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HIBBARD SKILLED NURSING & REHABILITATION CENTER	1037 WEST MAIN STREET DOVER FOXCROFT, ME 04426

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F 000	INITIAL COMMENTS From 7/8/24 through 7/11/24, on-site visits were conducted at Hibbard Skilled Nursing & Rehabilitation Center for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification and to investigate complaints #ME00047682 #ME00046913, #ME00046386, #ME00046361, #ME00046166, and Faciilty Reported Incidents #ME00047895 and #ME00047539. It was determined that Hibbard Skilled Nursing & Rehabilitation Center was not in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 584	Continued From page 1 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in good repair and in a sanitary condition for 3 of 3 environmental tours. On 7/22/24 at 8:01 a.m. through to 8:35 a.m., environmental tours were completed with the Administrator and surveyors with the following findings at the time of the observations. 1. Room 44a - the veneer/stain on the bedside table and dresser drawer was chipped and missing creating an uncleanable surface. Room 47a - the Lansko fan was soiled with dust. Room 48a - the veneer/stain on the bedside table and dresser drawer was chipped and missing creating an uncleanable surface. Room 51a - the covers on the fall safety floor	F 584		

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mats are soiled and cracked creating an uncleanable surface. The cove base on the floor, left of the bathroom door was pulled away from the wall. The room divider curtain was soiled.
Room 53a - the veneer/stain on the bedside table and dresser drawer was chipped and missing creating an uncleanable surface.
2. In the locked unit, there were multiple torn cloth chairs that were placed around the tables and in the hallway.
In the locked unit, there were multiple cloth living room chairs that had wet spots or dried soiled areas on them.
Room 30b - there were two fans at the entrance of the room that were soiled with dust.
Room 34a - there were small holes in the wall behind the headboard of the bed, the headboard of the bed was chipped around the edges creating an uncleanable surface, and there was torn white stuff on the floor between the bed and chair that was first observed on 7/8/24 at 12:00 p.m. and still there at the time of the tour.
Room 34b - a quarter rail on the bed was soiled with a brown substance. This was first observed on 7/8/24 at 12:00 p.m. and still there at the time of the tour.
Room 36 - the front covers of the baseboard register were not secured to the brackets and there was a broken tile in the bathroom.
Room 37 - the bathroom smelled like urine (first observed on 7/8/24 at 11:46 a.m. and present at the time of the tour) and the drywall to the right of the toilet was bulged.
Room 37a - the chair cover was soiled.
Room 37b - the arm of the blue chair was soiled.
3. Room 41a - there was one fan in the room that was soiled with dust, and there was a screen on the window that was bent on the bottom.
Room 41b - the veneer/stain on the dresser was

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F 584	Continued From page 3 worn creating an uncleanable surface. Room 44b - the veneer/stain on the top of the dresser was worn creating an uncleanable surface, and the top dresser drawer was missing.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the Minimum Data Set (MDS) 3.0 was coded accurately on an admission and annual MDS assessment to indicate that a resident had a state Level II Preadmission Screening and Resident Review (PASRR) and Post Traumatic Stress Disorder (PTSD) for 1 of 1 sampled residents reviewed for PASRR (Resident #61 [R61]). Finding: On 7/9/24, R61's clinical record was reviewed and included a PASSR, dated 5/2/23, that indicated that R61 qualified for Level II services. Review of R61's admission MDS, dated 5/22/23, and annual MDS, dated 4/17/24, Section: A1500 were coded to indicate that R61 did not have a Level II PASRR. During review of R61's clinical record, the PASSR Level II, dated 5/2/23, indicated that the resident had a diagnosis of PTSD and physician progress notes repeatedly included documentation that PTSD was well managed considering his/her diagnosis. Review of R61's admission MDS,	F 641		

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F 641	Continued From page 4 dated 5/22/23, and annual MDS, dated 4/17/24, Section: I6100 were coded to indicate that R61 did not have PTSD. On 7/9/24 at 1:44 p.m., during an interview with a surveyor, the MDS Coordinator reviewed R61's clinical record. R61's original admission MDS, dated 4/8/23, was coded to include both the PTSD and PASRR Level II. R61 was discharged on 4/11/23 and returned to the facility on 5/16/23. This information was inaccurately entered into R61's clinical record and therefore R61's admission MDS, dated 5/22/23 and annual MDS, dated 4/17/24, were both inaccurately coded for PASSR and PTSD. The surveyor confirmed these findings during this interview.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		

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F 656	Continued From page 5 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that a care plan was developed for a resident with the diagnosis of Post Traumatic Stress Disorder (PTSD) for 1 of 1 sampled residents reviewed for PASRR (Resident #61 [R61]). Finding: On 7/9/24, Resident #61's clinical record was reviewed which included documentation on the Level II PASRR and physician progress notes that	F 656		

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F 656	Continued From page 6 R61 had a diagnosis of PTSD and a trauma assessment, dated 7/9/23, had been completed that indicated R61 had an traumatic experience in the past. On 7/10/24 at 10:00 a.m., during an interview with a surveyor, the Long Term Care (LTC) Manager reviewed R61's care plan and was unable to find a care plan that addressed R61's possible triggers of PTSD and no evidence of interventions of what staff should do if R61 displayed signs of re-traumatization or should not do that may cause re-traumatization to the resident. The surveyor confirmed this finding during this interview.	F 656		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that physician orders for medications and treatments were followed for 6 of 8 Residents reviewed for unnecessary medications and/or treatments (Resident #39 [R39]), R22, R77, R55, R49, and R50). Findings: 1. On 7/10/24, R39's clinical record/medication orders were reviewed. R39 had a medication	F 684		

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order for Prazosin Hydrochloric acid (HCL) 1 milligram (mg) by mouth every day for Post Traumatic Stress Disorder (PTSD). Prazosin is an antihypertensive drug also used to manage nightmares and sleep disturbances associated with PTSD. R39's May and June 2024 Medication Administration Record (MAR) and medication exception report indicated that from 6/13/24 through to 7/6/24 (25 days), R39's Prazosin was held (not administered to the resident).

On 7/10/24 at 2:22 p.m., in an interview with the surveyor, the Long Term Care Manager (LTC) stated the medication was held because the facility was unable to get the correct dose from the pharmacy. She stated she made several calls to the pharmacy but was told the medication was not available at that time.

2. On 7/10/24, R22's clinical record/medication orders were reviewed. A review of the clinical record from April thru July indicated the following:

R22 had a medication order for Cranberry capsules, 450 mg to be given twice a day. on 4/11/24, this medication was not given at 9:00 a.m. and 8:00 p.m. because the medication was not available and on 4/12/24, this this medication was not given at 9:00 a.m. because the medication was not available.

R22 had a medication order for Mirabegron Extended Release (ER) 25 mg tablet (used to treat overactive bladder) to be given once a day at 9:00 a.m. On 4/23/24, 4/28/24, and 4/29/24 this medication was not given because the medication was not available.

R22 had a medication order for Calcium with

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Vitamin D3 to be given once daily at 8:00 p,. On 5/9/24, this medication was not given because the medication was not availabe.

R22 had a medication order for Memantine HCL 10 mg tablet (used to treat moderate to severe dementia) to be given once a day. This medication was not given on 5/14/24, 6/19/24, 6/20/24, 6/22/24, 6/23/24, and 6/24/24 because the medication was not available.

R22 had a medication order for Tramadol 50 mg tablet (pain medication) to given at 3:00 a.m. It was was given on 6/3/24 because the prescription needed to be renewed and tehy were waiting for the prescription to be renewed because they could get a code to remove it from the emergency stock.

3. On 7/10/24, R77's clinical record/medication orders were reviewed. A review of the clinical record from April thru July indicated the following:

R77 had a medication order for Trazodone HCl 50 mg table, give 1/2 tablet (used for depression or sleep) to given at 8:00 p.m.. This medication was not given on 6/20/24 because the medication was not available.

On 7/10/24 at 10:00 a.m., during an interview with a surveyor, the LTC Manager stated that this has been ongoing issue with medications not coming in and she has been trying to monitor it but it seems to still be happening. The surveyor confirmed that R22 and R77 missed medications because they were not available.
4. On 7/10/24, R55's clinical record/medication orders were reviewed. R55 had a physician medication order to hold one dose of Eliquis (a

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blood thinner) prior to a surgical procedure on 6/25/24. The medication dose was held on the evening of 6/24/24 and on the morning of 6/25/24, two doses prior to a surgical procedure, one dose too early.

On 7/10/24, R55's discharge instructions from a medical facility were reviewed. R55 had a medical facility discharge instructions to restart Eliquis on the evening of 6/27/24. The discharge instructions state, "no Eliquis until PM (evening) dose on 6/27/24". The medication was held on the PM evening dose on 6/27/24, and not given until the morning dose on 6/28/24, one dose too late.

5. On 7/10/24, R49's clinical record/medication orders were reviewed. R49 had a physician medication order for Humalog Lispro 100 unit/ml (milliliter) solution that states to hold sliding scale insulin if blood sugar level is below 151. On 7/7/24 the 11:30 a.m. blood sugar was 146, and Humalog Lispro 100 unit/ml solution 2 units was given subcutaneously (injection). R29 was administered 2 units of insulin when there was no additional coverage needed per order.

On 7/10/24 at 10:45 a.m., in an interview with the Skilled Nursing Facility (SNF) Manager, a surveyor confirmed that physician orders were not followed for R55's medication, Eliquis, to be held and restarted, and for R49 receiving insulin when not needed.

6. On 7/10/24 at 10:50 a.m., R50's clinical record was reviewed and included a physician's order to, "Check weight daily every morning using the same scale at the same time of day with the same amount of clothes", dated to start 1/26/24. R50's clinical record lacks evidence that the

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F 684	Continued From page 10 weights were done as ordered on 7/7/24, 7/6/24, 7/5/24, 7/2/24, and 6/26/24, and lacked evidence indicating the resident refused these treatments. On 7/10/24 at 10:55 a.m., in an interview with the Administrator and SNF Manager, a surveyor confirmed daily weights were not completed as ordered for R50.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interviews and observations, the facility failed to follow physician orders for use a equipment (wedge pillow) to maintain and/or improve residents' highest level of bed mobility for 1 of 1 resident reviewed for positioning and mobility. (Resident #50 [R50])	F 688		

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F 688	Continued From page 11 Finding: On 7/09/24 at 10:55 a.m., a surveyor observed R50's position to be slouched in bed on R50's right side. In an interview with the surveyor, R50 stated the need for a wedge pillow to maintain positioning, without the wedge pillow he/she often ends up lying on their right side. R50 stated it also is hard to reach items at meal times without extra support, and the wedge pillow has been missing for a while. No wedge pillow or other support pillows were observed in use at the time of the interview. On 7/10/24 at 7:29 a.m., a surveyor observed R50 lying in bed waiting for breakfast. No wedge pillow or other support pillows were observed in use at the time of the observation. On 7/10/24 at 10:00 a.m., clinical record review for R50 included a doctor's order dated 6/17/24 to "use wedge daily", the Plan of Care Summary indicated "use pillows to position [R50] comfortably" and "[R50] should not be laying on the right side due to shoulder going in and out of placement." On 7/10/24 at 10:11 a.m., in an interview with the Skilled Nursing Facility Manager, a surveyor observed and confirmed R50 was not supported by a wedge pillow as ordered by the doctor to assist with positioning.	F 688		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who	F 695		

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needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observations, manufacturer's manual review, and interview, the facility failed to ensure that an oxygen concentrator was operated and maintained per manufacturer's directions for 1 of 1 residents reviewed with oxygen (Resident #22 [R22]).

Finding:

On 7/8/24, a review of R22's physician order's indicated that R22 used oxygen at night and there was a weekly treatment to clean the filter and change the tubing on Sunday nights (7/7/24).

On 7/8/24 at 12:17 p.m., a surveyor observed the oxygen concentrator in R22's room noting that it was missing the cabinet filter compartment which snaps on the back of the concentrator. Review of the manufacturer's manual for the Invacare Perfecto2 reads on page 24, "do not operate the concentrator without the filter installed".

On 7/9/24 at 10:35 a.m., a surveyor observed the oxygen concentrator again without the cabinet filter compartment attached to the concentrator.

On 7/10/24 at 10:08 a.m., a surveyor showed the Long Term Care (LTC) Manager the diagram that outlined the oxygen concentrator parts in the manufacturer's manual and then went to R22's room to observe the oxygen concentrator. During

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F 695	Continued From page 13 this observation, the surveyor confirmed that the cabin filter compartment was missing and had been missing at least since Monday (7/8/24). The LTC Manager removed the concentrator from the room.	F 695		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a Physician ordered lab was completed for a urine test for 1 of 2 urinalysis ordered for Resident #35 (R35). Finding: On 7/9/24, R35's clinical record was reviewed and included a physician order, dated 6/17/24, for a urinalysis as the physician thought that symptoms R35 was having was being caused by an infection. The order was entered into the computer to be completed on 6/18/24. The clinical record lacked evidence that a urine was collected for testing until another order was received and collected on July 7th. On 7/11/24 at 11:25 a.m., during an interview with a surveyor, the Long Term Care Manager stated	F 770		

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F 770	Continued From page 14 she was unable to find evidence that a urine as collected and tested on 6/18/24.	F 770		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings,	F 842		

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law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and interviews, the facility failed to accurately document resident weights for 2 of 3 resident reviewed for weight loss concerns (Resident #39 [R39] and R14).

Findings:

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F 842	Continued From page 16 1. On 7/10/24, R39's clinical record was reviewed. A Registered Dietician's (RD) note, dated 6/18/24, indicated a follow up was done due to a weight loss of 51% over the past 30 days. The RD indicated from 4/9/24 to 6/13/24, weights ranged from 148.4 pounds (#) to 216# making it difficult to fully access trends. The following weights were documented: 4/9/24 - 216#, 4/18/24 - 167.3#, 5/7/24 - 156.4#, 6/4/24 - 190.6#, 6/13/24 - 148#. On 7/10/24 at 9:33 a.m., in an interview with the surveyor, the Long Term Care Manager (LTC Manager) confirmed that several of the weights were inaccurate and a re-weigh should have been done. 2. On 7/8/24, R14's clinical record was reviewed and included a RD note, dated 5/19/24, that indicated this was a follow up due to significant weight loss in April of 13.7% over 30 days and 14.8% over 90 days. RD does question this weight as it is 17.2 lbs less than prior weight and R14 consumed 75-100% meal on average and resident has eaten 79% of meals on average over the past two weeks per Certified Nursing Assistant (CNA) charting. RD will follow upcoming weights as there was no May weight yet to review. The following weights were documented: 2/26/24-117.6#, 3/26/24-125.4#, 4/24/24-108.2#, 5/19/24-108.2# from 4/24/24, 5/23/24-116#, and 6/21/24-127.6#. On 7/10/24 at 12:04 p.m., during an interview with the surveyor, the LTC Manager stated the weights wed not seem correct (noting mainly 4/24/24 weight) and that R14 probably did not have that much weight loss. The LTC Manager immediatley contacted the Staff Development Coordinator about arranging education to staff on how to properly weigh residents.	F 842		

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T 001	Initial Comments From 7/8/24 through 7/11/24, on-site visits were conducted at Hibbard Skilled Nursing and Rehabilitation Center for the purpose of completing the annual Long Term Care Survey Process for Recertification and to investigate complaints #ME00047682 #ME00046913, #ME00046386, #ME00046361, #ME00046166, and Faciilty Reported Incidents #ME00047895 and #ME00047539. It was determined that Hibbard Skilled Nursing and Rehabilitation Center is not in substantial compliance with 10-144 Chapter 110-Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities.	T 001		
T 222	9.A.4. Minimum Staffing Rules The nursing staff-to-resident ratio is the number of nursing staff to the number of occupied beds. Nursing assistants in training shall not be counted in the ratios. The minimum nursing staff-to-resident ratio shall not be less than the following: a. On the day shift, one direct-care provider for every 5 residents; b. On the evening shift, one direct-care provider for every 10 residents; and c. On the night shift, one direct-care provider for every 15 residents The definition of direct care providers and direct care is found in Chapter 1 of these Regulations.	T 222		

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This Regulation is not met as evidenced by:
Based on review of the staffing schedules, daily resident census, and interview, the facility failed to ensure staffing minimums were met in accordance with the "State of Maine Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities," Chapter 9.A.4.A., for 8 days out of 42 days reviewed for minimum staffing.

Findings:

The "State of Maine Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities," Chapter 9.A.4.A., indicates the minimum nursing staff-to-resident ratio shall not be less than one direct care provider for every 5 residents on the day shift; not be less than one direct care provider for every 10 residents on the evening shift, and not be less than one direct care provider for every 15 residents on the night shift. "Direct Care" means hands-on care provided to residents, including, but not limited to feeding, bathing, toileting, dressing, lifting, moving residents, treatments, and medication administration per the definition in Chapter 1 of the regulations.

1. On 6/23/24, the facility had a census of 79 residents which required 16 direct care staff to be on duty. The facility's schedule indicated that 15 staff worked on that day shift from 12 noon to 3:00 p.m..

2. On 3/3/24, the facility had a census of 77

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residents which required 16 direct care staff to be on duty. The facility's schedule indicated that 15 staff worked on that day shift.

3. On 3/8/24, the facility had a census of 80 residents which required 16 direct care staff to be on duty. The facility's schedule indicated that 15 staff worked on that day shift from 1:00 p.m. to 3:00 p.m.

4. On 3/9/24, the facility had a census of 78 residents which required 16 direct care staff to be on duty. The facility's schedule indicated that 15 staff worked on that day shift.

5. On 3/10/24, the facility had a census of 79 residents which required 16 direct care staff to be on duty. The facility's schedule indicated that 14 staff worked from 6:30 a.m.-9:00 a.m. and from 9:00 a.m.-3:00 p.m. 15 staff were on the day shift.

6. On 3/16/24, the facility had a census of 77 residents which required 16 direct care staff to be on duty. The facility's schedule indicated that 13 staff worked on that day shift.

7. On 3/18/24, the facility had a census of 78 residents which required 16 direct care staff to be on duty. The facility's schedule indicated that from 6:30 a.m. to 10:30 a.m. 14 staff worked and from 10:30 a.m. to 3:00 p.m. 15 staff worked on that day shift.

8. On 3/19/24, the facility had a census of 79 residents which required 16 direct care staff to be on duty. The facility's schedule indicated that 15 staff worked on that day shift from 6:30 a.m. to 10:30 a.m.

9. On 3/23/24, the facility had a census of 7

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residents which required 16 direct care staff to be on duty. The facility's schedule indicated that 15 staff worked on that day shift.

10. On 3/24/24, the facility had a census of 79 residents which required 16 direct care staff to be on duty. The facility's schedule indicated that 14 staff worked on that day shift.

11. On 3/25/24, the facility had a census of 78 residents which required 16 direct care staff to be on duty. The facility's schedule indicated that 15 staff worked on that day shift from 6:30 a.m. to 10:30 a.m.

12. On 3/30/24, the facility had a census of 78 residents which required 16 direct care staff to be on duty. The facility's schedule indicated that 13 staff worked from 6:30 a.m.-10:30 a.m. and from 10:30 a.m.-3:00 p.m. 14 staff were on the day shift.

13. On 3/31/24, the facility had a census of 77 residents which required 16 direct care staff to be on duty. The facility's schedule indicated that 14 staff worked on that day shift.

14. On 4/6/24, the facility had a census of 76 residents which required 16 direct care staff to be on duty. The facility's schedule indicated that 15 staff worked on that day shift.

15. On 4/20/24, the facility had a census of 77 residents which required 16 direct care staff to be on duty. The facility's schedule indicated that 15 staff worked on that day shift from 12:30 p.m. to 3:00 p.m.

16. On 4/20/24, the facility had a census of 82 residents which required 17 direct care staff to be

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T 222	Continued From page 4 on duty. The facility's schedule indicated that 16 staff worked on that day shift from 10:30 a.m. to 3:00 p.m. On 7/11/24 at 8:30 a.m., the surveyor discussed these findings with the Administrator.	T 222		