| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065415 | A. Building<br>B. Wing | 10/19/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Pikes Peak Post Acute | 2719 N Union Blvd<br>Colorado Springs, CO 80909 |

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| F 0550<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022<br><br>Based on observations, interviews and record review, the facility failed to ensure six (#5, #9, #10, #7, #6 and #8) of 10 residents reviewed for dignity out of 10 sample residents had the right to a dignified existence.<br><br>The facility failed to ensure residents experienced a dignified living experience by not promptly answering call lights for Resident #5, Resident #9 and Resident #10.<br><br>Resident #5 was admitted to the facility on [DATE]. She needed extensive assistance with activities of daily living (ADLs). The resident required assistance with incontinence care and was concerned that staff would not promptly answer her call light. On 10/18/22 at 3:15 a.m. the resident was observed lying in bed with her call light initiated. The resident was interviewed on 10/18/22 at 3:30 p.m. She said she initiated her call light as she had an incontinence episode and needed to be changed. She said it was embarrassing to sit in her own waste. She said she typically waited at least 30 minutes for staff to assist her.<br><br>Resident #9 was admitted to the facility on [DATE]. She needed extensive assistance with ADLs. The resident required assistance with incontinence care. The resident said it was awful to wait so long for staff to assist her in cleaning herself up. She said she was embarrassed, disgusted and humiliated sitting in her soiled brief for extended periods of time.<br><br>Resident #10 was admitted to the facility on [DATE]. She needed extensive assistance with ADLs. The resident needed assistance with incontinence care. The resident said she had laid in bed in her soiled undergarments for about an hour before she was provided assistance. Resident #10 said she was embarrassed sitting in her room in her soiled undergarments.<br><br>Additionally, Residents #5, #6, #7, #8, #9 and #10 had expressed ongoing frustration over the inconsistent meal times in the facility. The facility failed to ensure meals were delivered to residents in a timely manner.<br><br>Findings include:<br><br>I. Failure to ensure call lights were answered in a timely manner after residents had experienced incontinence episodes<br><br>(continued on next page) |

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.

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

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| F 0550<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A. Facility policy and procedure<br><br>The Resident Rights Under Federal Law policy and procedure, revised 3/1/22, was provided by the nursing home administrator (NHA) on 10/20/22 at 2:30 p.m. It revealed in pertinent part, Patients/Residents (hereinafter 'resident' ) have the fundamental right to considerate care that safeguards their personal dignity along with respecting cultural, social, and spiritual values. Centers will comply with resident rights under Federal law.<br><br>Purpose: to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his/her self-esteem and self-worth.<br><br>The Call Lights policy and procedure, revised 6/1/21, was provided by the NHA on 10/20/22 at 2:30 p.m. It revealed in pertinent part, All (name of facility) patients will have a call light or alternative communication device with their reach at all times when attended. Staff will respond to call lights and communication devices promptly.<br><br>The Nursing Services policy and procedure, revised 6/1/21, was provided by the NHA on 10/20/22 at 2:30 p. m. It revealed in pertinent part, Centers will have sufficient nursing staff, including nurse aides, with the appropriate competencies and skills sets to provide nursing and related services to assure patient safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each patient, as determined by patient assessments and individual plans of care and considering the number, acuity and diagnoses of the Center's patient population, in accordance with the Facility Assessment.<br><br>Nursing care includes, but is not limited to, assessing, evaluating, planning and implementing patient care plans and responding to patient's needs as well as the provision of all prescribed medications and treatments, personal care, hygiene, and nursing interventions in response to physical, emotional, or behavioral needs/problems.<br><br>B. Resident #5<br><br>1. Resident status<br><br>Resident #5, under the age of 70, was admitted to the facility on [DATE]. According to the October 2022 computerized physician orders (CPO), the diagnoses included diabetes mellitus type two, morbid obesity, colostomy status (an opening from the colon to the outside of the body) and kidney disease.<br><br>The 11/9/22 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. She required extensive assistance of two staff members for bed mobility, toileting and personal hygiene. She had an ostomy for bowel and was always incontinent of bladder. The resident did not have any rejection of care.<br><br>2. Record review<br><br>The gastrointestinal care plan, initiated on 9/12/22, revealed the resident was at risk for gastrointestinal symptoms or complications related to a colostomy. The interventions included, in pertinent part: ostomy care daily and as needed.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | C. Resident #9<br><br>1. Resident status<br><br>Resident #9, age 92, was admitted to the facility on [DATE]. According to the October 2022 CPO, the diagnoses included hearing loss and hemiplegia and hemiparesis following a cerebral infarction affecting the right side (paralysis of the right side of the body following a stroke).<br><br>The 8/3/22 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The resident required extensive assistance from two staff members for bed mobility, transfers and toileting. She required extensive assistance of one staff member for dressing and personal hygiene. She was occasionally incontinent of bladder and always incontinent of bowel. The resident did not have any rejection of care.<br><br>2. Record review<br><br>The ADL care plan initiated on 8/8/19 and revised on 9/11/2020, revealed the resident required assistance for bathing, personal hygiene, grooming, dressing, eating, bed mobility, transfers and locomotion related to left sided weakness. The interventions included: providing cueing for safety and providing support on the residents weaker side when assisting the resident with ADLs.<br><br>The bladder and bowel care plan initiated on 1/21/16 and revised on 5/5/21, revealed the resident was incontinent of urine and occasionally incontinent of bowel. The interventions included: encouraging the resident to consume all fluids during meal, monitoring for signs and symptoms of infection, offering assistance with toileting upon arising, before meals, at bedtime and as needed, providing incontinence care as needed, using absorbent products as needed.<br><br>D. Resident #10<br><br>1. Resident status<br><br>Resident #10, age 73, was admitted to the facility on [DATE] and readmitted on [DATE]. According to the October 2022 CPO, the diagnoses included left leg below the knee amputation, adult failure to thrive, gastric ulcer and blindness of one eye.<br><br>The 9/27/22 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The resident required limited assistance of one staff member for bed mobility and dressing. The resident required extensive assistance of two staff members for transfers and total dependence of one staff member for toileting. The resident was always incontinent of bladder and bowel. The resident did not have any rejection of care.<br><br>2. Record review<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The ADL care plan, initiated on 9/16/22 and revised on 9/29/22, revealed Resident #10 was at risk for decreased ability to perform ADLs in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfers, locomotion and toileting related to amputation of bilateral lower extremities. The interventions included: monitoring conditions that may contribute to ADL decline, monitoring for pain, monitoring for complications of immobility, monitoring for symptoms of shortness of breath, providing cueing for safety and arranging the residents environment to facilitate ADL performance.<br><br>The bladder and bowel care plan, initiated on 9/29/22, revealed Resident #10 was incontinent of urine. The interventions included: assisting with incontinence care as needed, completing an incontinence assessment, monitoring for signs and symptoms of infection, monitoring her skin for redness, therapy to evaluate as needed and utilizing appropriate continent products.<br><br>E. Observations and staff interviews<br><br>During a continuous observation on 10/18/22 beginning at at 3:15 p.m. and ended at 4:10 p.m. the following was observed:<br><br>-At 3:15 p.m. Resident #5 was lying in bed with her call light initiated. She required assistance with incontinence care (see interview below).<br><br>-At 3:20 p.m. the admission director (AD) entered Resident #5's room and turned off the resident's call light. The AD did not assist the resident with incontinence care.<br><br>.<br><br>Resident #5 was interviewed at 3:30 p.m. She said she had initiated her call light since she had an incontinence episode. She said it was embarrassing to sit in her own waste for long periods of time. She said she typically waited at least 30 minutes for staff to assist her.<br><br>Resident #9 was interviewed at 3:40 p.m She said she initiated her call light as she had soiled herself and needed assistance. She said it was awful to wait so long for staff to assist her in cleaning herself up. She said she was embarrassed, disgusted and humiliated sitting in her soiled brief for extended periods of time.<br><br>Resident #10 was interviewed at 3:44 p.m She said she initiated her call light to get assistance in getting cleaned up after an incontinence episode. She said a certified nurse aide (CNA) did answer her call light, but told her there were several other residents that needed to get up. Resident #10 said she had laid in bed in her soiled undergarments for about an hour before she was provided assistance. Resident #10 said she was embarrassed sitting in her room in her soiled undergarments.<br><br>-At 3:45 p.m. licensed practical nurse (LPN) #7 entered Resident #9's room and turned her call light off. LPN #7 told Resident #9 that she needed to find another staff member to assist the resident. LPN #7 left the resident's room.<br><br>LPN #7 was interviewed at 3:46 p.m. She said four residents on the 600 unit needed bathroom assistance. She said the CNA was on her lunch break, so she was the only staff member on the unit. LPN #7 said she was trying her best to answer all of the call lights. LPN #7 said one CNA for the hallway was not enough help to ensure all of the residents received timely incontinence care.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The AD was interviewed at 3:55 p.m. She said she answered Resident #5's call light. The AD said Resident #5 needed incontinence care. The AD said she was not a CNA and did not help Resident #5. The AD said she turned off the call light and told the resident someone would come to assist her. The AD said since she turned off the call light nursing staff were not aware the resident still needed help.<br><br>-At 4:01 p.m. Resident #9's call light was answered and she was provided incontinence assistance.<br><br>Resident #9's call light was initiated prior to the start of the observation, but was initiated for 21 minutes during the observation period.<br><br>-At 4:08 p.m. CNA #1 assisted Resident #5. CNA #1 said she was working on the 200 unit that was on the other side of the facility. She said she had gone to the kitchen to get a snack for a resident and was stopped to assist in answering call lights on the 600 unit. She said there were no other CNAs assisting the residents on the 200 unit that she was assigned to when she was pulled to answer call lights. CNA #1 said there was not enough staff scheduled to ensure the residents received timely assistance.<br><br>Observations revealed Resident #5 waited at least 53 minutes. The call light had already been initiated when the observation began.<br><br>Cross-reference F725 the failure to consistently provide adequate nursing staff.<br><br>II. Failure to ensure residents experienced a dignified living experience by ensuring meals were served timely<br><br>A. Facility policy and procedure<br><br>The Meal Distribution policy and procedure, revised September 2017, was provided by the NHA on 10/20/22 at 2:30 p.m. It revealed in pertinent part, Meals are transported to the dining locations in a manner that ensures proper temperature maintenance, protects against contamination, and are delivered in a timely and accurate manner.<br><br>For point-of-service dining, the Dining Services department staff, under the supervision of the licensed nurse, will assemble the meal in accordance with the individual meal care and present it to the resident/patient or care staff for delivery to the resident/patient.<br><br>The Department Staffing policy and procedure, revised September 2017, was provided by the NHA on 10/20/22 at 2:30 p.m. It revealed in pertinent part, The Dining Services department will employ sufficient staff, with appropriate competencies and skill sets to carry out the functions of food and nutrition services in a manner that is safe and effective.<br><br>Adequate staffing will be provided to prepare and serve palatable, attractive, nutritionally adequate meals, at proper temperatures, at appropriate times and to support proper sanitary techniques being utilized.<br><br>B. Record review<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The posted meal service times were as follows:<br><br>-Breakfast: 7:30 a.m.<br><br>-Lunch: 11:30 a.m.<br><br>-Dinner: 4:30 p.m.<br><br>C. Observations<br><br>On 10/18/22 at 2:39 p.m. CNAs were observed passing meal trays on the 100 unit.<br><br>The lunch meal was being delivered to the 100 unit three hours and nine minutes after the posted meal time.<br><br>On 10/18/22 the meal cart was delivered to the north units (100, 200, 300 and 400) at 5:00 p.m.<br><br>The lunch meal was delivered two hours and 21 minutes after the posted meal time. The dinner meal was delivered to the north units 30 minutes after the posted meal time, which was approximately three hours after lunch was served.<br><br>On 10/19/22 the meal cart was delivered to the 200 unit at 8:16 a.m.<br><br>-At 8:29 a.m. the meal cart was delivered to the 300 unit.<br><br>-At 8:41 a.m. the meal cart was delivered to the 400 unit.<br><br>The breakfast meal was delivered 46 minutes after the posted meal time on the 200 unit, 59 minutes on the 300 unit and 71 minutes after the posted meal time on the 400 unit.<br><br>D. Resident interviews<br><br>Resident #6 was interviewed on 10/18/22 at 2:25 p.m. She said her meals were delivered at different times each day. She said sometimes her breakfast would come at 6:00 a.m. and other times it would come at 9:00 a.m. She said she had received her lunch at 2:30 p.m., which was normal lately. She said the CNAs were responsible for passing the meal trays. She said the CNAs already had enough to do let alone make them pass meal trays as well.<br><br>Resident #7 was interviewed on 10/18/22 at 2:30 p.m. She said she had just received her lunch tray. She said her meals were always delivered late and the times were very inconsistent. She said her lunch was often delivered between 2:00 p.m. and 3:00 p.m.<br><br>Resident #8 was interviewed on 10/18/22 at 2:40 p.m. She said she had recently been admitted to the facility. She said in the few days she had been at the facility the meal times were very inconsistent. She said she had received her lunch at 2:30 p.m., which was too late. She said dinner was often served at 5:00 p.m. She said she was not hungry at 5:00 p.m., since she had just received her lunch a couple hours earlier.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Resident #5 was interviewed on 10/18/22 at 3:30 p.m. She said all of the meals were often delivered late. She said the meal times were very inconsistent.<br><br>Resident #9 was interviewed on 10/18/22 at 3:40 p.m. She said all of the meals were often delivered late. She said the meal delivery times were very inconsistent.<br><br>Resident #10 was interviewed on 10/18/22 at 3:45 p.m. She said all of the meals were often delivered late. She said the meal delivery times were very inconsistent.<br><br>E. Staff interviews<br><br>CNA #8 and CNA #9 were interviewed on 10/18/22 at 2:39 p.m. They said the meals were delivered to the units at different times each day.<br><br>CNA #8 and CNA #9 said breakfast came between 7:30 a.m. to 10:30 a.m. They said lunch often came after 1:30 p.m. and dinner was often delivered between 5:00 p.m. and 7:00 p.m.<br><br>CNA #8 and CNA #9 said they were often told that the dining department was short staffed. They said the CNAs were responsible for serving drinks and meals to the residents. They said they were also responsible for obtaining the residents' meal orders.<br><br>Licensed practical nurse (LPN) #5 was interviewed on 10/19/22 at 8:15 a.m. She said she was an agency nurse and had worked in the facility for about eight weeks. She said the meals were never served at the same time.<br><br>LPN #5 said breakfast was delivered to the units between 8:00 a.m. and 11:00 a.m. and lunch was served between 11:30 a.m. and 3:00 p.m. She said the CNAs were responsible for delivering the meals. She said since the meal times were variable it made it difficult for the CNAs to finish their daily tasks.<br><br>Cook #1 and dietary aide (DA) #1 were interviewed on 10/19/22 at 8:32 a.m. They said they were responsible for plating the food and putting the trays into the hot boxes. They then delivered the hot boxes to the units.<br><br>DA #1 said it was not their responsibility to serve the residents their meals.<br><br>CNA #2 was interviewed on 10/19/22 at 8:43 a.m. She said the CNAs were responsible for serving the meals to the residents. She said they were also responsible for brewing coffee for the residents, which required her to leave the unit she was assigned to.<br><br>CNA #12 was interviewed on 10/19/22 at 8:46 a.m. She said the CNAs were responsible for serving the meals to the residents.<br><br>Registered nurse (RN) #1 was interviewed on 10/19/22 at 8:50 a.m. He said the CNAs were responsible for serving the meals to the residents. He said he attempted to assist the CNAs with this task when he had time.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | CNA #1 was interviewed on 10/19/22 at 8:53 a.m. She said the CNAs were responsible for serving the meals to the residents.<br><br>The dietary account manager (DAM) was interviewed on 10/19/22 at 10:30 a.m. He said breakfast was at 7:30 a.m., lunch was at 11:30 a.m. and dinner was at 4:30 p.m. He said these times were when the kitchen began plating food for the residents. He said some meals took longer to plate than others, which caused variable meal times.<br><br>The DAM said he was aware the meals were often delivered late. He said the lunch was delivered late on 10/19/22 as the kitchen did not have enough staff.<br><br>The director of nursing (DON) and the administrator in training (AIT) were interviewed on 10/19/22 at 11:57 a.m. The AIT said he was aware the meal delivery times were not good. He said the kitchen staff were contracted. He said he had been in contact with the contracted agency to improve several issues that had been brought to his attention.<br><br>The AIT said the meals should be delivered to the residents at the posted meal times.<br><br>Cross-reference F802 the failure to ensure a sufficient number of food and nutrition staff were available.<br><br>39261 |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>46022<br><br>Based on observations, interviews and record review, the facility failed to provide sufficient nursing staff with the appropriate competencies and skills to ensure the residents received the care and services they required as determined by resident assessments and individual plans of care.<br><br>Specifically, the facility failed to consistently provide adequate nursing staff which considered the acuity and diagnoses of the facility's resident population in accordance with the facility assessment, resident census and daily care required by the residents.<br><br>As a result of inadequate staffing, the facility failed to ensure a resident's were treated with respect and dignity. Cross-reference F550.<br><br>I. Resident census and conditions<br><br>According to the 10/18/22 Resident Census and Conditions of Residents report, the resident census was 177. The following care needs were as identified:<br><br>-119 residents needed assistance of one or two staff with bathing and 55 residents were dependent, and three were independent.<br><br>-162 residents needed assistance of one or two staff members for toilet use and nine residents were dependent, and six were independent.<br><br>-157 residents needed assistance of one or two staff members for dressing and 19 residents were dependent, and one was independent.<br><br>-145 residents needed assistance of one or two staff members for transfers and 25 were dependent, and seven were independent.<br><br>-169 residents needed assistance of one or two staff members with eating and four residents were dependent, and four were independent.<br><br>II. Staffing requirements for each unit<br><br>The human resources (HR) and scheduler in training (SIT) were interviewed on 10/19/22 at 9:36 a.m. and provided the staffing requirements for each unit in the facility based on their current census and resident need.<br><br>The HR said the facility was divided into five units. The North unit, 600 unit, 700 unit, 800 unit and the 900 unit.<br><br>The HR said all nursing staff worked 12 hour shifts. She said the day shift worked 7:00 a.m. to 7:00 p.m. and the night shift worked 7:00 p.m. to 7:00 a.m.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The HR said the facility's staffing goal for the day shift on the North unit was six to seven certified nurse aides (CNAs) and four licensed nurses. She said the night shift goal was three CNAs and two to three licensed nurses. She said the North unit had approximately 85 residents.<br><br>The HR said the facility's staffing goal for the 600 unit was two CNAs and one licensed nurse during the day shift and one nurse and one CNA for the night shift. She said the 600 unit had approximately 20 residents.<br><br>The HR said the facility's staffing goal for the 700 unit was four CNAs and two licensed nurses during the day shift and two CNAs and one nurse for the night shift. She said the 700 unit had approximately 40 residents.<br><br>The HR said the facility staffing goal for the 800 unit was one CNA and one licensed nurse during the day and the night shift. She said the 800 unit had approximately 22 residents.<br><br>The HR said the facility staffing goal for the 900 unit was one CNA and one licensed nurse during the day and the night shift. She said the facility was working on closing the 900 unit by moving the residents from that unit to other units. She said the 900 unit had approximately eight residents left on the unit.<br><br>III. Working schedule<br><br>Review of the facility working schedule from 10/1/22 to 10/19/22 revealed at most times the working schedule did not have licensed nurses or CNAs scheduled according to resident needs and staff interviews.<br><br>The HR was interviewed on 10/19/22 at 9:36 a.m. She said there were frequently not enough staff scheduled on the night shift (7:00 p.m. until 7:00 a.m.) on the North unit. She said she tried to fill all the open shifts, and the facility was also utilizing seventy-five percent agency staff, but even with the agency staff they had difficulty filling all the open shifts.<br><br>IV. Resident interviews<br><br>Resident #8 was interviewed on 10/18/22 at 2:40 p.m. She said she was recently admitted to the facility. She said it often takes a long time for her call light to be answered. She said at the time of the interview her call light had been on for at least 10 minutes.<br><br>Resident #5 was interviewed on 10/18/22 at 3:30 p.m. She said there were not enough staff to help her. She said she typically waited at least 30 minutes for her call light to be answered, but it was often much longer than that.<br><br>Resident #9 was interviewed on 10/18/22 at 3:40 p.m. She said she often had to wait a long time for staff to assist her. She said she often had to wait for staff to assist after she had soiled herself.<br><br>Resident #10 was interviewed on 10/18/22 at 3:45 p.m. She said she always waited a long time for staff to answer her call light. She said she had soiled her undergarments and was sitting in her own waste for over an hour.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | V. Staff interviews<br><br>CNA #11 was interviewed on 10/19/22 at 6:50 a.m. She said she was the only CNA from 11:00 p.m. to 5:00 a.m. on the secured 700 unit, which had approximately 41 residents.<br><br>Licensed practical nurse (LPN) #3 was interviewed on 10/19/22 at 6:51 a.m. She said she had been called in to help and work the 200 and 300 unit because State (referring to surveyors) was in the facility. She said she typically worked the 900 unit night shift. She said more often than not she was the only staff on the 900 unit, and that was a secure unit. She said she did not feel comfortable being the only staff member, and when she was assisting residents in their rooms, there was no staff to make sure the other residents were safe.<br><br>LPN #9 was interviewed on 10/19/22 at 6:52 a.m. She said she was the only nurse from 7:00 p.m. to 7:00 a.m. on the secured 700 unit.<br><br>LPN #8 was interviewed on 10/19/22 at 6:53 a.m. He said CNA #3 and himself were covering two units. He said it was difficult to cover both units during the night shift.<br><br>CNA #3 was interviewed on 10/19/22 at 6:55 a.m. She said LPN #8 and herself were covering two units. CNA #3 was unable to finish the interview as a resident needed assistance.<br><br>CNA #6 was interviewed on 10/19/22 at 6:57 a.m. She said she was an agency CNA and had worked in the facility for about four months. She said the facility typically staffed two CNAs for the North unit (100-400 units), which had approximately 85 residents, for the night shift. She said two CNAs was simply not enough help for residents, and oftentimes residents would have to wait at least half an hour for staff to assist them.<br><br>CNA #1 was interviewed on 10/19/22 at 8:46 a.m. She said registered nurse (RN) #1 and herself were working both the 800 and 900 units. She said several of the residents on the 900 unit needed two person assistance with transfers. She said she would leave the secured 800 unit to help RN #1 with transfers.<br><br>RN #1 was interviewed on 10/19/22 at 8:50 a.m. He said CNA #1 and himself were working both the 800 and 900 units.<br><br>The HR was interviewed on 10/19/22 at 9:36 a.m. She said hiring new staff was very difficult. She said she had been completing the nursing schedule for a couple of months, but they recently hired a new staffing coordinator.<br><br>The HR said the facility had attempted sign-on bonuses and retention bonuses, but had not had success with these methods. The HR said the facility had 23 open CNA positions and 21 opened licensed nurse positions.<br><br>The director of nursing (DON) and the administrator in training (AIT) were interviewed on 10/19/22 at 11:57 a.m.<br><br>The DON said they were trying to staff the building by utilizing agency staff. She said the facility was using 75% agency staff.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The AIT said residents should not be waiting an hour to be changed after incontinence episodes.<br><br>The AIT said they have been in a staffing crisis and they stopped taking new admissions on 10/17/22.<br><br>The DON said they have attempted staff retention bonuses, sign on bonuses, and gift cards to help with staffing. The DON said none of these efforts have helped improve with staffing.<br><br>The DON said there were several days and nights that they did not meet their set staffing goals. She said the night shift was more difficult to staff and had more missing shifts.<br><br>39261 |

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| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.<br><br>46022<br><br>Based on observations, record review and interviews, the facility failed to employ sufficient dietary support staff to carry out the functions of the food and nutrition services for eight of eight hallways.<br><br>Specifically, the facility failed to ensure a sufficient number of adequately trained food and nutrition staff were available which contributed to the prolonged wait times for meals and overall decreased resident satisfaction with dining service.<br><br>Findings include:<br><br>I. Facility policy and procedure<br><br>The Meal Distribution policy and procedure, revised September 2017, was provided by the NHA on 10/20/22 at 2:30 p.m. It revealed in pertinent part, Meals are transported to the dining locations in a manner that ensures proper temperature maintenance, protects against contamination, and are delivered in a timely and accurate manner.<br><br>For point-of-service dining, the Dining Services department staff, under the supervision of the licensed nurse, will assemble the meal in accordance with the individual meal care and present it to the resident/patient or care staff for delivery to the resident/patient.<br><br>The Department Staffing policy and procedure, revised September 2017, was provided by the NHA on 10/20/22 at 2:30 p.m. It revealed in pertinent part, The Dining Services department will employ sufficient staff, with appropriate competencies and skill sets to carry out the functions of food and nutrition services in a manner that is safe and effective.<br><br>Adequate staffing will be provided to prepare and serve palatable, attractive, nutritionally adequate meals, at proper temperatures, at appropriate times and to support proper sanitary techniques being utilized.<br><br>II. Observations<br><br>On 10/18/22 at 2:39 p.m. certified nurse aides (CNAs) were observed passing meal trays on the 100 unit.<br><br>The lunch meal was being delivered to the 100 unit three hours and nine minutes after the posted meal time.<br><br>The dining staff did not assist in serving the meal to the residents.<br><br>The meal was delivered two hours and 21 minutes after the posted meal time.<br><br>(continued on next page) |

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| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 10/18/22 the meal cart was delivered to the north units (100, 200, 300 and 400) at 5:00 p.m. by an unidentified dining staff member.<br><br>The lunch meal was delivered two hours and 21 minutes after the posted meal time. The dinner meal was delivered to the north units 30 minutes after the posted meal time, which was approximately three hours after lunch was served.<br><br>The dining staff did not assist in serving the meal to the residents.<br><br>On 10/19/22 the meal cart was delivered to the 200 unit at 8:16 a.m. by dietary aide (DA) #1. He then returned to the kitchen.<br><br>-At 8:16 a.m. CNA #10 was observed serving meals to the residents on the North unit.<br><br>-At 8:18 a.m. CNA #2 was observed in the kitchen brewing coffee (see interviews below). She then returned to her assigned hallway and began serving meals to the residents on the North unit.<br><br>-At 8:29 a.m. the meal cart was delivered to the 300 unit by DA #1. He then returned to the kitchen.<br><br>-At 8:41 a.m. the meal cart was delivered to the 400 unit. He then returned to the kitchen.<br><br>The breakfast meal was delivered 46 minutes after the posted meal time on the 200 unit, 59 minutes on the 300 unit and 71 minutes after the posted meal time on the 400 unit.<br><br>The dining staff did not assist in serving the meal to the residents.<br><br>III. Resident interviews<br><br>Resident #6 was interviewed on 10/18/22 at 2:25 p.m. She said her meals were delivered at different times each day. She said sometimes her breakfast would come at 6:00 a.m. and other times it would come at 9:00 a.m. She said she had received her lunch at 2:30 p.m., which was normal lately. She said the CNAs were responsible for passing the meal trays. She said the CNAs already had enough to do let alone make them pass meal trays as well.<br><br>Resident #7 was interviewed on 10/18/22 at 2:30 p.m. She said she had just received her lunch tray. She said her meals were always delivered late and the times were very inconsistent. She said her lunch was often delivered between 2:00 p.m. and 3:00 p.m.<br><br>Resident #8 was interviewed on 10/18/22 at 2:40 p.m. She said she had recently been admitted to the facility. She said in the few days she had been at the facility the meal times were very inconsistent. She said she had received her lunch at 2:30 p.m., which was too late. She said dinner was often served at 5:00 p.m. She said she was not hungry at 5:00 p.m., since she had just received her lunch a couple hours earlier.<br><br>Resident #5 was interviewed on 10/18/22 at 3:30 p.m. She said all of the meals were often delivered late. She said the meal times were very inconsistent.<br><br>(continued on next page) |

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| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #9 was interviewed on 10/18/22 at 3:40 p.m. She said all of the meals were often delivered late. She said the meal delivery times were very inconsistent.<br><br>Resident #10 was interviewed on 10/18/22 at 3:45 p.m. She said all of the meals were often delivered late. She said the meal delivery times were very inconsistent.<br><br>IV. Record review<br><br>The posted meal service times were as follows:<br><br>-Breakfast: 7:30 a.m.<br><br>-Lunch: 11:30 a.m.<br><br>-Dinner: 4:30 p.m.<br><br>V. Staff interviews<br><br>CNA #8 and CNA #9 were interviewed on 10/18/22 at 2:39 p.m. They said they were often told that the dining department was short staffed. They said the CNAs were responsible for serving drinks and meals to the residents. They said they were also responsible for obtaining the residents' meal orders.<br><br>Licensed practical nurse (LPN) #5 was interviewed on 10/19/22 at 8:15 a.m. She said the CNAs were responsible for delivering the meals. She said since the meal times were variable it made it difficult for the CNAs to finish their daily tasks.<br><br>Cook #1 and DA #1 were interviewed on 10/19/22 at 8:32 a.m. They said they were responsible for plating the food and putting the trays into the hot boxes. They then delivered the hot boxes to the units.<br><br>DA #1 said it was not their responsibility to serve the residents their meals.<br><br>CNA #2 was interviewed on 10/19/22 at 8:43 a.m. She said the CNAs were responsible for serving the meals to the residents. She said they were also responsible for brewing coffee for the residents, which required her to leave the unit she was assigned to.<br><br>CNA #12 was interviewed on 10/19/22 at 8:46 a.m. She said the CNAs were responsible for serving the meals to the residents.<br><br>Registered nurse (RN) #1 was interviewed on 10/19/22 at 8:50 a.m. He said the CNAs were responsible for serving the meals to the residents. He said he attempted to assist the CNAs with this task when he had time.<br><br>CNA #1 was interviewed on 10/19/22 at 8:53 a.m. She said the CNAs were responsible for serving the meals to the residents.<br><br>(continued on next page) |

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| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The dietary account manager (DAM) was interviewed on 10/19/22 at 10:30 a.m. He said breakfast was at 7:30 a.m., lunch was at 11:30 a.m. and dinner was at 4:30 p.m. He said these times were when the kitchen began plating food for the residents. He said some meals took longer to plate than others, which caused variable meal times.<br><br>The DAM said he was aware the meals were often delivered late. He said the lunch was delivered late on 10/19/22 as the kitchen did not have enough staff.<br><br>The DAM said he was not aware the federal regulation required dining staff to serve the residents their meals. He said the dining department currently did not have enough staff members to serve meals to the residents for any of the meals throughout the week.<br><br>The director of nursing (DON) and the administrator in training (AIT) were interviewed on 10/19/22 at 11:57 a.m. The AIT said he was aware the meal delivery times were not good. He said the kitchen staff were contracted. He said he had been in contact with the contracted agency to improve several issues that had been brought to his attention.<br><br>The AIT said the meals should be delivered to the residents at the posted meal times.<br><br>The AIT said he was not aware the federal regulation required dining staff to serve the residents their meals.<br><br>The DON said the CNAs always served the meals and drinks to all of the residents. She said this made it difficult for the nursing staff as they already were short on staff and had several other tasks to do throughout the day.<br><br>Cross-reference F725 the failure to consistently provide adequate nursing staff.<br><br>The AIT said he would speak with the contracted dining agency on updating the policy for the dining staff to serve all meals to the residents as the federal regulation read. |