STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035234	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arizona State Veteran Home-Phx	4141 North S Herrera Way Phoenix, AZ 85012

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility documentation, staff interviews, and policy review, the facility failed to ensure one resident's (#32) Preadmission Screening and Resident Review (PASARR) was completed accurately and was referred to state designated authorities for evaluation and determination. The deficient practice could result in residents not receiving specialized services needed. Findings include: Resident #32 was admitted to the facility on [DATE] with diagnoses that included diffuse traumatic brain injury, bipolar disorder, and major depressive disorder. Review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS also revealed that Resident #32 had diagnoses of anxiety disorder, depression, and bipolar disorder. Review of physician orders revealed the following orders: Depakote Sprinkles (divalproex) capsule, delayed [NAME] sprinkle; 125 milligram; oral Twice A Day 07:30, 19:00 04/23/2025 hydroxyzine pamoate capsule; 25 milligram; oral 1 Time Per Day - PRN 04/23/2025 trazodone tablet; 50 milligram; oral At Bedtime 21:00 04/23/2025 Review of the Pre-admission Screening and Resident Review (PASARR) Level One Screening, dated May 5, 2025, revealed that the resident's mental health diagnoses were not all reflected. The PASARR level I confirmed that the resident was not exempt from the evaluation as per documented 'No' for the resident not qualifying for 30 day convalescent care as well as not having dementia as primary diagnosis. The PASARR reflected that the resident had a serious mental illness diagnosis of psychotic/delusional disorder. The PASARR also reflected that the resident had the mental disorders of anxiety disorder and bipolar disorder. However, the PASARR did not document the resident's diagnosis of Major Depressive Disorder. The PASARR further indicated that a referral for level two evaluation was not necessary. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035234	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arizona State Veteran Home-Phx	4141 North S Herrera Way Phoenix, AZ 85012

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan revealed a problem focus, initiated on May 27, 2025 that indicated that Resident #32 was receiving antidepressant medication related to his diagnosis of major depressive disorder. Additionally, another problem focus, initiated on May 27, 2025 indicated that Resident #32 was receiving mood stabilizer medication related to his diagnosis of anxiety disorder. Interview was conducted on May 30, 2025 at 9:44AM with a Medical Social Worker (Staff #84), who stated that any mental health related diagnoses should be reflected on a PASARR assessment. The Social Worker stated that the purpose of a PASARR assessment would be to help with accountability and to ensure that placement at the facility would be appropriate and able to meet the needs of the residents. When reviewing the PASARR completed for Resident #32, the Social Worker agreed that the form did not reflect Resident #32's mental health diagnoses accurately. He acknowledged that the resident's major depressive disorder diagnosis was not included; and that, the level one screening should be redone. Interview was conducted on May 30, 2025 at 2:06PM with the Director of Nursing (DON/Staff #24) and the Assistant Director of Nursing (ADON/Staff #22). In this interview, the DON stated that she would expect a completed PASARR to reflect mental health diagnoses such as major depressive disorder. When discussing Resident #32's PASARR, the DON agreed that major depressive disorder was not reflected on the PASARR, and stated that she would expect corrective action to make the PASARR accurate. Review of the facility policy titled, Behavioral Assessment, Intervention and Monitoring (dated October 2021), indicated that nursing staff and the attending physician, as part of the initial assessment, identify individuals with a history of impaired cognition, altered behavior, substance use disorder, or mental disorder. The policy indicated that all residents would receive a level one PASARR prior to admission, and if the level one screen indicated that the individual may meet the criteria for a mental disorder, intellectual disability, or related condition, he or she would be referred to the state PASARR representative for the Level two (evaluation and determination) screening process.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035234	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arizona State Veteran Home-Phx	4141 North S Herrera Way Phoenix, AZ 85012

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, interviews, and facility policy, the facility failed to ensure that pharmacy recommendations for one resident (#14) were reviewed and addressed by the attending physician. The deficient practice could result in medication irregularities that go unnoticed or are not acted upon. Findings include: Resident #14 was admitted to the facility on [DATE] with diagnoses that included dementia with agitation, adjustment disorder, anxiety disorder, depression, and schizophrenia. Review of the care plan revealed a problem focus, initiated November 25, 2022, which indicated that the resident received antidepressant medication related to his diagnosis of depression. The goal for this problem was that the resident's medication would be effective during his stay and until the next review. Interventions included carrying out the medication management regimen as prescribed. Review of the physician orders revealed the following active medication order: Mirtazapine tablet; 15 mg; amt: 15 mg; oral Special Instructions: Dx: Depression aeb poor appetite At Bedtime 21:00 11/28/2023 Open Ended Review of the Medication Regimen Review (MRR) dated March 31, 2025 revealed recommendations made by the consultant pharmacist conducting the review (Staff #199), which included a recommendation to discontinue the resident's mirtazapine as the patient's weight on March 4, 2025 was 191.6 and his BMI was 25.28. The pharmacist also recommended consideration of an alternative agent for depression that would not stimulate appetite, and the pharmacist recommended Sertraline 25mg by mouth daily. The MRR indicated that a note was written to the physician. Review of the MRR revealed no evidence that the physician had signed the MRR, or if the physician had agreed or disagreed with this recommendation. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] indicated that the resident was receiving antidepressants, opioids, and antipsychotic medication on a routine basis. Review of the progress notes revealed no evidence found that the attending physician had reviewed or acknowledged the pharmacist's medication recommendations from March 31, 2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035234	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arizona State Veteran Home-Phx	4141 North S Herrera Way Phoenix, AZ 85012

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated April 23, 2025, which was created on May 7, 2025, from the Psychiatric Nurse Practitioner (Staff #197) detailed that she had conducted a psychiatric reevaluation on Resident #14. The note indicated that the resident was last seen March 19, 2025, and no medications changes were made at that time or in the interim. The note included a plan, which detailed no medication changes, as the benefits outweighed the risks for prescribed psychotropic medications. The NP's note revealed no evidence that the pharmacist's March recommendations were seen and considered by either the attending physician or herself. Interview was conducted on May 29, 2025 at 8:15AM with the Consultant Pharmacist (Staff #199), who stated that non-emergent recommendations from the MRR are given to the Director of Nursing, who then takes it to the attending physician. He stated that if he makes recommendations, the physician should sign the MRR after reviewing. Interview was conducted on May 30, 2025 at 9:18AM with Resident #14's Attending Physician (Staff #198), who stated that he normally receives the pharmacist's recommendations in writing, and the forms are placed in his binder at the facility. He stated that he typically reviews any pharmacy recommendations every one or two weeks. The physician stated that he responds to the recommendations by marking whether he agreed or disagreed with the recommendation on the paper form, which is then sent to medical records to be uploaded. When asked if the physician had seen the pharmacy recommendation regarding mirtazapine on March 31, 2025, the physician stated that he was unsure if this had been addressed and that he would have to review the resident's chart to find out. The physician stated that it was also possible that the recommendation may have been sent to the Psychiatric Mental Health Nurse Practitioner (NP/Staff #197) instead. Interview was attempted via telephone on May 30, 2025 at 10:25AM with the Psychiatric Mental Health Nurse Practitioner (NP/Staff #197), but she could not be reached for interview. Interview was conducted on May 30, 2025 at 2:06PM with the Director of Nursing (DON/Staff #24) and the Assistant Director of Nursing (ADON/Staff #22). In this interview, the DON stated that pharmacy recommendations from the MRR are printed out and placed into the provider's folder for review. She explained that from this point, the provider either agrees or disagrees with the recommendation. If the provider agreed with the recommendations, the nurses would enter the orders. If the order required consents, the staff would obtain the consents, and then send them to medical records. The DON explained that the provider would respond to pharmacy recommendations directly on the paper form, marking agree or disagree, and then this form would be uploaded into the resident's Electronic Health Record. Upon reviewing Resident #14's uploaded documents and clinical records, the DON and ADON agreed that the pharmacist had given a recommendation, and they could not locate that the MRR recommendation had been responded to. Review of the facility policy titled, Medication Regimen Reviews (May 2019), revealed that within twenty-four hours of the MRR, the consultant pharmacist should provide a written report to the attending physicians for each resident identified as having a non-life-threatening medication irregularity, which would include the identified irregularity and the pharmacist's recommendation. The policy indicated that the attending physician should document in the medical record that the irregularity had been reviewed and what (if any) action was taken to address it. The policy also revealed that copies of medication regimen review reports, including physician responses, should be maintained as part of the permanent medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035234	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arizona State Veteran Home-Phx	4141 North S Herrera Way Phoenix, AZ 85012

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on documentation, resident and staff interviews, and facility policy and procedures, the facility failed to ensure that the medical record, including recorded weights, was complete and accurate for two residents (#59). The deficient practice could lead to interdisciplinary team members not being aware of the resident's status and could lead to a gap in care. Findings include: Resident #59 was admitted to the facility on [DATE] with diagnoses that included cirrhosis of the liver, major depressive disorder, and enterocolitis due to clostridium difficile. Review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS also indicated that the resident had not experienced any weight gain or loss. Review of the documented weights for Resident #59 revealed the following: 05/27/2025 17:31 - 236.8 lbs 05/22/2025 14:13 - 156.4 lbs 04/04/2025 01:20 - 258.2 lbs 03/23/2025 18:22 - 241 lbs Review of the care plan revealed a problem focus, initiated March 22, 2025, which indicated that Resident #59 was at risk for dehydration related to receiving daily diuretic medication. Interventions in place included to monitor weights as ordered, to give a diet as ordered, and to notify the physician of any abnormal findings. Review of physician orders revealed an order, dated April 3, 2025, which instructed staff to obtain weights monthly, which should be obtained by the third day of the month. Review of the progress notes revealed no evidence of staff acknowledging the low weight recorded on May 22, 2025 or any potential weight loss. Interview was conducted on May 27, 2025 at 09:35AM with Resident #59, who stated that he felt that he had lost weight. The resident stated that he had been having almost daily vomiting and had noticed that he had lost weight. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035234	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arizona State Veteran Home-Phx	4141 North S Herrera Way Phoenix, AZ 85012

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview was conducted on May 28, 2025 at 10:25AM with a Diet Technician (Staff #196) who stated that Certified Nursing Assistants often obtain the resident's weights, and the obtained weights are reviewed by nurses, herself, and the dietician. The Diet Technician stated that if the obtained weights seemed inaccurate, staff would obtain a re-weight. When asked to review Resident #59's documented weights, the Diet Technician stated that she did not yet see the weight recorded on May 22, 2025 but stated that this was inaccurate documentation. The Diet Technician stated that she was familiar with Resident #59, and stated that he did not appear to have had a significant weight loss. She also stated that in an instance where a weight is noted to be much different than the others is obtained, a re-weight should be obtained, and the Diet Technician stated that this was done in this case. Interview was conducted on May 29, 2025 at 11:21AM with a Certified Nursing Assistant (CNA/Staff #195), who stated that both the CNAs and the RNAs (Restorative Nursing Assistants) obtain resident weights. The CNA stated that if staff obtain a weight that seemed very different from other weights, the staff should reweigh them. She also stated that when obtaining weights, the nurses would compare the weights obtained to previous weights. The CNA stated that she felt that a lot of the staff did not know the proper way to obtain weights, including the RNAs. The CNA explained that the facility did not offer much training on obtaining weights, and she stated that this is a training that the staff need, as the weights could affect a resident's medications. The CNA stated that a lot of the staff do not know that residents need to be weighed the same way each time to get an accurate weight. The CNA also stated that staff conducting hoyer weights often weigh the resident in the hoyer sling and then subtract a certain amount of weight for the sling, stating that, they take the weight and subtract five pounds for the sling. The CNA voiced concerns at this, stating that residents should be weighed with the sling, and this weight should be recorded without subtracting anything. The CNA voiced great concern about the inconsistencies in methods used by staff to obtain weights on residents. Interview was conducted on May 29, 2025 at 12:17PM with a Nurse Supervisor (Staff #29), who stated that weights are often obtained by CNAs. She explained that the person who obtained a weight should chart the weight or refer it to the nurse or supervisor. She stated that the nurse or supervisor then reviews the weights. She stated that if she noticed a change, she would assess the resident and notify the provider and dietician if a weight change was noticed. The Nurse Supervisor also stated that if a weight seemed inaccurate, she would expect a re-weigh to be done, though she could not state the timeframe in which this should be completed. The Nurse Supervisor stated that if a weight was found to be inaccurate, the weight should not be removed from the Electronic Health Record, but a note should be made explaining that the weight was deemed inaccurate documentation. Interview was conducted on May 29, 2025 at 2:33PM with Resident #59's Attending Physician (Staff #198) who was unable to recall if he had seen or been notified of Resident #59's low recorded weight on May 22, 2025. The Physician stated that upon reviewing the weights, the low weight was likely a typo, as he did not believe that the resident experienced such a drastic weight change. The Physician acknowledged that an incorrect weight reading could potentially affect a resident's care, especially depending on their disease process. The physician stated that certain residents, such as those with heart failure, need to have their weights monitored very closely. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035234	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arizona State Veteran Home-Phx	4141 North S Herrera Way Phoenix, AZ 85012

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview was conducted on May 30, 2025 at 1:00PM with the Restorative Nursing Assistant (RNA/Staff #194) who had documented Resident #59's weight on May 22, 2025. She stated that whoever obtained the weight should document it in the Electronic Health Record (EHR) and report it to the nurse. If the nurse noticed that the weight appeared very different from other weights, they would ask the RNA or CNA to repeat the weight. When asked about the weight of 156.4 pounds recorded by the RNA on May 22, 2025, the RNA stated that she did not see this lower number. She explained that the CNA had obtained the weight that day and given it to her to document. The RNA could not recall which CNA had obtained this weight, and the RNA was unsure if this was reported to the nurse. Observation was conducted on May 30, 2025 at 1:15PM of a weight being obtained via Hoyer lift by the RNA (Staff #194) and a CNA who assisted. During the observation, the staff first zeroed the Hoyer scale and attached a Hoyer sling. The staff obtained the weight of the sling. The RNA stated the weight of the sling was 1.8 pounds. The staff then zeroed the scale again, placed a sling under the resident, and attached the sling to the Hoyer. The staff then raised the resident in the sling via the Hoyer lift, and announced the displayed weight as 129.8 pounds. When asked what would be the weight recorded in the record, the RNA replied that she would record the weight as 129.8 pounds, and that she would not subtract the weight of the sling before documenting the weight. Interview was conducted on May 30, 2025 at 2:06PM with the Director of Nursing (DON/Staff #24) and the Assistant Director of Nursing (ADON/Staff #22). In this interview, the DON stated that weights should be obtained per the facility policy. The DON and ADON agreed that when weighing a resident with a Hoyer lift, the resident should either be transferred for a chair weight, or if the Hoyer lift had a scale, the weight of the sling should be known and should be removed from the total weight. When asked what staff should do if they obtain a weight that is abnormal for a resident, the DON stated that a reweight should be obtained and documented per policy and the provider and family would be notified. Upon reviewing Resident #59's weight reading from May 22, 2025, the DON and ADON stated that they thought the reading was an error, as the other readings were consistent within a few pounds. The DON and ADON could not identify any charting where this weight was addressed or confirmed to be inaccurate. Review of the facility policy titled, Weighing and Measuring the Resident (dated October 2021) revealed that significant weight loss/weight gain should be reported to the nurse supervisor. This policy also contained procedures for obtaining residents weights via a standing scale, a platform scale, and by using a mechanical lift to move a resident into a chair scale. Review of this policy revealed no evidence of a policy or procedure in place for staff to obtain or record resident weights using a Hoyer lift with a scale.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035234	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arizona State Veteran Home-Phx	4141 North S Herrera Way Phoenix, AZ 85012

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on facility documentation, staff interviews, and policy review, the facility failed to ensure that the required staffing information and Certification and Survey Provider Enhanced Reporting (CASPER) Payroll-Based Journal (PBJ) data was submitted to CMS (Centers for Medicare & Medicaid Services) for one quarter. The deficient practice could result in residents receiving inadequate care due to a potential lack of staffing. Findings include: A review of the [NAME] PBJ Staffing Data Report that was run on May 21, 2025 revealed that the facility was triggered for failure to submit data for the quarter for the following: Fiscal year, quarter four (July 1 - September 30) 2024 Interview was attempted with the staffing coordinator on May 30, 2025 at 10:37AM, but she could not be reached for interview. Interview was conducted with the Assistant Director of Nursing (ADON/Staff #22) on May 30, 2025 at 12:02PM, who stated that the previous staffing coordinator used to be very involved with submitting PBJ data. The ADON explained that this staff member was no longer employed, but that the new staffing coordinator would likely be the person responsible for submitting PBJ data. The ADON stated that she did not know much about PBJ staffing data, but the Regional Compliance Director of Nursing would know more. Interview was conducted on May 30, 2025 at 12:22PM with the Regional Compliance Director of Nursing (Staff #200), who stated that the staffing coordinator was responsible for submitting PBJ data for the facility. She stated that she did not believe that the facility had a staffing coordinator at this time. Staff #200 stated that the facility's prior Administrator and Director of Nursing were aware that staffing data was not submitted for quarter four of 2024, though she was not aware of why. Staff #200 identified the risks of not submitting staffing data to CMS to be that the facility could face a penalty, and that the facility's star rating would be affected.