STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003628	A. BUILDING: _____ B. WING _____	C 01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE GLENWOOD	19330 SOUTH COTTAGE GROVE GLENWOOD, IL 60425

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S 000	Initial Comments Complaint Investigation #2390458/IL155445 #2390526/IL155540 #2290594/IL155614	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)5) 1/2 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These regulations were not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow their pressure ulcer prevention policy by failing to ensure that interventions were carried out, including turning and repositioning, in order to prevent residents from developing new pressure ulcers while in the facility. This failure applied to three (R3, R4, and R5) of three residents reviewed for pressure ulcers and resulted in (R3, R4, and R5) developing multiple stage 3 pressure ulcers while in the facility. Findings include: R3 is a 66 year old male who was admitted to the	S9999		

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S9999	Continued From page 2	S9999		

facility 9/3/21 with diagnoses that include Cerebral Infarction, Adult Failure to Thrive, Dementia and Dysphagia.

According to R3's health record, MDS (Minimum Data Set) dated 1/9/23 notes R3 to have impaired cognition as with a BIMS (Brief Interview for Mental Status) score of 07. The MDS also indicated R3 required Extensive two person staff assist for bed mobility, toileting, and hygiene.

On 1/23/23 at 12:36PM, R3 was observed sleeping in bed, presented with contractions of both legs and a urinary catheter hanging from the bed frame. Surveyor periodically observed R3 between 12:36PM and 3:15PM and R3 was noted to be in the same position as evidenced by position of head, body positioning wedge and urinary catheter bag which had not been emptied.

Medical records indicate R3 is seen weekly by V19 Wound Care Physician and is being treated for a Stage 4 pressure wound on the right hip identified in the facility 11/15/22, Stage 3 pressure wound to the left hip identified in the facility 12/21/22 and Stage 3 pressure wound to the right lateral fifth toe identified in the facility 1/16/23. According to most recent Wound Care Physician Assessment dated 1/23/23, left hip and right toe are healing and the right hip wound did not change in status.

On 1/26/23 at 2:29PM, V19 Wound Care Physician said, "some of the wounds I am currently treating for R3 are healing based on my notes so I wouldn't consider them to be unavoidable."

On 1/24/23 at 2:07PM V8 CNA (Certified Nursing Assistant) said, I work with R3 regularly during

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S9999	Continued From page 3 the morning shift. He has wounds and should be repositioned every two hours because he has sores. When we are short staffed, it can be hard to turn and change every body within that time. R3's care plan for alterations in skin integrity initiated 10/9/22 and revised 1/19/23 include interventions that state: Follow facility policies/protocols for the prevention/treatment of skin breakdown; Assist and encourage turning and repositioning every two hours as tolerated every shift. R4 is a 43 year old male who was admitted to the facility 12/7/22 with diagnoses that include Multiple Sclerosis and paraplegia. According to R4's health record, MDS (Minimum Data Set) dated 1/3/23 indicates R4 has full cognition and requires extensive two person physical assistance with bed mobility, extensive one person assist with personal hygiene and is always incontinent of bowel and bladder function. According to wound care notes R4 arrived to the facility with multiple wounds and was initially assessed by V19 Wound Care Physician on 12/12/22. V19 weekly assessment dated 1/2/23 indicated all wounds present on admission were resolved. On 1/18/23 the facility identified two newly acquired wounds: a Stage 3 Pressure Ulcer to the left lateral lower leg, and Stage 3 pressure ulcer to the right medial knee. On 1/23/23 at 1:08PM, R4 was interviewed, and said, I developed new sores on my legs while in the facility. I can't turn on my own because I can't move my lower body. I need help from staff to turn and sometimes I'm in the same position for a	S9999		

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S9999	Continued From page 4 while. Sometimes, I don't see a CNA regularly or every two hours in the evening or night. Care Plan for R4 initiated 12/14/22 revised 12/19/22 state R4 has potential for impairment to skin integrity related to impaired mobility and requires turning and repositioning frequently and as needed. R5 is an 86 year old male admitted to the facility 4/20/2012 with diagnoses that include cerebral infarction with hemiplegia and hemiparesis affecting left side, dysphagia, dementia and contracture of the left hand. According to R5's medical records, MDS dated 11/21/22 indicated R5 has mild cognitive deficits with a BIMS (Brief Interview for Mental Status) score of 09. R5 is incontinent of bowel and bladder and requires extensive two person assistance with bed mobility, transfers and hygiene. According to R5's wound care notes, the facility identified a Stage 3 pressure ulcer to the left lateral calf on 11/7/22. On 1/23/23 at 1:17PM R5 said, I have a pressure sore on my left leg that they change every day. I've had it for a while, and they say it is healing but I can't see it. I have occasional pain, and a while back the pain was too much for me about a month ago. It would sometimes prevent me from wanting to get up out of bed. The CNA's don't help me to change position and most of the time I lay in the same spot. R5 Care plan for Impaired Skin integrity initiated 7/21/22 and revised 7/28/22 include interventions that states, "assist with turning and repositioning as needed." On 1/24/23 at 3:54PM V2 Assistant Director of	S9999		

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S9999	Continued From page 5 Nursing said, CNAs should be turning and repositioning dependent residents every two hours and charting once per shift. The (electronic record) where they chart does not prompt every two hours, so it is unclear if the task is completed. I am not aware of any where else they would document this. I wouldn't know that turning and repositioning is happening if it isn't documented. Facility policy titled, Pressure Ulcer Prevention (revised 1/15/18) states in part: The purpose to prevent and treat pressure sores/pressure injury. 3. Turn dependent resident approximately every two hours or as needed and position resident with pillow or pads protecting bony prominences as indicated. (B) 2/2 300.610a) 300.1210b)3)4) 300.1230e) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.	S9999		

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S9999	Continued From page 6 Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. 4)All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. Section 300.1230 Direct Care Staffing e) The facility shall schedule nursing personnel so that the nursing needs of all residents are met. These regulations were not met as evidenced by:	S9999		

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S9999	Continued From page 7 Based on observation, interview. and record review, the facility failed to have sufficient staff to provide necessary care and services to residents required to meet their plan of care and to ensure that staff provide timely incontinence care in a manner consistent hygiene standards of practice for residents dependent on staff for care. This failure applied to six (R1, R4, R5, R6, R7, and R8) of seven residents reviewed for nursing care and for incontinence care and resulted in R1 requiring interventions for newly acquired MASD (moisture associated dermatitis); R6 requiring current treatment for a facility acquired UTI (urinary tract infection); and R7 has experienced emotional distress as a result of having to wait for an extended amount of time to be provided with incontinence care. Findings include: R1 is a 67-year-old female who has resided at the facility since 2020, with past medical history of other specified arthritis, chronic obstructive pulmonary disease, abnormal posture, schizoaffective disorder bipolar type, other benign neoplasm of skin, morbid severe obesity due to excess calories, essential primary hypertension, iron deficiency anemia, etc. 1/23/2023 at 12:45PM, observed R1 in her room in bed, awake, alert and oriented x 3, stated she does not get changed very often; they will tell her that they are coming back but never do. R1 said that when she gets cleaned, staff do not clean inside vagina, they just clean around the area. R1 said that staff get upset when she has a bowel movement because it is loose and sticky; she even refuses her stool softener because she does not need them, though she takes Norco for	S9999		

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S9999	Continued From page 8 pain, but she never gets constipated. R1 said that she has not been changed today, the last time she was changed was yesterday. Surveyor asked R1 if it is okay to observe her incontinence care and she said yes. At 1:58PM, observed incontinence care for R1 with V4 (CNA) and noted resident's incontinence brief visibly soaked with urine and brown in color, resident's bed sheet was also noted very wet with brown colored marks from dried urine all around the sheet. An open area was noted to the resident's sacral area actively bleeding. V4 (CNA) said that due to the number of people they need to care for, sometimes it takes a while before getting to some of the residents. V4 was observed wiping resident's front and vaginal area with a gloved hand using one wet towel, after removing the wet incontinence brief and sheets, then wiped resident's bottom area with another wet towel, removed the wet incontinence brief and sheets and proceeded to put clean sheets and a clean incontinence brief on the resident without changing her gloves or performing any hand hygiene. V4 also applied Vaseline and powder all over resident's body with the same pair of gloves. When V4 was about to put a clean brief on R1, R1 complained of itching in her vaginal area. V4 told R1 that she must go and get another towel. V4 covered R1 with a clean sheet, brought a clean towel and wiped resident's vaginal area and some dark/brownish substances that looked like bowel movement was noted on the towel. V4 said that this must have been left there from before because the resident does not have any bowel movement at this time. 1/24/2023 at 11:16AM, R1 was observed again in her room, awake and alert and states that she was not changed again last night, the staff did not	S9999		

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S9999	Continued From page 9 change her because they said that she ran out of incontinence briefs. R1 stated that the facility provides the incontinence briefs but they keep a particular size for her in her drawer, but some staff will use them for her roommate. R1 said that she is wet right now and just had a bowel movement. 1/24/2023 at 12:25PM, observed staff providing incontinence care to R1, V8 (CNA) said that she is the assigned staff and had not yet changed R1 today. At this time, observed with V8 that R1 had a bowel movement and her brief was heavily soiled. V8 was not sure if R1 was changed last night. V8 asked R1 if she was changed last night and she said no. R1 was still noted with an open area in her bottom that was actively bleeding. At 12:30PM, V7 (Nurse Consultant) said that R1 (currently) has a laceration on her left buttocks due to moisture. V7 was asked what the cause of the moisture was and she said it might be urine. V7 added that she will apply some barrier cream to resident now and call the doctor for some orders. Review of physician orders for R1 shows an order to apply dermaseptin to gluteal folds q (every) shift and each incontinent care every shift for incontinent care and as needed, order date 1/24/2023. Care plan dated 7/11/2018 and revised 7/08/2022 states that R1 is incontinent of bowel and bladder. Interventions include to check resident frequently and as needed for incontinence, change incontinent brief frequently and as needed, etc. Facility MDS section C (cognitive pattern) coded R1 with a BIMS score of 13, section G (functional) coded R1 as requiring extensive assistance with two persons physical	S9999		

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S9999	Continued From page 10	S9999		

assist for dressing toilet use bed mobility and personal hygiene. Section H of the same MDS coded R1 as always incontinent for bowel and bladder.

1/23/2023 at 12:35PM R6 was observed in her room awake and alert, stated that she is doing okay, she was asked if she has been changed and she said no, the last time she was changed was yesterday. R6 said that this happens most of the time, she finishes eating lunch before being changed. At 12:50PM, observed incontinence care for R6 with V3 (CNA), resident was noted with an incontinence brief that is saturated with urine and brown in color with a very strong smell. R6 was noted to be lying on top of two draw sheets, which were wet. Staff wiped resident's frontal area with a wet cloth, and wiped the back area with a wet cloth, did not clean the labial area. V3 proceeded to put clean linens and a clean incontinence brief on resident without changing her gloves or performing any type of hand hygiene. V3 added that she still has some people to change, she is not sure how many.

Review of R6's medical record shows a urine culture dated 1/22/2023 with a positive result for ESBL, physician orders for R6 shows that she is currently receiving Bactrim DS Tablet 800-160 MG (Sulfamethoxazole-Trimethoprim), give 1 tablet by mouth every 12 hours for UTI for 7 Days.

Review of medical records showed the following care plan initiated 1/8/2020, I have had functional, bladder and bowel incontinence due to Impaired mobility, generalized weakness. Interventions include Brief use: resident uses, disposable briefs. Change frequently and prn. Check resident frequently and as needed for incontinence. Wash,

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rinse, and dry perineum. Change clothing PRN after incontinence episodes, etc. MDS assessment dated 1/13/2023 coded R6 as requiring extensive assistance with 2 persons physical assist for dressing, toilet use and personal hygiene, section H coded resident as always incontinent of bowel and bladder.

1/23/2023 at 12:55PM, R7 was observed in the same room with R1, awake and alert and stated that she is waiting to get up, she was left in bed since Friday, she has not been changed either and is wet right now.

At 1:30PM, observed incontinence care for R7 with V3 (CNA) and V4 (CNA) and noted resident with what looked like like two incontinence briefs, when surveyor asked if resident was wearing two briefs, V3 said that it is an inserted pad, both the pad and brief were visibly saturated with urine, brown in color and has a strong smell. R7 was asked the last time she was changed, and she said, "Yesterday afternoon, the night shift staff here don't do sh**, they don't even come into the room". R7 added that she wears the insert in addition to her brief because she is a heavy wetter. V3 provided the incontinence care while V4 was assisting with holding the resident because resident is a two person assist. V3 removed the dirty brief and linen, wiped the resident with a wet cloth and proceeded to apply a clean brief, some powder and deodorant and clean linens to the bed without changing her gloves or performing any type of hand hygiene.

Care plan dated 3/5/2021 and revised 5/28/2022 states that R7 is incontinent of bowel and bladder, interventions include check resident as required for incontinence, wash, rinse, and dry perineum after incontinence episode. Facility

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S9999	Continued From page 12 MDS assessment section G (functional status) coded R7 as requiring extensive assistance with two persons physical assist for bed mobility, dressing, toilet use and personal hygiene, section H coded R7 as always incontinent of bowel and bladder. 1/24/23 at 1:00PM while surveyor was interviewing V5 (CNA), R7 approached and asked V5 when she could be changed because she had been waiting for a while. V5 informed R7 that she was busy but would find another staff to assist when possible because R7 is a two person staff assist. R7 said to surveyor, I asked a little while before and I was told I couldn't get changed right away. At 2:17PM R7 approached another surveyor in the hall and said, I am not happy. I have a feeling that they'll make me wait until after 3'o clock when the next shift comes to be changed. It has happened before. I haven't been changed since 6am today when they got me up and put me in the chair. R7 began crying and said, I know I am a two person assist and she needs help but why is that my problem? Why should I have to suffer and wait? V5 came in and changed both of my roommates, what about me? When I have a bowel movement it goes up into my pubic hair and vagina because I'm sitting and can't get up because I'm paralyzed. It's gotten to the point where I want to go somewhere else. The nurses don't help either. I ask the nurses for help and they say they don't know where the CNA is. At 2:33PM V15 (LPN) informed surveyor that V5 (CNA) told her that she had been waiting to be changed 15 minutes prior and did not know she had been waiting long before that. V15 said, the nurses help when we have time, but right now, I	S9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE GLENWOOD	19330 SOUTH COTTAGE GROVE GLENWOOD, IL 60425

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13 have been running around like crazy because we are short a nurse and two CNA's and it's the end of the shift. At 2:34PM, V5 (CNA) was heard behind the nurse's station loudly saying to another CNA, "I don't have no help! I shouldn't have to beg nobody to help me" V5 and the other CNA were then observed telling R7 they would change her. R4 is a 43-year-old male who was admitted to the facility 12/7/22 with diagnoses that include Multiple Sclerosis and paraplegia. According to R4's health record, MDS (Minimum Data Set) dated 1/3/23 indicates R4 has full cognition and requires extensive 2-person physical assistance with bed mobility, extensive one person assist with personal hygiene and is always incontinent of bowel and bladder function. According to wound care notes R4 arrived to the facility with multiple wounds and was initially assessed by V19 Wound Care Physician on 12/12/22. V19 weekly assessment dated 1/2/23 indicated all wounds present on admission were resolved. On 1/18/23 the facility identified two newly acquired wounds: a Stage 3 Pressure Ulcer to the left lateral lower leg, and Stage 3 pressure ulcer to the right medial knee. On 1/23/23 at 12:52PM V5 and V9 CNAs (Certified Nursing Assistants) were observed providing incontinence care for R4. Before securing the incontinence brief, V5 placed an additional folded brief inside the front and said, I put an extra brief because sometimes R4 urinates so much it soaks the brief. No one told me to do this, this is just something that I do.	S9999		

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S9999	Continued From page 14 On 1/23/23 at 1:08PM, R4 was observed alert and oriented in bed and said during an interview, "I get changed at least once per shift. I urinate more than that but they come when they come. Sometimes I wait so long for them to come that I have to ask or pull my light which also takes a while for them to answer." R4's health record contained a care plan for incontinence initiated 12/9/22 and revised 12/14/22 which stated "check R4 s required for incontinence; Wash, rinse, and dry perineum; Change clothing as needed after incontinence episodes. 1/24/2023 at 11:10AM, observed incontinence care for R8 with V9 (CNA) who tried to wash resident up in her bed. R8 was alert with confusion and continuously asking unrelated questions. V8 wiped resident's face with one end of a bath towel soaked in water, used the same towel to wipe resident's upper body and went down to wiping the vaginal area with the same towel. Surveyor asked V8 if she is using only one towel to wash and dry the entire body and she said yes. V9 was asked if that is the standard or that they do not have any towels and she said sometimes they don't have enough towels. Facility Minimum Data Set (MDS) assessment dated 1/3/2023 coded R8 as requiring extensive assistance with one-person physical assist for transfer, bed mobility, dressing, toilet use and personal hygiene. Care plan for R8 dated 2/22/2022, revised on 10/11/2022 states that resident is incontinent of bowel and bladder related to moderate to severe cognitive impairment and impaired mobility.	S9999		

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S9999	Continued From page 15 Interventions include but not limited to provide peri care after each incontinent episode, apply barrier cream after each incontinent episode, etc. R5 is an 86-year-old male admitted to the facility 4/20/2012 with diagnoses that include cerebral infarction with hemiplegia and hemiparesis affecting left side, dysphagia, dementia, and contracture of the left hand. According to R5's medical records, MDS dated 11/21/22 indicated R5 has mild cognitive deficits with a BIMS (Brief Interview for Mental Status) score of 09. R5 is incontinent of bowel and bladder and requires extensive 2-person assistance with bed mobility, transfers, and hygiene. On 1/23/23 at 1:17PM R5 was observed in bed alert and oriented. R5 said during an interview, I have to use the brief to relive myself. Sometimes I must wait an hour or more which is quite a time to sit in urine or feces. I like to be clean, and I just have to sit and wait. R5's health record contained a care plan for incontinence initiated 10/28/21 and revised 1/19/22 stating that R5 is incontinent f bowel and bladder and requires staff assistance with toileting task due to diagnoses of Parkinson's, Arthritis, Neuropathy and Hemiplegia. Care plan Interventions include checking R5 as required for incontinence; Wash, rinse, and dry perineum; Change clothing as needed after incontinence episodes. 1/24/2023 at 3:54PM, V2 (ADON) said that she has not provided any in-services on incontinence care since she started at the facility about six weeks ago. Her expectation from staff during	S9999		

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S9999	Continued From page 16 incontinence care is for them to clean residents using proper cleaning solution, making sure they are cleaning from front to back. If providing a bath, they are supposed to use soap and water but for changing incontinent briefs, a wet wipe is okay. V2 said that staff should have at least two towels when providing ADL care, one for the face and the other for the body. When providing incontinence care for a female resident, staff are supposed to clean from front to back as well as the vaginal/labial area. Staff are supposed to perform hand hygiene before and after care and between soiled and clean surfaces. Residents should be checked and changed every two hours and as needed. A resident not having any incontinence briefs in the room should not be an excuse for not changing a resident, the facility provides the briefs, and they always have some in storage. V2 said that MASD (moisture associated dermatitis) on an incontinent resident is probably from being wet and soiled all the time. Incontinent care policy dated 11/28/2012 and revised 1/16/2018 provided by V1 (Administrator) stated its purpose as to prevent excoriation and skin breakdown, discomfort and maintain dignity. Under guidelines, the policy states that incontinent residents will be checked periodically I accordance with the assessed incontinent episodes or every two hours and provided perineal and genital care after each episode. Under procedure, the policy states in part; soap one cloth at a time to wash genitalia using a clean part of the cloth for each swipe, wash the labia firs, then groin areas, in the female resident, separate labia, wash with strokes...each side separately with a clean cloth or clean...keep labia separated with one hand. Clean/rinse inner/upper thigh areas to remove urine moisture, change gloves and perform hand hygiene, apply clean	S9999		

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S9999	Continued From page 17 incontinence brief or incontinence pad, do not touch any clean surfaces while wearing soiled gloves, etc. B) On 1/24/23 at 3:54PM V2 ADON (Assistant Director of Nursing) said I am currently responsible for the nursing schedule. A fully staffed shift is four to five nurses and 10 CNAs (Certified Nursing Assistant). The building is organized as A/B wing and C/D wing. A fully staffed day and evening shift has five CNAs for each wing and three CNAs for night shift. The A/B wing has three medication carts and can staff three nurses and the C/D wing is staffed with two nurses per shift. Staffing is challenging due to multiple call offs and because of that I am working the floor today. This is the second time that I have had to work the floor and I am a new employee to the facility. There is a registered nurse scheduled to work every shift and there is at least one working every day. On 1/25/23 at 12:10PM V1 Administrator said, the facility budget allows us to staff 13 nurses and 30 CNAs every day for direct patient care. We don't utilize any agency for staffing at this time. We hire some under contract but after the contract ends, often they don't stay. I think that the high turnover and the increased call ins are impacted by the fact that they really need a leader. We have had three DONs (Director of Nursing) in the past year and a new one just started today. When we don't have enough people to do what we need, we have to do the best we can. During the course of this survey, residents were observed to be soiled with feces and urine and in need of incontinence care for several hours. V1 was asked if lack of staff has contributed to delays in care and V1 stated, "I can't answer that.	S9999		

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S9999	Continued From page 18 We want them to be checked and changed and if that is not happening, we are looking at why." Nursing Assignment sheet dated for 1/23/23 and 1/24/23 were reviewed and included the following: 1/23/23 A/B wing: 7am to 3pm - 2 nurses, 3 CNAs - 3pm to 11pm, 3 nurses 2 CNAs C/D wing: 3pm to 11pm -2 nurses, 2 CNAs - 11pm to 7am, 2 nurses 2 CNA's 1/24/23 A/B wing: 7am to 3pm - 2 nurses 3 CNAs; 3pm to 11pm 2 nurses 2 CNAs; 11pm to 7am 1 nurse 3 CNAs C/D wing: 7am to 3pm - 2 nurses 3 CNAs; 3pm to 11pm 2 nurses 2 CNAs; 11pm to 7am 2 nurses 2 CNAs During the course of this survey, facility cited for concerns related to incontinence care not being provided (F690) and pressure ulcers (F686), with staffing as a contributing factor. (B)	S9999		