STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165118	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madrid Home for the Aged	613 West North Street Madrid, IA 50156

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review staff interview, and policy review the facility failed to identify non-pharmacological interventions and targeted behaviors related to high risk medications in 4 out of 5 sampled residents reviewed (Resident #2, #29, #1, and #4). The facility reported a census of 54 residents.Findings include:1. Review of Resident #2's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognitive functioning. The MDS indicated that Resident #2 was taking antidepressant medications during the look back period. The MDS further indicated that Resident #2 had diagnoses of depression, metabolic encephalopathy (an acute or subacute brain dysfunction caused by systemic illness, toxins, or organ failure rather than structural damage), and cognitive communication deficit. Review of Resident #2's Electronic Health Record (EHR) page titled, Clinical Physician's Orders revealed an order with a start date of 12/2/25 for Duloxetine HCl (antidepressant) oral capsule delayed release sprinkle 60mg to give 120mg by mouth daily. This order was discontinued on 3/21/26 and a new order was obtained for Duloxetine HCl (antidepressant) oral capsule delayed release particles 30mg to give 3 capsules by mouth one time a day. Review of the Care Plan with a revised date of 3/6/26 lacked non-pharmacological interventions and targeted behaviors with an antidepressant medication. 2. Review of Resident #29's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognitive functioning. The MDS indicated that Resident #29 was taking antipsychotic, and antidepressant medications during the look back period. The MDS further indicated that Resident #29 had diagnoses of Alzheimer's disease, depression, and bipolar disorder. Review of Resident #29's EHR page titled, Clinical Physician's Orders revealed an order with a start date of 5/14/25 for Quetiapine Fumarate (Antipsychotic) oral tablet 50mg to give 50mg by mouth one time a day. Further review revealed an order for Quetiapine Fumarate (Antipsychotic) oral tablet 25mg to give 25mg by mouth one time a day with a start day of 5/14/25. Further review of the Clinical Physician Order's revealed an order with a start date of 11/16/25 for Trazodone HCl (Antidepressant) oral tablet to give 25mg by mouth one time a day. Review of the Care Plan with a revised date of 12/29/25 lacked non-pharmacological interventions and targeted behaviors with an antidepressant, and antipsychotic medication. Interview on 3/25/26 at 1:15 PM with the Director of Nursing (DON) revealed that there should be non-pharmalogical interventions listed on the care plan for antipsychotic medications as well as the antidepressants. (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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #1's MDS dated [DATE] revealed a BIMS score of 14 indicating intact cognitive functioning. The MDS indicated that Resident #1 was taking antianxiety and antidepressant medications during the look back period. The MDS further indicated that Resident #2 had diagnoses of depression, cerebrovascular accident (CVA, or stroke, caused when blood flow to the brain is interrupted, causing brain cells to die from lack of oxygen), and dysphagia (difficulty swallowing, often caused by neurological conditions, i.e., stroke, resulting in pain, coughing, or choking while eating). Review of Resident #1's EHR page titled, Clinical Physician's Orders revealed an order with a start date of 12/22/25 for Bupropion HCl (antidepressant) oral tablet extended release 300mg to give 300mg by mouth daily. Further review revealed an order for Duloxetine HCl (antidepressant) oral capsule delayed release particles 30mg to give 3 capsules by mouth one time a day (used to treat depression, anxiety, diabetic nerve pain, fibromyalgia, and chronic musculoskeletal pain). Review of Resident #1's Care Plan with a revised date of 2/16/26 revealed it lacked non-pharmacological interventions and targeted behaviors with an antidepressant and antianxiety medication. 4. Review of Resident #4's MDS dated [DATE] revealed a BIMS score of 11 that indicated moderately impaired cognitive functioning. The MDS indicated that Resident #4 was taking antipsychotic and antidepressant medications during the look back period. The MDS further indicated that Resident #29 had diagnoses of Non-Alzheimer's dementia, anxiety disorder, depression, and psychotic disorder. Review of Resident #4's EHR page titled, Clinical Physician's Orders revealed an order with a start date of 12/27/24 for Risperidone (Antipsychotic) oral tablet 0.5mg to give 0.5mg by mouth one time a day. Further review revealed an order for Sertraline HCl (Antidepressant) oral tablet 75mg to give 75mg by mouth one time a day with a start day of 3/18/26. Further review of the Clinical Physician Order's revealed an order with a start date of 3/18/26 for Lorazepam (Antianxiety) oral tablet to give 0.5mg by mouth every 12 hours as needed for anxiety for 14 days, with an end date of 4/3/26. Review of Resident #4's Care Plan with a revised date of 2/16/26 revealed it lacked non-pharmacological interventions and targeted behaviors with an antidepressant, antianxiety, and antipsychotic medication. Review of a facility provided policy titled, Comprehensive Person-Centered Care Planning with a revision date of December 2025 indicated The comprehensive care plan will be developed and implemented consistent with the resident's rights and include measurable objectives and timeframes to meet the resident's medical, nursing, and mental/psychosocial needs that are identified in the comprehensive assessment.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and facility policy review, the facility failed to prepare, serve and distribute food in accordance with food service safety. The facility also failed to ensure sanitary and safe conditions in the two kitchenette areas in the facility maintained for food services. These failures posed the risk of food borne illness to the residents. The facility reported a census of 54 residents. Findings include:Observation on 3/25/26 in the facility's kitchen of the noon meal service with Staff B, Dietary Aide/Cook revealed at:11:36 a.m., he put on a pair of disposable gloves and took a plate with those gloves on he touched a pair of tongs to plate one piece of beef steak with mushroom and onion gravy from the steam table, a scoop to plate the mashed potatoes, a ladle to plate mixed vegetables, and set the plate on the steam table's counter. He then handled an insulated cart with those same gloved on, touched the sides of the cart to position it next to the steam table and opened a door of that cart. He then opened a bag of sliced bread, removed one slice of bread with those same gloved hands, placed the slice of bread on the plate, covered the plate with an insulated cover, placed the covered plate on a tray along with the paper meal slip, and handled the tray to place it in the insulated cart.11:38 a.m., he handled another plate and began plating a second meal with those same gloves on. With that pair of gloves on, he touched a pair of tongs to serve the beef steak with gray, a scoop to plate the mashed potatoes, the ladle to plate the mixed vegetables, removed one slice of bread with those same gloved hands, placed the slice of bread on the plate, placed an insulated cover over the plate, and placed it on a tray, with the resident's meal slip in the insulated meal cart.11:39 a.m., he handled another plate and began plating the third meal. With that same pair of gloves on, he touched a pair of tongs, a scoop, a ladle, removed one slice of bread with those same gloved hands, placed the slice of bread on the plate, placed an insulated cover over the plate, and placed it on a tray, along with the resident's meal slip in the insulated meal cart and closed the door of the insulated meal cart.11:40 a.m., he took off those gloves. He had not sanitized his hands after removing the gloves.During an interview on 3/25/26 at 11:46 a.m. with Staff B, Dietary Aide/Cook, the observations of his glove use were reviewed that included his touching multiple surfaces that contaminated the gloves before handling the ready-to-eat sliced bread, and not limiting glove use to only one task. Staff B, Dietary Aide/Cook, agreed that he had touched multiple surfaces prior to handling the ready-to-eat sliced bread. During an interview on 3/25/26 at 12:07 p.m. with the Dietary Manager, the observations of Staff B were discussed including his glove use, touching multiple items, and handling the ready-to-eat sliced bread with those contaminated gloves. She stated she encouraged dietary staff not to wear gloves when preparing and serving resident meals and that she expected the dietary staff to use tongs with the ready-to-eat sliced bread to place it on the plate. Review of the facility policy Use of Gloves, revised December 2024 revealed Single-use gloves may be worn by all employees when handling. single use food items to protect residents from food borne illness or spread of diseases. The procedure included: Gloved hands are an extension of the employees hands and are considered a food contact surface that can be contaminated or soiled and therefore will be used for only one task. Gloves may be worn during the following processes. Handling ready-to-eat foods. Gloves must be changed whenever hands would normally be washed or after any of the following:As soon as they become damaged or soiled.When interruptions occur in the operation.Before beginning a new task.After touching any equipment.Any time touching a surface that may be contaminated. During an interview later that same day at 12:25 p.m. with the Dietary Manager, the refrigerators in the kitchenettes on the second and third floor of the facility were discussed. She stated the snacks, nourishments, condiments, and other food items for the residents were placed in those refrigerators and that the dietary department stocked those refrigerators daily. She stated it was the responsibility of the nursing department to ensure the cleanliness and proper temperature of those refrigerators to prevent the potential for foodborne illness. Observation on 3/25/26 at 12:55 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	p.m. of the second-floor kitchenette revealed there was no thermometer in the fridge. On the door of the fridge there was posted a Refrigerator Temperature Check form with boxes for the 31 days of the month. The form stated the Refrigerator temperature should be 36-40 F [Fahrenheit] The form's spaces to record the Location, Month, and Year were blank. Seven of the boxes were completed with staff initials that indicated temperature readings of 38 F and 39 F. The inside of the fridge was dirty with debris noted on the shelves and dried juice on the bottom of the fridge. Observation on 3/25/26 at 1:30 p.m. of the third-floor kitchenette revealed the fridge had no Refrigerator Temperature Check form posted. The inside of the fridge had a dried brown substance on the bottom shelf of the fridge and in one of the bottom drawer's of the fridge was a Garlic Herb cream cheese container that was 1/3 full of cream cheese, dated 10/28/25. During an interview on 3/25/26 at 1:45 p.m. with the Scheduling Coordinator in the third-floor kitchenette, she stated that the dietary department was responsible for the kitchenette's refrigerators and there was supposed to be a Refrigerator Temperature Check form posted to record the fridge's daily temperature. She agreed there had been some discussion between the nursing and dietary department regarding which department was responsible for the kitchenettes. She agreed that the fridge was not clean. During an interview on 3/25/26 at 3:05 p.m. with the Director of Nursing stated it was the responsibility of the dietary department to monitor the second and third floor kitchenettes and the refrigerators in those kitchenettes. During a follow-up interview on 3/25/26 at 3:37 p.m. with the Dietary Manager, she confirmed it was the nursing department's responsibility to monitor kitchenettes and the cleanliness and proper temperature of the second and third floor kitchenette refrigerators. During an interview on 3/25/26 at 4:03 p.m. with the Administrator, he revealed he had started his role as the facility's administrator last week and stated he did not know who was responsible for the kitchenette areas on the second and third floor. Review of the facility policy Food Temperatures/Food Safety, reviewed December 2023 revealed Documentation of equipment temperatures for food storage are recorded at least daily and recorded electronically. or recorded manually in the. designated location.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on facility investigation review, staff interview, and facility policy review, the facility failed to report allegations of abuse to the state survey agency (SSA) within the required time period in 1 of 1 incidents reviewed. The facility reported a census of 54. The facility corrected the deficiency per past noncompliance on 3/10/26 through the following actions:The facility self identified on 3/9/26 a resident to resident event happened that met the threshold for reporting requirements under state and federal guidelines. Former administration failed to notify the SSA within 2 hours of the event happening. All staff were re-educated on the abuse policy specifically all resident to resident altercations, regardless of injury, must be reported to the supervisor immediately, who then reports it to the Director of Nursing/Administrator immediately. Audits initiated on 3/10/26 and will be conducted by reviewing nursing notes, risk management, grievances and conversations with residents/staff. Findings include: The Facility Investigation titled Resident to Resident Altercation documented an incident occurred on 02/07/2026 at approximately 5:00 PM between two residents. The document revealed the residents were immediately separated. Under additional information it is documented the incident as reported as of 03/09/2026. In a conversation on 03/24/2026 at 03:09 PM with the Systems Process and Policy Specialist, she took over for the previous administrator in early March and on 03/10/2026 noticed a resident-to-resident interaction had not been reported to the SSA as required. She reported the allegation of abuse to the SSA on 03/10/2026. She confirmed it should have been reported within 24hrs. In a conversation on 03/24/2026 at 03:19 PM with the Administrator he agreed that if the allegations met the criteria of abuse they should be reported within 24hrs without injury and within 2hrs with injury. Review of a facility provided document titled Abuse Prevention, Identification, Investigation and Reporting Policy, with a last revised day of 12/2025, stated the following: All allegations of Resident Neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation shall be reported to the Iowa Department of Inspections and Appeals, not later than two (2) hours after the allegation is made, if the events that caused the allegation resulted in serious bodily injury, or not later than twenty-four (24) hours if the events that caused the allegation involved neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation, but do not result in serious bodily injury.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and policy review the facility failed to develop a comprehensive care plan that included problems, goals, or interventions for 3 of 8 residents (Resident #2, #29, and #27) reviewed with a diagnosis of Alzheimer's, anticoagulant medication usage, antidepressant medication usage, and catheter usage. The facility reported a census of 54. Findings include:1. Review of Resident #2's Minimum Data Set (MDS) dated [DATE] revealed an admission to the facility 12/2/25 from a short-term general hospital stay. The MDS further indicated that Resident #2 was taking antidepressant medications during the look back period. Review of Resident #2's Electronic Health Record (EHR) page titled, Clinical Physician's Orders revealed an order with a start date of 12/2/25 for Duloxetine HCl (antidepressant) oral capsule delayed release sprinkle 60mg to give 120mg by mouth daily. This order was discontinued on 3/21/26 and a new order was obtained for Duloxetine HCl (antidepressant) oral capsule delayed release particles 30mg to give 3 capsules by mouth one time a day. Review of Resident #2's Care Plan with a revision date of 3/6/26 revealed no problems, goals, or interventions for antidepressant medication usage. 2. Review of Resident #29's MDS dated [DATE] indicated that Resident #29 was taking anticoagulant, and antidepressant medications during the look back period. The MDS further indicated that Resident #29 had diagnoses of Alzheimer's disease, depression, and bipolar disorder. Review of Resident #29's EHR page titled, Clinical Physician's Orders revealed an order with a start date of 11/16/25 for Trazodone HCl (Antidepressant) oral tablet to give 25mg by mouth one time a day. Further review of the Clinical Physician's Order's revealed an order for Apixaban (anticoagulant) oral tablet 5mg to give one tablet by mouth two times a day with a start date of 1/20/26. Review of Resident #2's Care Plan with a revision date of 12/29/25 revealed no problems, goals, or interventions for antidepressant medication usage. Interview 3/25/26 at 1:19 PM with the Director of Nursing (DON) revealed that Resident #2 should have had antidepressants on the care plan. The DON further revealed that Dementia should have been on Resident #29's care plan with goals and interventions as well as anticoagulant medication usage, and Alzheimer's disease. 3. Review of Resident #27's quarterly review MDS, dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognitive functioning. The MDS indicated that Resident #27 had an indwelling catheter. The MDS further indicated that Resident #27 had a primary diagnosis of Parkinson's Disease with dyskinesia (involuntary, erratic, and uncontrollable muscle movements), with fluctuations. The MDS indicated other diagnoses of benign prostatic hyperplasia with lower urinary tract symptoms (frequent, urgent, or weak-stream urination, waking at night, and incomplete bladder emptying), depression, and cognitive communication deficit. Review of Resident #27's EHR revealed a Health Status progress note dated 2/26/26 at 3:19 p.m. that stated .New indwelling Foley catheter placed today for urinary retention secondary to neurogenic bladder. This is resident's first catheter placement. Foley inserted to relieve retention and to assess (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	whether urinary retention was contributing to reported discomfort. Further review of his EHR's page titled, Clinical Physician's Orders revealed the following orders: On 2/27/26, for Foley output to be completed every shift. On 3/8/26, to Ensure resident has leg drainage bag on when out of bed. On 3/15/26, Routine Catheter Change. to be completed every 4 weeks. Review of Resident #27's Care Plan, that was printed on 3/24/26 at 1:30 p.m., with a revision date of 12/29/25 revealed the care plan had not been revised by the interdisciplinary team after his 3/11/26 quarterly review assessment with a focus or problem, goals, and interventions for the resident's catheter use. During an interview and observation on 3/25/26 at 10:18 a.m. with Resident #27, he stated that his Parkinson's disease was affecting his body and slowing him down. The resident was observed not to have a leg drainage bag on, but had a bed bag attached under his wheelchair seat covered in a cloth bag. He stated the staff had not changed his catheter to a leg bag as they had no leg bags available in his room. During an interview on 3/25/26 at 3:05 p.m. with the DON revealed that she stated resident care plans were revised with each new diagnosis, change in condition, physician order, and MDS assessment. She further stated the individualized care plan would be updated with new concerns, devices (including a catheter placement), or when a new intervention was implemented. She agreed that Resident #27's physician orders and cares had changed within the last month with the placement of his indwelling catheter and should have been addressed on his care plan. She confirmed that the resident's care plan had not addressed his catheter and they had not developed goals or person-centered, measurable objectives and interventions related to his catheter use. During an interview on 3/25/26 at 4:03 p.m. with the Administrator regarding Resident #27, he agreed that his catheter use had not been addressed on his care plan with measurable goals or individualized interventions. He stated there were two instructions noted on his Kardex (an electronic document that contained daily tasks and essential resident data) on how to clean the resident's catheter bed bag and leg bag. Review of the facility policy Comprehensive Person-Centered Care Planning, reviewed December 2025 revealed: a. The comprehensive care plan will be developed and implemented consistent with the resident's rights and include measurable objectives and timeframes to meet the resident's medical, nursing, and mental/psychosocial needs that are identified in the comprehensive assessment. b. The comprehensive care plan will be. Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, resident interviews, staff interviews, and policy review the facility failed to provide food at an appetizing temperature to 3 of 5 residents (Residents #2, #29, and #41) reviewed. The facility reported a census of 54 residents.Findings include:1. Review of Resident #2's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 14 indicating intact cognitive function. Interview on 3/23/26 at 10:53 AM with Resident #2 revealed that the food served is cold when delivered to the room on room trays. 2. Review of Resident #29's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognitive function. Interview on 3/23/26 at 11:37 AM with Resident #29 revealed that the food is often cold when it is delivered to the unit for the room trays. Resident #29 revealed that this happens frequently. 3. Review of Resident #41's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognitive function. Interview on 3/23/26 at 11:25 AM with Resident #41 revealed that the food is often served cold when delivered on the room trays. Observation on 3/25/26 at 7:33 AM revealed the food cart was delivered to the 3rd floor at this time. The food cart was then left in the hallway by the nurses office at this time.During continuous observation on 3/25/26 from 7:33 AM until 7:43 AM it was observed that the first room tray on the 3rd floor was delivered at 7:43 AM with the cart doors left open while delivering the food to the residents room. The last tray was delivered at 7:49 AM. Interview on 3/25/26 at 11:27 AM with Staff A Certified Medication Aide (CMA) revealed that on the 3rd floor the CMA is responsible for delivering trays to the rooms as dietary staff prepare the food in the kitchen. Staff A further revealed that the food is then delivered to the 3rd floor. Staff A then indicated that sometimes she will be working with residents, and not know that the food has arrived at the hallway. Staff A then revealed that the CMA is responsible for getting the drinks as well, and this takes a little bit and then food will be delivered. Observation on 3/25/26 at 11:37 AM food trays were delivered to the unit on the 3rd floor and placed in the hallway. During continuous observation on 3/25/26 from 11:37 AM until 11:54 AM revealed drinks were started to be prepared at 11:54 AM while the food delivered sat in the food cart. The first tray was delivered at 11:59 AM. A sample tray was obtained 3/25/26 at 12:04 PM with food temperatures obtained at this time from the 3rd floor food cart that was delivered. The steak with mushrooms and onion gravy temperature was 109.8 degrees, whipped potatoes were 121.3 degrees, and the mixed vegetables were 104.5 degrees. Interview on 3/25/26 at 12:24 PM with the Certified Dietary Manager (CDM) revealed that she would have liked to see the food temps higher when delivered to the floor for room trays. Interview on 3/25/26 at 12:32 PM with the Administrator revealed he would expect food temps to be at the appropriate temperatures.Review of a facility provided policy titled, Food Temperatures/Food Safety with a revision date of 12/23 indicated food temperatures should be taken periodically to assure hot foods stay about 135 degrees. Further review of the policy indicated foods should be transported quickly to maintain temperatures for delivery and service.

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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 - Few	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on the Center for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report for Quarter 1, 2026 (October 1-December 31) review and staff interviews, the facility failed to submit accurate staff reports for the PBJ Staffing Data Report. The facility reported a census of 54 residents. The facility corrected the deficiency per past noncompliance on 3/9/26 through the following actions:The facility self identified on 3/9/26 the PBJ report was not accurate due to agency hours were not submitted. The clinical specialist identified the issue and education was completed immediately with the administration. Audits initiated on 3/9/26 and will be ongoing. Findings include: The PBJ Staffing Data Report run date 3/18/26 triggered for Excessively Low Weekend Staffing October 1- December 31.Review of the facility policy titled, Payroll Based Journal Report, effective 3/17/25 and reviewed 2/2026, it is the policy of this facility to submit PBJ staffing information as required by CMS. At a minimum of quarterly, the facility will electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specification established by CMS.During an interview 3/26/26 at 8:25 AM the Administrator revealed the PBJ information had been submitted incorrectly by the previous Administrator who had failed to submit hours for agency staff 10/1/25-12/31/25. The Administrator stated on 3/9/26 the Clinical Specialist audited invoices for agency hours on the PBJ and they were incorrect. The Administrator revealed he was not able to obtain a report of the incorrect information. The Administrator revealed on 3/9/26 the Clinical Specialist resubmitted the agency hours that had been missing to correct the PJB report. Review of the current PBJ Analysis Summary for the 1st quarter of 2026, 10/1/25-12/31/25 revealed the hours had been corrected as no issue were found for staffing being excessively low on the weekends.