STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145389	A. Building B. Wing	07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Watseka Rehab & Hlth Care Ctr	715 East Raymond Road Watseka, IL 60970

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 34201 Based on observation, interview and record review, the facility failed to provide Activities of Daily Living Assistance of toileting, eating and bathing for two of five dependent residents (R4, R6) on the sample list of 22. Findings Include: The facility Bath/Shower Policy dated January 2018 documents a bath/shower is scheduled for all residents in the facility at least weekly. 1.) R6's July 2021 Physician Order Sheets document a diagnosis of Alzheimer's Dementia. R6's MDS (Minimum Data Set) dated 6/15/21 documents R6 has severe cognitive impairments, requires extensive assistance of two staff for transfers and toileting, requires physical help with bathing and is frequently incontinent of urine. On 7/7/21 at 11:59 am, V3 CNA (Certified Nursing Assistant) stated residents are suppose to get two showers a week but they don't always get done. V3 also stated residents are shaved on shower days. On 7/7/21 at 12:23 pm, R6 was sitting up in the Dining Room. R6 had a slight urine odor about R6, and had 1/2 inch long chin whiskers. At this time, V5 CNA stated V5 had gotten R6 up around 6:45 am. V5 stated V5 had checked and repositioned R6 since R6 had been up ,but V5, who is the only CNA on the unit R6 resides, has not toileted or changed R6. On 7/7/21 at 1:10 pm, V5 CNA and V4 Agency CNA entered R6's room. V4 and V5 stood R6 up, from the wheelchair and a large amount of liquid poured out from under R6 and fell on the floor. V4 and V5 confirmed this was urine, and V5 stated, R6 must have just urinated a lot. V4 and V5 changed R6's incontinence brief which was saturated with urine, and stool. At this time, V5 again stated R6 had not been changed or toileted since getting up for the day{almost 6.5 hours earlier}. On 7/13/21 at 3:45 am, V9 RN (Registered Nurse) stated residents need to be changed and/or toileted at least every two hours. The facility Bath Schedule dated 4/6/21 documents R6 is to have a bath on day shift every Wednesday and Saturday. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R6's Shower/Abnormal Skin Report Sheets for June and July 2021 document R6 received showers only four times; on 6/9/21, 6/21/21, 6/26/21 and 6/28/21. 2.) R4's Physician Order Sheet dated July 2021 documents diagnoses of Mild Mental Retardation and Bipolar. R4' MDS (Minimum Data Set) dated 5/21/21 documents R4 requires limited assistance for eating and physical assistance with bathing. On 7/7/21 at 8:50 am, R4 was sitting up in a wheelchair in R4's room, with the call light activated. R4 was attempting to feed R4's self with R4's right hand. R4 had food spilt down the front of R4's shirt. R4 stated, I need help. R4 stated R4's right arm is achy and that R4 needed help with eating. R4 stated breakfast was served at 8:30 am, and nobody has offered to assit R4 with eating . R4 also stated R4 is waiting on a bath, I (R4) am suppose to get one at least weekly and I (R4) haven't had one since a week ago Friday. On 7/7/21 at 9:05 am {35 minutes after breakfast was served}, V4 CNA (Certified Nursing Assistant) entered R4's room and assisted R4 with eating. The facility Bath Schedule dated 4/6/21 documents R4 is to have a bath on day shift every Monday and Thursday. R4's Shower/Abnormal Skin Report Sheets for June and July 2021 documents R4 received only 4 showers; 6/11/21, 6/16/21, 6/23/21, and 6/27/21. On 7/13/21 at 10:16 am, V2 DON (Director of Nursing) stated there are no other documented showers/baths for R4 or R6.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 34201 Based on observation, interview and record review, the facility failed to assess and report a change of condition to the physician and family for one of three residents (R6) reviewed for improper nursing on the sample list of 22. This failure resulted in R6 becoming verbally unresponsive and being admitted to the hospital with diagnoses of Hypernatremia, with a Critical Sodium Level, Hypokalemia, and Urinary Tract Infection. Findings Include: The facility Notification of Change in Resident Condition or Status Policy dated 12/7/2017 documents, the facility shall promptly notify appropriate individuals (Administrator, DON (Director of Nursing), Physician, Guardian, Power of Attorney, etc) of changes in the resident's medical/mental condition and/or status. The Charge Nurse or Nursing Supervisor will notify the resident's attending physician or on-call physician when there has been a significant change in the resident's physical/emotional/mental condition, a need to alter the resident's medical treatment significantly, a need to transfer the resident to a hospital/treatment center, or any symptoms of an infectious process. On 7/7/21 at 12:23 pm, R6 was sitting up in the Dining Room R6 was not verbally responsive. R6's MDS (Minimum Data Set) dated 6/15/21 documents R6 has severe cognitive impairment but has clear speech and is able to make R6's needs known and is able to understand others. On 7/7/21 at 1:10 pm, V4, Agency CNA (Certified Nursing Assistant) and V5, CNA entered R6's room. V4 and V5 provided transfer instructions/request to R6 and R6 did not respond verbally or physically. V4 and V5 repeated instructions several times and R6 still did not respond. V4 and V5 transferred R6 from the wheelchair to the bed, and R6 still did not respond verbally or physically. At this point, V4 stated, this isn't like (R6), I (V4) don't know what is going on with (R6). Normally (R6) will talk to you. (R6) is able to follow some instruction. V5 agreed with V4's statement. R6's Progress Notes dated 7/7/21 does not document R6's change in mental status and does not document that V16, Physician or V21, R6's Family was notified of the change in condition. R6's next Progress Note dated 7/9/21 {2 days later} at 8:30 am by V18, RN (Registered Nurse) documents R6's blood glucose levels as high and that R6 appears lethargic and not answering back verbally to questions and instructions. Monitoring accordingly. At 11:50 am, V18 documents there have been no changes since previous assessment. At 1:20 pm, V16, Physician notified and orders received to send R6 to the ER (emergency room). R6's Hospital History and Physical dated 7/10/21 documents R6 was sent to the hospital for Hyperglycemia and found to have Hypernatremia, Hypokalemia, and UTI (Urinary Tract Infection). R6's Laboratory Values dated 7/9/21, while at the hospital, documents the following: Sodium Level of 158 (Critical High) with a normal range of 135-145 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Potassium Level of 3.4 (Low) with a normal range of 3.5-5.5 BUN (Blood Urea Nitrogen) Level of 37 (High) with a normal range of 8-25 Creatine Level of 2.16 (High) with a normal range of 0.70-1.50 Glucose Level of 432 (High) with a normal range of 70-110 R6's Urinalysis dated 7/9/21 and resulted on 7/11/21 documents greater than 100,000 Escherichia Coli in R6's urine. R6's Discharge Summary dated 7/12/21 documents R6's Hypernatremia was resolved with Intravenous Hypotonic fluids and that R6's UTI is still being treated with an oral ABT (antibiotic) versus an Intravenous ABT which R6 received while in the hospital. On 7/13/21 at 8:20 am, V18, RN stated V18 was R6's nurse on 7/7/21 and that staff did not report a change of condition to V18 on 7/7/21. V18 stated on 7/9/21, V18 noticed R6 was lethargic and not responding as usual, and had a high blood glucose level when checked. V18 stated V18 gave the ordered medication but when V18 reassessed R6 several hours later and there was no change {improvement in condition}, V18 notified V16, Physician and R6 was sent to the Hospital. V18 stated, that was the first I knew of any change of condition with R6. On 7/13/21 at 9:24 am, V16, Physician stated V16 was first notified of R6's change of condition; decrease LOC (Level of Consciousness) and high blood glucose levels on 7/9/12. V16 stated when notified, V16 told the facility that we{staff}could either do blood work there at the facility, or if they truly felt (R6) had a change in condition, we could send (R6) to the hospital because they are able to do things more quickly. R6 was sent to the ER. V16 stated with a Critical {high} NA (Sodium) level, (R6) was dehydrated. R6 has Alzhiemers, and R6 doesn't drink enough, so R6 isn't able to hydrate R6's self. V16 also stated, with high blood sugars, R6 will be urinating more, which will cause dehydration. The facility really needs to observe and monitor (R6) better due to (R6's) mental status and (R6) not being able to do that for R6's self. The high NA level is the cause of the mental change (non-verbal) and the elevated BUN and Creatine is from dehydration. I (V16) should have been notified sooner and we {facility} could have managed (R6) better, I (V16) could have ordered labs {laboratory tests} and started {R6} on IV (Intravenous) fluids at the facility, before it got to the point of being sent out to the hospital. V16 stated V16 always tell the nurses if they {nurses} feel something is wrong, do not hesitate to call me (V16). If they had called sooner with the change, further issues could have been prevented with prompt treatment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 34201 Based on observation, record review and interview, the unlicensed facility nursing staff failed to report a new pressure ulcer to the licensed nursing staff in order to assess the pressure ulcer and obtain a treatment order for one of three residents (R6) reviewed for pressure ulcers on the sample list of 22. Findings Include: The facility Skin Condition Monitoring Policy dated January 2018 documents it is the policy of this facility to provide proper monitoring, treatment, and documentation of any resident with skin abnormalities. It is the responsibility of the licensed nursing personnel that upon notification of a skin lesion, wound, or other skin abnormality, the nurse will assess and document the findings. The physician will be notified and a treatment order will be obtained. On 7/7/21 at 1:10 pm, V4 Agency CNA (Certified Nursing Assistant) and V5 CNA transferred R6 from the wheelchair to the bed and removed R6's pants and incontinence brief to reveal a urine soaked, balled up, unidentifiable dressing to R6's coccyx. V5 removed the dressing to R6's coccyx to reveal what appeared to be a stage II pressure ulcer to R6's coccyx. V5 stated, V5 don't know if the wound is documented in R6's chart or not. V5 stated V5 knows the nurses should be taking care of it {wound} but I (V5) put this on (R6), while pulling a Hydrocolloid dressing out of R6's dresser drawer, over the weekend when I (V5) noticed it. V5 then applied a new Hydrocolloid Dressing to R6's coccyx without cleansing the wound. V5 CNA stated R6's coccyx was open on Saturday {7/3/21}, that is why I (V5) started putting the {Hydrocolloid}on R6. V5 stated V5 could not recall if V5 reported the new open area to V18 RN (Registered Nurse), who was assigned to R6 on 7/3/21, when the open area was observed. R6's Medical Record does not contain any documentation of a pressure ulcer to R6's coccyx or a treatment order for the pressure ulcer. On 7/7/21 at 1:50 pm, V2 DON (Director of Nursing) stated when a new wound is found, the staff are to report it to the nurse, then the nurse fills out a newly acquired skin sheet, obtain a treatment order, chart it in the progress notes and notify V2. At this point in time, V2 stated it is never acceptable for a CNA to complete a pressure ulcer dressing. V2 was not aware of R6 having a pressure ulcer and stated, R6 use to have a pressure ulcer but it is healed. On 7/7/21 after being told of R6's open coccyx wound, V2 assessed R6's coccyx and documented on a New Acquired Skin Conditions Sheet that R6 has MASD (Moisture Associated Skin Damage) measuring 2.2 cm (centimeters) by 2 cm by no depth. R6's Progress Notes dated 7/12/21 documents open area to buttocks continues, dressing dry and intact. Approximately 1 cm stage II, which is the only documentation of the pressure ulcer in the progress notes. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/13/21 at 8:20 am, V18 RN (Registered Nurse) stated V5 nor any other CNA told V18 about R6 having a pressure ulcer. V18 stated V18 found out about the pressure ulcer after the surveyor reported it to V2. V18 stated the CNA's should report any and all skin issues to the nurse for assessment and treatment orders, since they are the ones who complete daily skin checks during cares.

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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. 41002 Based on observation, interview, and record review the facility failed to employ the services of Certified Nursing Assistants (CNAs) in sufficient numbers to meet the needs of four of five residents (R1, R4, R5 and R6) reviewed for staffing in the sample list of 22 residents. Findings include: The facility's Daily Census Report dated 7/6/21 documents 63 residents reside in the facility. Watseka Rehabilitation and Health Care Center Facility Assessment not dated; documents Facility Staff Needs (hours per day) Nurse Aides 134-170 hours per day. The Facility's Individual Employee Timecards dated 7/2/21 documents one Certified Nursing Assistant (CNA) worked the 6:00am to 6:00pm shift, and three CNA's worked the 6:00pm to 6:00am shift, for a total of 96 hours. The Facility's Individual Employee Timecards dated 7/4/21 documents two CNA's worked the 6:00am to 6:00pm shift, and two CNA's worked the 6:00pm to 6:00am shift, for a total of 96 hours. The Facility's Individual Employee Timecards dated 7/6/21 documents one CNA worked 6:00am to 11:30am, and Four CNA's worked the 6:00pm to 6:00am shift, for a total of 101.5 hours. There were no documented CNA hours worked on 7/6/21 from 11:30 am - 6:00 pm (6.5 hours) on the Timecards. Resident Council Meeting Minutes dated May 20, 2021 documents under concerns and suggestion that residents suggested they need more CNA's. The facility Bath/Shower Policy dated January 2018 documents a bath/shower is scheduled for all residents in the facility at least weekly. The following care issues were observed during the survey related to lack of staff: 1.) R4's Physician Order Sheet dated July 2021 documents diagnoses of Mild Mental Retardation and Bipolar. On 7/7/21 at 8:50 am, R4 was sitting up in a wheelchair in R4's room, with the call light activated. R4 was attempting to feed R4's self with R4's right hand. R4 had food spilt down the front of R4's shirt. R4 stated, I need help. R4 stated R4's right arm is achy and that was the reason R4 activated the call light. R4 stated breakfast was served at 8:30 am, and no staff have come to assist R4 with eating yet. R4 also stated R4 is waiting on a bath, I (R4) am supposed to get one at least weekly and I (R4) haven't had one since a week ago Friday. On 7/7/21 at 9:05 am {35 minutes after breakfast was served}, V4 CNA (Certified Nursing Assistant) entered R4's room and assisted R4 with eating. The facility Bath Schedule dated 4/6/21 documents R4 is to have a bath on day shift every Monday and Thursday. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R4's Shower/Abnormal Skin Report Sheets for June and July 2021 documents R4 received only 4 showers: 6/11/21, 6/16/21, 6/23/21, and 6/27/21. On 7/13/21 at 10:16 am, V2 DON (Director of Nursing) stated there are no other documented showers/baths for R4. 2.) R5's Physician Order Sheet dated July 2021 documents diagnoses of Parkinson's Disease, Dementia, and difficulty walking. On 7/7/21 at 1:30pm R5 stated R5 sometimes must wait 20 minutes to 30 minutes to get assistance, and that's too long. R5 stated R5 sometimes feels uncomfortable waiting to get assistance to use the bathroom. R5 is afraid R5 might have an (incontinence) accident. R5 said, the facility just needs to hire more aides (Certified Nursing Assistants). 3.) R6's July Physician Order Sheets document a diagnosis of Alzheimer's Dementia. R6's MDS (Minimum Data Set) dated 6/15/21 documents R6 has severe cognitive impairments, requires extensive assistance of two staff for transfers and toileting, requires physical help with bathing and is frequently incontinent of urine. On 7/7/21 at 11:59 am, V3 CNA (Certified Nursing Assistant) stated residents are supposed to get two showers a week but they don't always get done. V3 also stated residents are shaved on shower days. On 7/7/21 at 12:23 pm, R6 was sitting up in the Dining Room. R6 had a slight urine odor about R6, and had 1/2-inch-long chin whiskers. At this time, V5 CNA stated V5 had gotten R6 up around 6:45 am. V5 stated since R6 had been up, R6 has not toileted or changed R6. On 7/7/21 at 1:10 pm, V5 CNA and V4 CNA entered R6's room. V4 and V5 stood R6 up, from the wheelchair and a large amount of liquid rolled out from under R6 and fell on the floor. V4 and V5 confirmed this was urine. V4 and V5 changed R6's incontinence brief which was saturated with urine. R6 had also been incontinent of stool. At this time, V5 again stated R6 had not been changed or toileted since getting up for the day {almost 6.5 hours earlier}. On 7/13/21 at 3:45 am, V9 RN (Registered Nurse) stated residents need to be changed and/or toileted at least every two hours. The facility Bath Schedule dated 4/6/21 documents R6 is to have a bath on day shift every Monday and Thursday. R6's Shower/Abnormal Skin Report Sheets for June and July 2021 document R6 received showers only four times: on 6/9/21, 6/21/21, 6/26/21 and 6/28/21. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4.) On 7/7/21 at 8:55am R1 was sitting outside of R1's room in wheelchair. R1 said, R1's roommates call light (R4) has been on for an hour now, and the Director of Nursing (DON) walked past the call light twice without answering it. V4, Certified Nursing Assistant (CNA), observed walking past room with light going off, without answering call light. R1 said I know I shouldn't help R4 with eating however I have in the past due to R4's call light not being answered for more than 1 hour. R1 said, I (R1) just can't stand to see (R4) hungry and needing help. There is only 1 or 2 CNA's here and that is why it takes so long, breakfast is supposed to be served at 7 am but today it was 8:30 before we got our food. 5.) On 7/7/21 at 11:59am V3, Certified Nursing Assistant said, V3 is often the only CNA out on the main floor (100, 200 and 300 rooms). V3 stated sometimes there is no CNA on the Dementia Unit (300 hall), and the nurse has to work as a CNA. V3 stated V3 and a nurse are usually working the main floor, and running non-stop. V3 said, sometimes I'm not able to get to a resident in time,causing them to be incontinent. V3 said, residents are supposed to get 2 showers a week, but they often only get 1. 6.) On 7/7/21 at 2:30pm V17, Activities, said, there was no Certified Nursing Assistants on the Dementia Unit last Friday {7/2/21} , was just V17 and V7,Dementia Unit Coordinator. V17 stated we have a CNA shortage, and when care is needed V17 will toilet and feed residents, even though V17 is not a licensed or certified staff member. V17 said V17 can't let residents sit in wet clothing. V17 stated this happenes at least 1 time a week. 7.) On 7/7/21 at 2:38pm V7, Dementia Unit Coordinator, stated there is no Certified Nursing Assistant on the Dementia Unit at least once a week. V7 said, when V7 and V17 A are on the unit without a CNA, they are forced to assist the residents themselves. V7 said V7 knows they are not supposed to do this, because they are not CNA's. V7 said, V7 and V17 assist residents with toileting and feeding. V7 said, on 7/6/21 V19, Certified Nursing Assistant was working the Dementia Unit, and went to lunch and never returned. V7 said V20, Registered Nurse (RN) , was then assigned to become a CNA for the whole facility, because V19 left, and there were no CNA's in the Building. 8.) On 7/13/21 at 216pm V1 (Administrator) stated On 7/6/21 ,we had 3 nurses, and 1 CNA scheduled to work the facility. V1 said, V19, Certified Nursing Assistant, clocked out at 11:30am, and never returned back to work. V1 stated V20, Registered Nurse (RN), assigned to Dementia Unit, was pulled and worked as a CNA. V1 said, 3 nurses worked the facility until the next shift came in. 9.) On 7/13/21 at 9:24 am, V16, Physician stated V16 believed the facility is short staffed, and needs to hire more staff to ensure residents get good assistance.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 34201 Based on observation, interview and record review, the facility failed to have trained and competent staff on the Dementia Unit, in order to provide cares and Activities of Daily Living Assistance for 16 of 16 residents (R6, R8-R22) reviewed for staffing on the sample list of 22. Findings Include: 1.) On 7/7/21 at 1:10 pm, V4, Agency CNA (Certified Nursing Assistant) and V5, CNA transferred R6, who resides on the Dementia Unit, from the wheelchair to the bed and removed R6's pants and incontinence brief to reveal a urine soaked, balled up, unidentifiable dressing to R6's coccyx. V5 removed the dressing to R6's coccyx, which was covering a superficial open area with a beefy red center,. V5 stated V5 don't know if the wound is documented in R6's chart or not. V5 stated V5 knows the nurses should be taking care of it {wound}, but I (V5) put this on (R6), pulling a Hydrocolloid dressing out of R6's dresser drawer. Over the weekend when I (V5) noticed it. I put this on. V5 then applied a new Hydrocolloid Dressing to R6's coccyx without cleansing the wound. V5 stated R6's coccyx was open on Saturday {7/3/21}, that is why I (V5) started putting the {Hydrocolloid}on R6. V5 stated V5 could not recall if V5 reported the new open area to V18, RN (Registered Nurse), who was assigned to R6 on 7/3/21, when the open area was observed. On 7/7/21 at 1:50 pm, V2, DON (Director of Nursing), stated it is never acceptable for a CNA to complete a pressure ulcer dressing. The facility Skin Condition Monitoring Policy dated January 2018 documents it is the responsibility of the licensed nursing personnel to provide proper monitoring and treatment to any resident with a skin abnormality. 2.) On 7/7/21 at 9:40 am, V5, CNA (Certified Nursing Assistant) assigned to the Dementia Unit, stated V5 and V7, Dementia Coordinator (non CNA and non nurse), were the only two staff assigned to the Dementia Unit. V5 stated V5 always works first shift, 6 am - 6 pm, on the Dementia Unit, and is the only CNA assigned to the Unit. V5 stated on third shift, 6 pm - 6 am, there are times when nobody is assigned to the Dementia Unit. V5 stated Administration says it's okay that there is no staff on the Unit because staff open the curtains on the door to the unit so they can see down the hall. V5 stated on those days, V5 comes into work and residents are all saturated and nobody is up for breakfast. V5 stated, I (V5) feel bad for them {resident's} and wish there was something more I (V5) can do. These are real people and they need cared for. On 7/7/21 at 11:59 am, V3, CNA, stated sometimes there is no CNA assigned to the Dementia Unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145389	A. Building B. Wing	07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Watseka Rehab & Hlth Care Ctr	715 East Raymond Road Watseka, IL 60970

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/7/21 at 2:30 pm, V17, Activities, stated on Friday 7/2/21, there was no CNA assigned to the Dementia Unit, it was just V7, Dementia Coordinator and V17 on the unit. V17 stated V18, RN (Registered Nurse) would come and go on and off the unit for medications, but did not complete personal cares for the residents. V17 stated there was not a CNA on the unit on 7/6/21 either. V17 stated, we {facility} have a CNA shortage. When cares need given, I (V17) will toilet and feed residents to give them the help they need versus letting them sit in wet clothing. I (V17) used to be a CNA but I retired in 2009. V17 stated when V17 returned to the work force after retirement, V17's CNA certificate was no longer good so I (V17) applied for activities. I (V17) know it is against state policy but we {facility}have to do what we have to do. (V7) is always with me though, I (V17) don't do it alone. V17 stated V17 and V7 are on the unit alone without a CNA at least one time a week. On 7/7/21 at 2:38 pm, V7, Dementia Coordinator, confirmed there is no CNA assigned and working on the Dementia Unit at least one time a week, if not more. V7 explained that when V7 and V17, Activities are on the unit without a CNA, we will page for help for resident cares, but if nobody is here to help, we are forced to do it ourselves. V7 stated V7 knows V7 and V17 aren't suppose to do hands on care due to not being a licensed or certified staff member. V7 stated In the past when I (V7) has talked to V1, Administrator, about not having staff and asking what we are suppose to do, V1 says to do our best. It's like (V1) knows we (V17 and V7) aren't suppose to do the cares, but there isn't any other choice. V7 stated V7 and V17 will feed and toilet residents, really the only thing we won't do is give baths/showers. V7 stated V7 and V17 do the cares because we (V7 and V17) can't stand to see them (residents on the unit) sit in their body fluids and be neglected like that. V7 also stated that V2, DON (Director of Nursing) is aware that V7 and V17 are providing cares and explained that last night {7/6/21} due to no CNA being on scheduled on the Dementia Unit and only one CNA scheduled for the entire building, V17 was feeding the residents when (V2) walked by and did not offer to help. V7 also stated that the only one CNA assigned (V19) from 6:00 am - 6:00 pm, left around 11:30 am for lunch and never returned, leaving the entire facility without any CNA's. On 7/13/21 at 12:25 pm, V1, Administrator, stated the facility does struggle with staffing and that there are times that V17 and V7 might be on the Dementia Unit by themselves for a short while, while staff are taking breaks. V1 stated when V7 and V17 are alone with the residents, they should be calling for assistance if a resident needs care, and not providing the cares themselves. V1 stated V1 has asked V7 and V17 to assist as able, meaning to answer call lights, get bed linens and remake a bed, offer drinks, cut up food, that type of stuff. The facility Daily Assignment Sheet dated 7/6/21 documents no CNA was assigned to the Dementia Unit from 6:00 am - 6:00 pm, and that there was only one CNA assigned from 6:00 am - 6:00 pm for the entire rest of the building. On 7/13/21 at 2:10 pm, V1 confirmed that on 7/6/21 when V19,CNA, left the facility at 11:30 am, there was no CNAs in the building then until 6:00 pm (5.5 hours later), so V7 and V17 could have been on the Dementia Unit alone. The facility Nursing Midnight Census dated 7/6/21 documents R6, and R8-R22 reside on the Dementia Unit.