess for pain every shift (QS), 0 =No Pain; 1-4 = Mild Pain; 5-7 = Moderate Pain; 8-10 = Severe Pain every shift. Review of the MD order dated, 3/2/20 indicated, [MEDICATION NAME] (Tylenol) Tablet 325 mg. Give 2 tablet by mouth every 4 hours as needed for Mild Pain ., [MEDICATION NAME] HCL tablet 5 mg. Give 1 tablet by mouth every 6 hours as needed for Moderate Pain. Review of the Medication Administration Record [REDACTED]. MAR indicated [REDACTED]. MAR indicated [REDACTED]. In an interview with the Assistant Director of Nursing (ADON) on 3/10/20 at 9:00 a.m., the ADON stated Resident 172 should have been given the stronger medication for complaints of moderate pain. The ADON stated the medication was available in the emergency kit while waiting for the pharmacy delivery. Review of the facility's policy titled, Pain Assessment and Management, dated March 2015 indicated, Review the resident's clinical record to identify conditions or situations that may predispose the resident to pain, including: Musculoskeletal Conditions: . Fractures; and Amputation.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure its medication error rate did not exceed five percent. There were two medication errors out of 29 opportunities resulting to 6.9 percent (%) medication error rate when: 1. For Resident 47, [MEDICATION NAME] (a medication that helps control blood sugar levels) was administered after meals, instead of before meals as ordered by the physician. 2. For Resident 26,(NAME)vite (treats and prevents vitamin deficiency in the body) was administered, instead of the Nephro vite Plus Iron as ordered by the physician. These deficient practices had the potential to jeopardize Resident 47 and Resident 26's health and the safe administration of medications. Findings: 1. During a review of Resident 47's Admission Record, dated March 10, 2020, the Admission Record indicated,

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 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Resident 47 was originally admitted to the facility on [DATE] and readmitted on [DATE] with a [DIAGNOSES REDACTED]. During a review of Resident 47's Minimum Data Set (MDS, an assessment tool used to direct care) Admission Assessment, dated January 17, 2020, the MDS Assessment indicated, Resident 47 had intact cognition. During a review of Resident 47's Medication Review Report, dated March 10, 2020, the Medication Review Report indicated, Resident 47 had a physician order [REDACTED]. During a concurrent medication administration observation and interview on 3/10/20 at 8:13 a.m. with Resident 47, in the resident's room, Resident 47 stated, he had already taken his breakfast. Registered Nurse (RN) 1 administered [MEDICATION NAME] to Resident 47, without asking if resident had already eaten his breakfast. During an interview on 3/12/20 at 8 a.m., with RN 1, RN 1 stated, she usually gave Resident 47 his [MEDICATION NAME] before breakfast. RN 1 stated, she got behind with another resident who had an early appointment, and was unable to see Resident 47 to administer his [MEDICATION NAME] before the meal. 2. During a review of Resident 26's Admission Record, dated March 10, 2020, the Admission Record indicated, Resident 26 was originally admitted to the facility on [DATE] and readmitted on [DATE], with a [DIAGNOSES REDACTED]. During a review of Resident 26's Medication Review Report, dated March 10, 2020, the Medication Review Report indicated, Resident 26 had a physician order [REDACTED]. During a concurrent medication administration observation, interview, and record review on 3/10/20 at 9:06 a.m., with the Licensed Vocational Nurse (LVN) 1, LVN 1 administered(NAME)vite one tablet by mouth to Resident 26. When Resident 26's Medication Administration Record [REDACTED]. LVN 1 stated, she had been giving(NAME)vite and not(NAME)vite Plus Iron to Resident 26 because this was the only medication available in the medication cart. During a telephone interview on 3/10/20 at 11:45 a.m., with the Registered Pharmacist (RP), the RP stated,(NAME)vite and Nephro vite were not the same, and did not contain Iron. Resident 26's physician order [REDACTED]. During a concurrent interview and record review on 3/12/20 at 9:41 a.m., with the RP, Resident 26's Pharmacy Medication Regimen Review (MRR), dated 12/1/19 12/14/19, 1/1/20 1/19/20, and 2/1/20 2/15/20 were reviewed. The MRR for the last three months indicated no medication recommendation for Resident 26. The RP stated, he comes to the facility on ce a month and only did spot checks from the medication carts. The RP was not aware that Resident 26's ordered medication Nephro vite Plus Iron, was never available in the medication cart for administration. Review of facility's policy and procedure (P&P) titled, Administering Medications, dated April 2019, indicated, Medications are administered in a safe and timely manner, and as prescribed . Medications are administered in accordance with prescriber orders including any required time frame. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: a. Enhancing optimal therapeutic effect of the medication; b. Preventing potential medication or food interactions; and . The individual administering the medication checks the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route), of administration before giving the medication .
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that one (Resident 23) of 27 surveyed residents was free from significant medication errors when: 1. [MEDICATION NAME] (a [MEDICATION NAME] binder drug used to lower high blood phosphorus ([MEDICATION NAME]) levels in patients with [MEDICAL CONDITION]) was administered to Residents 23 before meals. 2. the physician was not notified that the [MEDICATION NAME] binder medication for Resident 23 was not given on certain days. These failures had the potential to result in significant electrolyte imbalance for Resident 23 that could lead to life threatening complications. Findings: 1. Review of the Record of Admission showed, Resident 23 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. In an observation and concurrent interview on 3/9/20 at 8:05 a.m., Resident 23 was awake in bed eating breakfast. Resident 23 stated that the nurse gave her medications early this morning before breakfast. In an interview with the Licensed Vocational Nurse (LVN 3) on 3/9/20 at 8:25 a.m., LVN 3 confirmed that the night nurse gave Resident 23 [MEDICATION NAME] early morning before breakfast. Review of the physician's (MD) order dated, [MEDICATION NAME] (Sevelarmer HCL) Tablet 800 mg, Give 1 tablet by mouth before meals for control phosphorus with CKD ([MEDICAL CONDITION]). In an interview with the Pharmacist (RP) on 3/11/20 at 9:00 a.m., the RP stated, a [MEDICATION NAME] binder medication should be given with meals. According to the National Institute of Health publication Daily Med, dated, 10/19/18, [MEDICATION NAME] is a [MEDICATION NAME] binder indicated for the control of serum phosphorus in patients with [MEDICAL CONDITION] on [MEDICAL TREATMENT]. Take [MEDICATION NAME] with meals based on serum phosphorus level (https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=5e b-f2bf-43a0-86b2-44ae996dc681). 2. Review of the Medication Administration Record [REDACTED]. In an interview with the Assistant Director of Nurses (ADON) on 3/10/20 at 9:00 a.m., the ADON was not able to show documentation for the missed dose and there were no notes indicating that the MD was notified of the medications not given. The ADON stated dose omitted must be documented stating the reason for not giving the medication and the MD should have been notified.
F 0790 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide routine and 24-hour emergency dental care for each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow the physician's order to provide routine dental services for two (Residents 13 and 63) of 27 surveyed residents when: 1. Resident 13 did not receive routine follow up dental services for ill-fitting dentures. 2. Resident 63 did not receive routine dental services for missing teeth since admission. These failures had the potential to cause resident avoidable dental discomfort and weight loss. Findings: 1. Review of the Admission Record indicated Resident 13 was admitted on [DATE] with multiple [DIAGNOSES REDACTED]. In an observation and concurrent interview with Resident 13 on 3/9/20 at 09:10 a.m., Resident 13 was awake in bed eating breakfast. Resident 13 was complaining that it is hard to chew her food because she still did not have her dentures fixed. Resident 13 was not wearing her dentures. Review of the Physician's (MD) diet orders, dated 3/27/17, indicated, Mechanical soft, Chopped meats . Review of the MD order dated, 8/3/15 indicated, Dental consult with treatment as needed. In an interview on 3/9/20 at 9:00 a.m., Social Services Director (SSD) 1 stated Resident 13 had complained about dentures back in September 2019 and was fitted in December 2019. SSD 1 stated Resident 13 still was uncomfortable with the dentures but SSD 1 was not able to show any followup communication with the Dentist. Review of the weight summary record indicated Resident 13 weighted 150 lbs on 1/2/19 and 146.7 on 1/2/20. In an interview with SSD 1 on 3/9/20 at 9:00 a.m., SSD 1 stated, Resident 13's dentures were delivered in December 2019 but it was not fitting right. SSD 1 added, the facility had a new dentist following the residents and had not seen Resident 13. SSD 1 stated Resident 13 had dental appointment scheduled but the dentist did not show up and there was no arrangements for another dentist to come. There were no documentation of the Dentist's visit, plan, instructions and recommendations regarding the fitting of the dentures. In an interview with the Dietician (RD) on 3/11/20 at 9:30 a.m., the RD stated she was not aware of Resident 13 had complained of discomfort in chewing her food. Review of the facility's policy titled, Dental Services, dated December 2016 indicated, Routine and 24-hour emergency dental services are provided to our residents through . a contract agreement with a licensed dentist that comes to the facility monthly . 2. Review of the Admission Record indicated Resident 63 was admitted on [DATE] with multiple medical history including, Diabetes (high blood sugar) and Mild Calorie Malnutrition. During an observation and concurrent interview on 3/9/20 at 8:45 a.m., Resident 63 was awake in bed eating breakfast. Resident 63 stated that she did not like hard food because it was hard to chew and it hurt her gums. Resident 70 added she had no teeth and no dentures. Review of the MD diet order, dated, 1/24/20 indicated, Renal, CCHO (consistent or controlled carbohydrate) diet Mechanical Soft, Chopped texture . Review of the Weight Summary indicated Resident 63 weighed 161 pounds (lbs) on 11/19/19 and 144.7 lbs on 3/3/20. Resident 63 lost 16 pounds, a 10% weight loss. In an interview with the Dietician (RD) on 3/11/20 at 9:00 a.m., the RD confirmed Resident 63 had significant weight loss. The RD stated there were no notes indicating Resident 63 had difficulty chewing her food otherwise she would have referred her to the Speech Therapist. Review of the MD orders dated 1/24/20 indicated, Dental consult with treatment and follow-up as indicated. In an interview with SSD 2 on 3/9/20 at 10:27 a.m., SSD 2 confirmed there was no dental referral notes and Resident 63 has not seen a dentist since admission. Review of the facility's policy titled, Dental Services, dated December 2016 indicated, if dentures are damaged or lost, residents will be referred for dental services within 3 days. If the referral is not made within 3 days, documentation will be provided regarding what is being done to ensure that the resident is able to eat and drink adequately while awaiting the dental services; and the reason for the delay .

F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.**

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) Based on observation, interview and record review, the facility failed to store, prepare, and serve food under sanitary conditions when: 1. A pile of wet blankets was observed under the prep sink; 2. A pocket book and a jacket were observed inside the kitchen on a portable air conditioner near the refrigerator; 3. Boxes of food supplies were found, on the floors of kitchen and storage room. These failures had the potential to cause food contamination and food borne illness. Findings: During the initial tour of the kitchen with the Dietary Manager (DM) on 03/09/20 at 8 a.m., the following were observed: 1. A pile of wet blankets were observed under the prep sink; 2. One box of dairy pure milk, one box of scrambled egg mix, one box of whipping cream, several boxes of produce, one box of canned tomatoes were found on the floor of the storage room; 3. A pocket book and a jacket were observed inside the kitchen on a portable air conditioner near the refrigerator. During a concurrent interview with the DM on 03/09/20 at 8 a.m., the DM stated that sink was leaking, so the blankets were put there to soak up the water, and maintenance was supposed to take care of it. The DM also stated the supplies should not be kept on the floor, we have no storage space. Review of the facility's undated policy titled, Canned and Dry Goods Storage, indicated, Food supplies should be stored 6 inches off the floor.
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 maintain an infection prevention and control program to prevent the development and transmission of communicable diseases when: 1. A peripheral Intravenous (IV) catheter was left without care and monitoring for ten days. 2. A staff feed two residents simultaneously without hand hygiene in between residents. These deficient practices had exposed the residents to the spread of infection within the facility. Findings: 1. During a record review on 3/9/20 at 8:40 a.m., the Admission Record indicated Resident 174 was admitted on [DATE] with multiple [DIAGNOSES REDACTED]. During an observation on 3/9/20 at 8:44 a.m. and on 3/10/20 at 8:46 a.m., Resident 174 was awake in bed watching television. An IV catheter was seen hanging from his left lower arm without label and date. In an interview with Resident 174 on 3/9/20 at 8:44 a.m., Resident 174 stated the staff has not come to give him anything through the IV since 3/7/20. In an interview with the Assistant Director of Nursing (ADON) on 3/9/20 at. 9:00 a.m., the ADON stated the IV Antibiotic was completed on 3/7/20. The ADON confirmed that the IV has not been changed since it was put in on 2/29/20. The ADON added that the facility's policy is to change the IV every three days. Review of the Medication Administration Record [REDACTED]. Review of the care plan, dated February and March 2020 indicated, no care plan to direct staff on the care and management of Resident 174's IV. Review of the facility's policy titled, Peripheral IV Dressing Changes, dated April 2016 indicated, Change the dressing if it becomes damp, loosened or visibly soiled and at least every 5 to 7 days. Change dressing and perform site care if signs and symptoms of site infection are present . Label dressing with date, time, and initials . Document the following, date, time, type of dressing and reason for dressing change . Resident's response to procedure. The US Centers for Disease Control publication titled, Guidelines for Prevention of Intravascular Catheter Related Infections, dated 2011, recommend replacement of peripheral intravenous (IV) catheters no more frequently than every 72-96 hours - ie every 3-4 days. Routine replacement is thought to reduce the risk of phlebitis and bloodstream infection (https://www.cdc.gov/hai/pdfs/bsi-guidelines-2011.pdf). 2. During a review of Resident 30's MDS Quarterly Assessment, dated December 25, 2019, the MDS Assessment indicated, Resident 30 has severe cognition impairment, and required extensive assist with one person physical assistance in eating. During a review of Resident 19's MDS Quarterly Assessment, dated February 3, 2020, the MDS Assessment indicated, Resident 19 has severe cognition impairment, and required limited assistance with one person physical assistance in eating. During an observation on 3/9/20 at 9:10 a.m., inside the residents' room, Resident 30 and Resident 19 were each seated upright in their beds, food served on top of their over bed tables in front of them, and were ready for breakfast. The Certified Nursing Assistant (CNA) 1 started to feed Resident 30, then walked towards Resident 19 to feed the resident. CNA 1 did this repeatedly during feedings, while standing over residents. CNA 1 stated, this was what she did, she fed the residents simultaneously. During an interview on 3/10/20 at 1:06 p.m., with the Director of Nursing (DON), the DON stated, it is not dignified to feed two residents at the same time. During an interview on 3/11/20 at 8:30 a.m., with the DSD, the DSD stated, staff members should feed residents one at a time and with staff sitting at the level of the resident.
F 0883 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** Based on observation, interview and record review, the facility failed to follow the standards of practice to prevent the spread of disease when two of five sampled staff did not have an influenza vaccination. Findings: Review of personnel health records and concurrent interview with the Nurse Consultant (NS 1) on 3/11/20 at 1:12 p.m., NS 1 confirmed Registered Nurse 1 and LVN 2 did not have current and required enfluenza immunization. NS 1 stated personnel who did not have influenza immunizations must wear a mask when caring for residents. During an observation on 3/10/20 at 9:00 a.m., and again on 3/11/10 at 10:00 a.m., RN 1 was passing medications to residents without wearning a mask. In an interview with the Assistant Diretor of Nurses (ADON) on 3/11/10 at 11:00 a.m., the ADON stated RN 1 should wear a mask because she did not have a flu shot. According to the Occupational Safety and Health Administration (OSHA), Healthcare Advisor publication titled, Requiring Masks for Healthcare Workers, dated, 11/22/11 indicated, Healthcare workers either need to get an influenza vaccination or wear a mask when working with patients during flu season.
F 0912 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide 80 square footage of space per resident for 34 residents who occupied 12 multi-beds bedrooms. This condition had the potential to result in lack of sufficient space for the provision of care both routine and emergency and for residents to have their personal belongings at bedside. Findings: During multiple room observations on 3/9/20 through 3/12/20., there were three residents in Rooms 22, 23, 24, 25, 26, 27, 31, 34, 35 and a resident occupying a three-bedroom in room [ROOM NUMBER]. 1. room [ROOM NUMBER] measured 11.3 feet by 19 feet which equaled 71.56 square feet per resident. 2. room [ROOM NUMBER] measured 19 feet by 11.4 feet which equaled 72.2 square feet per resident. 3. room [ROOM NUMBER] measured 19.3 feet by 11.4 feet which equaled 73.34 square feet per resident. 4. room [ROOM NUMBER] measured 19.1 feet by 11.3 feet which equaled 71.94 square feet per resident. 5. room [ROOM NUMBER] measured 19.1 feet by 11 feet which equaled 70.03 square feet per resident. 6. room [ROOM NUMBER] measured 19 feet by 11.4 feet which equaled 72.2 square feet per resident. 7. room [ROOM NUMBER] measured 19 feet by 11.4 feet which equaled 72.2 square feet per resident. 8. room [ROOM NUMBER] measured 18.9 feet by 11.4 feet which equaled 71.82 square feet per resident. 9. room [ROOM NUMBER] measured 18.9 feet by 11.4 feet which equaled 71.82 square feet per resident. 10. room [ROOM NUMBER] measured 18.9 feet by 11.3 feet which equaled 71.19 square feet per resident. 11. room [ROOM NUMBER] measured 18.1 feet by 11.7 feet which equaled 70.59 square feet per resident. 12. room [ROOM NUMBER] measured 19.1 feet by 11.3 feet which equaled 71.94 square feet per resident. During random observations of care and services from 3/9/20 to 3/12/20, there was sufficient space for the provision of care for the residents in all rooms. There was no heavy equipment kept in the rooms that might interfere with residents care and each resident had adequate personal space and privacy. There were no complaints from the residents regarding insufficient space for their belongings. There were no negative consequences attributed the decreased space and/or safety concerns in the six rooms. Granting of room size waiver recommended.