STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325131	A. Building B. Wing	04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spanish Trails Rehabilitation Suites	1610 Renaissance Blvd NE Albuquerque, NM 87107

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on observation, record review, and interview, the facility failed to ensure that the care plan had been revised for 1 (R #11) of 1 (R #11) residents reviewed by not updating the care plan to include oxygen (O2) use. This deficient practices is likely to result in residents care and needs not being addressed if care plans are not updated. The findings are: A. Record review of R #11's face sheet revealed R #11 was admitted into the facility on [DATE]. B. Record review of R #11's care plan dated 03/29/22 revealed R #11 O2 use was not in current care plan. C. On 04/14/22 at 12:49 pm during an interview with R #11, R #11 was observed wearing 3 LPM (Liters Per Minute) of O2. R #11 confirmed she wears O2 when she needs it. D. On 04/14/22 at 2:29 pm during an interview with the Director of Nursing (DON), he confirmed O2 use for R #11 should be care planned and it was not.

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 34439 Based on record review and interview, the facility failed to meet professional standards of quality by not: 1. Administering medications in accordance with the physician's orders for R #9. 2. Providing oxygen (O2) without physician orders for R #11. If the facility is not administering medications and treatments as prescribed, and administering O2 without physician orders, the residents are likely to not get the therapeutic results of medication/treatment needed and/or resident could likely be at risk of overdosing on medications or having adverse reactions. The findings are: Findings for R #9: A. On 03/30/22 at 10:28 am during an interview with R #9 he stated. Sometimes I don't get meds until noon, they are usually late with morning meds (medications) sometimes as late as noon to 1:00 pm for meds due at 8:00 am. If you go ask them then you can get your meds on time but if I stay in my room I might have to wait a while and it might be as late as noon. B. Record review of R #9's facesheet revealed he was admitted to facility on 12/23/21. C. Record review of R #9's Medication Administration Record dated 03/01/22 to 03/30/22 revealed: 1. Amlodipine tablet (medication used to treat high blood pressure) 5 mg (milligram) was administered late on 03/07/22, on 03/14/22 medication not administered was unavailable, 03/15/22 late administration, 03/22/22 administered late, 03/24/22 administered late, 03/25/22 late administration. 2. Carvedilol tablet (medication used to treat high blood pressure) 6.25 mg on 03/07/22 late administration, on 03/14/22 administered late,on 03/25/22 administered late, 3. Escitalopram Oxalate tablet (medication used to treat depression) 10 mg,on 03/07/22 late administration, on 03/14/22 late administration, on 03/15/22 late administration, on 03/24/22 late administration, on 03/25/22 late administration, 4. Gabapentin 600 mg 1 tablet (medication used to treat pain), on 03/07/22 late administration, 03/14/22 late administration, 03/25/22 late administration 5. Pro-stat sugar free liquid (protein supplement)15-100 gram k-cal on 03/10/22 late administration, 03/14/22 late administration, 03/24/22 late administration, 03/26/22 drug/item unavailable (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. On 03/31/22 at approx. 3:30 pm during an interview with the Director of Nursing (DON), he stated. Medications should be on time and if they refuse it should be documented. Sometimes they (nurses) administer medications on time and chart later when they have time, nurses should document in the MAR Administered on time charted late. If they are more then an hour late then it is considered to be administered late. DON confirmed medications were administered late and they should not have been and if they are it should reflect a reason as to why they were late or not administered. All medications should be available for administration we can pull it out of the Omnicell (machine used to dispense emergency medication). E. On 03/31/22 at 7:56 pm during an interview with the facility Administrator, she stated that nurses have a 2 hour window to administer medications. The expectation is that they chart as they give the medication. If there is a missed medication they should have documentation as to why the medication was missed. 41988 Findings for R #11: F. Record review of R #11's physician orders reviewed on 04/14/22 revealed no physician orders for O2 use. G. On 04/14/22 at 12:49 pm during an interview with R #11, R #11 was observed wearing 3 LPM (Liters Per Minute) of O2. R #11 confirmed she wears O2 when she needs it. H. On 04/14/22 at 1:22 pm during an interview with Registered Nurse (RN) #3, she stated, It's [R #11 O2 use] on and off. RN #3 confirmed R #11 wears O2. I. On 04/14/22 at 1:27 pm during an interview with Certified Medication Aide (CMA) #1, she stated, She [R #11] wears it [O2] on and off. CMA #1 confirmed R #11 was currently wearing O2. J. On 04/14/22 at 2:29 pm during an interview with the Director of Nursing (DON), he confirmed O2 should be ordered by a physician prior to resident uses. DON stated, No, she's [R #11] not supposed to be on O2. Me and the medical provider identified each one [resident who required O2 use].

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34439 Past Non-compliance Based on record review and interview the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for 1(R #7) of 3 (R#'s 7, 8, and 9) residents reviewed by: 1. Not administering oxygen as ordered 2. Not providing medications to treat a resident's anxiety 3. Not conducting an assessment of R #7 upon admission to facility and when notified that resident was in distress. These deficient practices are likely to result in residents experiencing worsened conditions and/or death. The findings are: A. Record review of Nursing progress notes dated [DATE] at 12:54 am [time nurses note was written] revealed resident was admitted to facility [approximately 7:00 pm]. B. Record review of R #7's face sheet revealed resident was admitted to facility on [DATE] with the following diagnosis: 1. Acute respiratory failure with hypoxia Primary/Admission Pulmonary 2. Type 2 diabetes mellitus (a condition that affects the way the body process blood sugar) 3. Hyperlipidemia, (abnormally high concentration of fats in the blood) 4. Personal history of COVID-19 (an acute respiratory illness) 5. Elevated white blood cell count, 6. Retention of urine, 7. Pneumonia due to SARS-associated (an acute respiratory illness) coronavirus (an acute respiratory illness) 8. Pain, 9. Generalized anxiety disorder 10. Acute pharyngitis, unspecified (inflammation of the tonsils and/or pharynx) (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	11. Essential (primary) hypertension (a condition in which the force of the blood against the artery walls is to high) 12. Constipation (a condition in which there is difficulty in emptying the bowels) 13. Inflammatory disease of prostate, 14. Weakness C. Record review of Physicians Orders dated [DATE] revealed: 1. Alprazolam 1 mg (milligram) tab (tablet) Three times a day PRN (as needed) (medication used to treat anxiety) 2. Buspirone 5 mg three times a day (medication used to treat anxiety) 3. Cepacol Sore Throat-cough Lozenge ,d+[DATE].5 mg PRN every two hours 4. Lantus Solostar u-100 insule pen 100 unit/ml 5. Lovenox 40 mg (medication used to prevent blood clots) 6. Miralax 17 g (grams) (used to treat constipation) 7. Pepcid 20 mg 1 tab twice a day (used to treat excess stomach acid) 8. Simethlcone 80 mg (medication used to reduce bloating caused by excessive gas) 9. Tamsulosin 0.4 mg w cap (medication used to symptoms of an enlarged prostate gland) 10. Toprol XL 50 mg (medication used to treat high blood pressure) 11. O2 (oxygen) at 5 LNC (liters nasal canula-plastic tube used to deliver oxygen from concentrator to patient) 12. CCHO (diabetic diet-Constant controlled carbohydrate diet) D. Record review of Nurses progress notes dated [DATE] at 11:46 am [late entry] revealed Resident came by transportation. Weighed resident he weighed 180.4 (pounds). Resident moved from w/c (wheelchair) to bed by staff. Resident is weak and is very anxious. E. Record review of Nursing progress notes [recorded as late entry on [DATE] at 11:50 am for [DATE]] Residents wife (R #7) came out of room and stated she was going home . Nurse let her know she was putting his meds (medications) and orders in computer. RX (prescription) for alprazolam (anxiety medication) was faxed to pharmacy. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	F. On [DATE] at 10:21 am during an interview with FM (Family Member) #1 (R #7's wife), she stated that her husband (R #7) had been transported to [Name of LTC facility] on [DATE] at about 7:00 pm. When he arrived at facility he was weighed by a CNA (Certified Nurse Aide) and [name of RN (Registered Nurse) #2] and then transferred with a gait belt to the bed. He was connected to the oxygen in the room and he was to be on 5L (Liters) of oxygen. Wife stated that she did not witness that the oxygen was set at 5L. She then stated that at about 7:20 pm, her husband was experiencing a full blown panic attack and the call light was activated and no one came to the room. She was unable to leave the room because her husband was having real bad anxiety, so she went to the door and looked up and down the hallway looking for help. Call light was still activated and she went to her husband's bedside and asked him to meditate and after some time was able to get him calm. At that point, she was able to walk over to the nurses station to ask for her husband's medication, where she encountered RN #2 asleep. RN #2 told her that her husband had a lengthy medical record and would be checking on him when she had time and she also stated that his medications had not arrived and she would be ordering them from the pharmacy. She stated I let her know that my husband had an anxiety attack and needed his medication as soon as possible because he was having a lot of anxiety. G. Record review of the medical record did not identify that R #7 had been administered any medications during his stay. H. Record review of Nurses progress noted dated [DATE] at 12:55 pm (late entry) revealed: CMA (Certified Medication Aide) started vitals on patient and noted SpO2 (oxygen level) of ,d+[DATE]% (percent, BP (blood pressure) ,d+[DATE], MAP 55 (calculation used to check whether there's enough blood flow to supply blood to all major organs), P (pulse) 114, T (temperature) 96.9, patient had nasal canula initu (sic) going at 2 L (liters) per minute, patient was pulled up in bed and elevated to high fowlers (seated upright) position and was switched to facemask, 911 was called at patients bedside, Spo2 increased to 85% then patient became unresponsive, pulse was checked no pulse, placed in supine (lying down face up) position, CPR (Cardiopulmonary Resuscitation -emergency procedure used in an effort to manually preserve intact brain function) was started call was ended with 911 (number used to contact emergency services), chest compressions were started without ambu bag (self inflating bag used to assist with breathing), head tilt chin lift until crash cart was brought to bed side. Completed 5 cycles of CPR were completed patient was reassessed eyes fixed and dilated (eye muscles relaxed and no visible signs of life), no caroid (two main arteries that carry blood to the head and neck) pulse palpated, no spontaneous breath sounds, CPR continued [Name of ambulance company] arrived at 7:26 am and took over CPR after completed several round of CPR patient was pronounced dead at 8:01 am. Wife was contacted and informed of his status via telephone and arrived at 7:55 am just before his death pronouncement. I. Record review of Vital sign sheet dated [DATE] to [DATE] revealed: 1. [DATE] at 11:51 pm BP ,d+[DATE], Respiration 22 per minute, Pulse 73 per minute, Temperature 98.4 Fahrenheit, O2 Saturation 93%. Oxygen Use at 5 liters 2. [DATE] at 6:55 am BP ,d+[DATE], at 9:33 am Temperature 96.9 , Pulse 114 per minute, at 9:38 am O2 saturations 61%. Oxygen use at 2 liters. 3. No other vital signs were recorded for R #7. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	J. On [DATE] at 10:21 am during an interview, FM #1 stated at about 7:23 am on [DATE], FM #1 received a call from RN #1 letting her know that he had gone to check on her husband and he did not have any O2 on and he was working on him [staff were providing life saving measures-CPR- Cardiopulmonary resuscitation emergency procedure used to manually preserve brain function] at that time. FM #1 arrived at facility before 8:00 am and was told visiting hours were not until 8:00 am and was told she could not enter the facility. She was met by Social Services Assistant at the facility entrance door and was told she need to call a mortuary to come pick up the body. The body was removed from the facility about 8:00 pm. K. Record review of Record of Death and Mortician's Receipt dated [DATE] revealed R #7 expired at 8:01 am on [DATE]. L. On [DATE] at 11:56 am during an interview with RN #1, he stated. At about 6:55 am the CNA (CNA #1) came to me and told me the patients O2 is at 64%, I ran down the hallway to assess him. I did not like his breathing pattern. I called 911 while I was on the phone with 911 we put a mask (oxygen mask) on him to get more O2 and put him on a high [NAME] position, he became unresponsive. I turned the O2 up to 5L it was set at 2L. I did 3 rounds of CPR by the time we got the crash cart in we started using the ambu bag when the ambulance arrive we had done 6 rounds of CPR and they switched to automatic compression device with no positive results. His wife was called and she arrived when they were calling the time of death. [Name of RN #2] was the night nurse and was assigned to this hallway. I was called and I jumped into emergency mode. I did not administer any medications nor do I know if his medications had arrived. I do know that his O2 was set at about 2L. I moved it to 5 L when I saw he was having breathing issues. M. On [DATE] at 2:23 pm during an interview with CNA #1, she stated. I was doing rounds about 7:00 am and I noticed he was having a had time breathing. I checked his O2 and it was real low I told [name of RN #1] to look at the patient and he went to get a mask (oxygen). His [R #7's] O2 was in the 60% we got it up to the 70's. [Name of RN #1] went to call 911 at that point his eyes were fixated I ran to get [name of RN #1] and we started compressions, the paramedics arrived and they did compressions. The wife arrived, it was all very fast. I know I was asked to bring in another concentrator because the one in the room was not filling up the bag and when I brought in the other concentrator the bag filled up immediately. I documented on my notes that when I checked the O2 it was at 2L. I do not know how many liters residents are to be at. I just document what they are at when I am doing my rounds. The nurses are the ones that set the liters according to the orders that is above my scope of practice. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	N. On [DATE] at 5:39 pm during an interview with the Administrator, she stated. I did an investigation and from my understanding, he (R #7) was admitted about 7:00 pm on [DATE] and expired on [DATE]. [Name of RN #2] was the night nurse the day R #7 was admitted . The nurse told me that the medications did not arrive with the resident and she was waiting for after hours (medications that are ordered from local pharmacy). RN #2 did not use the omicell (system that's helps acquire, dispense and provides medications on an as needed basis for emergency purposes). I would have expected her to use the omnicell to get the medications needed. We took the resident because his oxygen was stable and was at ,d+[DATE] liters. I wish the nurse would have assessed his anxiety because that is an indication of distress and does not help the fact that the nurse did not give the anxiety medication. We do not take titrate orders (oxygen adjusted based on residents needs) the nurses have to clarify a set amount of O2, he (R #7) came in with continuous O2 ordered with no liters indicated . RN #2 changed the orders herself to 5L. We spoke with the Physician and she stated she did not approve the 5L of O2. RN #2 wrote the order for 5L of O2 without consent from the Physician or without consulting any one else. When we admitted him (R#7) he was to be on 4L from my understanding, therapy later discovered in the notes from the hospital indicating that he (R #7) was on , d+[DATE]L of O2 at the hospital prior to discharge. After he arrived he was stable aside from the anxiety that started and the wife requested medication for his anxiety. Nurse did not administer the anxiety medication because it had not arrived from the local pharmacy. Again I would have expected her to access it from the omnicell. Resident should not have gone without his medication when we have the omnicell. The above identified non-compliance resulted in a Past Non-compliance Immediate Jeopardy (IJ) at a scope and severity of J (a pattern of jeopardy to resident health and safety). A Plan of Removal was not required because the facility demonstrated current compliance relating to this deficiency by: 1. Identifying all current residents that have a history of respiratory distress/illnesses and require oxygen (O2). 2. Identifying all current residents that have scheduled and PRN (as needed) antianxiety medications ordered, while also providing the Medication Administration Record (MAR) for each identified resident; demonstrating anitanxiety medications given. 3. O2 monitoring checklist- Resident on how many liters, Oxygen by Physician Order, Pulse Oxygen Saturation level (percent), Pulse Rate, Level of Activity (lying, sitting, standing), and Does resident have any issue regarding Oxygen? 4. PRN antianxiety monitoring checklist- Is resident on PRN anxiety, Is PRN anitanxiety meds [medications] have been administered per physician order, Does resident complain about his PRN Antianxiety meds? 5. In-Service Summary and Attendance dated [DATE] which covered Medication Management Program 6. Medication Pass Review/ Checklist- Which included Infection Control, Med Cart/ Safety, Procedures, Documentation, and Enteral Procedures that was completed. 7. Staff Education/ Orientation Policies and Procedures- Nursing Medication Administration Observation Checklist. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. QAPI (Quality Assurance and Performance Improvement) Planning and Execution Checklist. Surveyors conducted observations, record review, and interviews with selected residents and staff to confirm current facility compliance.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview the facility failed to ensure that they had sufficient staff for 3 (R #1, 2, and 10) of 3 (R #1, 2, and 10) to ensure the needs of the residents were met by: 1. Not providing enough staff to assist with Activities of Daily Living (ADL) care, resulting in R #1 having to urinate in water bottles. 2. Not providing enough staff to assist with ADL care for R #2 and R #10. This deficient practice is likely to negatively affect residents safety, comfort, and is likely to impede processes such as timely incontinence (lack of voluntary control over urination or defecation) care, regular turning schedules, timely showers and appropriate assistance with meals. The findings are: Findings For R #1: A. Record review of R #1's face sheet revealed R #1 was admitted into the facility on [DATE]. B. Record review of progress notes dated 03/20/22 revealed, Patient was counseled on wait time for his care, as he had concerns after receiving his medication late during the morning. He voiced concerns of not having his medication on time and how they could affect him, he was reassured that he would be prioritized. He received his medication within reasonable time that made him comfortable, he received Lidocaine patches to hips and back, steri strips were removed, incise wound completely with good intact wound edges, cleaned with skin prep and alcohol. Patient was given two addition urinals after waiting for urinals to be emptied. Patient requested to speak to management about his concerns, Director on duty [Name of director on duty] was contacted and spoke to patient. Patient mother was also counseled on his care. C. On 03/30/22 at 12:39 pm during an interview with R #1, he stated, I remembered using the water bottle for the bathroom [on 03/20/22]. They [facility] didn't have staff. Care was non existent, and it took 3-4 hours in between each call button during that time. A CNA [Certified Nursing Assistant]came from another area [in the facility], but they [CNA] didn't have time to help me. They [CNA's] said they were so short staffed and had nobody. I couldn't get turned, given water, or anything because there was no one here. I ran out of urinals and had a water bottle. They [nursing staff] didn't come and there was no one. R #1 confirmed that on 03/20/22, he had to urinate in water bottles instead of plastic urinals because the urinals he was using were already full and there was no staff present to empty the full urinals out. R #1 also stated that he used the water bottles while he waited for his call light to be answered and so he did not urinate on the floor. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. On 03/31/22 at 12:05 pm during an interview with Registered Nurse (RN) #1, he stated, He [R #1] did use a couple of water bottles [to urinate in]. We [staff] took the water bottles from him [R #1] and we gave him two extra urinals. The times where staff was to check on him [R #1], but couldn't, he [R #1] did use two water bottles. RN #1 confirmed R #1 urinated in water bottles due to there not being enough staff available to assist R #1. E. On 03/31/22 at 6:07 pm during an interview with the Administrator, she stated, I have no knowledge of that [R #1 urinating in water bottles], but that is unacceptable. ADM confirmed R #1 should not have had to urinate in water bottles due to staff not providing him with clean urinals. 39509 Findings for R #2 and 10 F. Record review of R #2 face sheet dated 03/31/22 revealed she was admitted to the facility on [DATE] with multiple diagnoses. G. Record review of R #2 Minimum Data Set (MDS) (a comprehensive assessment of a persons mental and physical needs) Section C (assessment section which indicates a person's mental and memory status) revealed a score of 14 (score is 0 which is the most impaired memory status to 15 which indicates no memory impairment). H. Record review of R #10's face sheet dated 03/31/22 revealed she was admitted to the facility on [DATE] with multiple diagnoses. I. Record review of R #10 MDS Section C revealed a score of 10. J. On 03/30/22 at 11:30 am during interview with R #10's son, he stated he was aware that on the weekend of 03/18/22, staffing was very limited and that his mother (R#10) was left in her own urine and feces as she waited for staff to come clean and assist her. K. On 03/30/22 at 1:55 pm during interview with R #2 she stated on the weekend of 03/18/22, she observed that there was only one nurse and one CNA on duty in the area of her residence for most of the weekend. She stated she received little attention as the nurse and CNA were busy with the other residents of the unit who required more care. R #2 stated that she noticed a strong smell of urine and feces about the unit. She also stated that her roommate was left unattended for an extended time without being provided care for ADL's. L. On 03/30/22 at 2:30 pm during interview with Registered Nurse (RN) #1, she stated that on the weekend of 03/19/22, she was one of two nurses working during the day shift. She stated they were assisted by only one Certified Nurses Aide (CNA). RN #1 stated that three staff cared for the entire Long Term Care unit which she estimated to be about 60 residents. She stated she was overwhelmed and unable to provide care as needed. She stated that many residents were not provided ADL care in a timely manner as there was inadequate staff to assist residents. She confirmed that many residents were left in urine and feces soaked briefs while waiting for assistance to change and be cleaned. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325131	A. Building B. Wing	04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spanish Trails Rehabilitation Suites	1610 Renaissance Blvd NE Albuquerque, NM 87107

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	M. On 03/30/22 at 3:00 pm during interview with RN #2 she confirmed that she had worked on 03/19/22. She stated she was one of two nurses and one CNA who worked that day. She stated that she attempted to provide care but she was overwhelmed and unable to provide care in a timely manner to residents of the Long Term Care unit. She stated that many residents had to wait for an hour or more to receive ADL care. N. On 03/30/22 at 4:00 pm during interview with facility scheduler (FS) (person responsible for scheduling staff to work) she stated she was aware that on 03/19/22 staffing was very short. She stated she was called on both Saturday 03/19/22 and Sunday 03/20/22 to address a staff shortage. She stated she was unable to find any staff willing to come in and work for either day. O. On 03/30/22 at 4:30 pm during interview with Administrator (ADM), she stated that much of the nursing staff are employed by contract through local nurse staffing agencies, (a service in which nurses and CNA's are employed and contracted to fill staffing needs in local medical facilities and nursing homes). ADM stated that a fired employee had terminated several scheduled staff causing a significant shortage of staff on the weekend of 03/18/22.