

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165214	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Lantern Park Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 Oakdale Road Coralville, IA 52241	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34821</p> <p>Based on observations, clinical record review, resident and staff interviews, and facility policy review the facility staff failed to treat residents with respect and dignity for 4 out of 4 residents reviewed (Residents #4, #13, #78, and #86). The facility reported a census of 84 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) Assessment for Resident #78 dated 5/2/24, included diagnoses of cancer, hepatitis, and malnutrition. The Brief Interview for Mental Status (BIMS) reflected a score of 15 (intact cognition).</p> <p>On 07/29/24 at 11:49 AM, Resident #78 reported as he walked around in his room. One nurse just got fired for her mistreatment of him. Resident #78 stated when he went to Staff A and asked for his pain medication, Staff A, Licensed Practical Nurse (LPN) told him he had cancer that metastasized and he's going to die and there's nothing to do about that. Resident #78 revealed that made him upset and angry.</p> <p>On 7/29/24 at 5:50 PM Staff E, LPN reported Resident #78 walked up to the nurses station and told the Staff A he needed a pain pill. Staff E said Staff A told him he had cancer that metastasized and he was going to die. Staff E reported she had to tell management after she talked about it with a few other staff. Staff E said Staff F, Certified Nurses Aid (CNA) was in the area when Staff A talked to the resident like that.</p> <p>On 7/31/24 at 11:55 AM, Staff F confirmed Resident #78 and Staff A held a heated conversation at the nurses station. Staff F reported he failed to hear all the conversation. Staff F said Resident #78 wanted pain medication.</p> <p>On 7/31/24 at 5:22 PM, Staff A confirmed a conversation with Resident #78 at the nurses station. Staff A reported another nurse recorded her conversation with Resident #78. Staff A denied she told Resident #78 his cancer metastasized and was going to die. Staff A confirmed her termination from the facility.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 7/31/24 at 5:49 PM Staff E, LPN sent the audio recording of the conversation between Staff A and Resident #78. The audio recording dated 7/13/24, revealed Staff A said what are you going to do when there are no nurses to take care of you? Resident #78 said what if nobody got in my way and I was getting well. Staff A responded you are not going to get well you have cancer that metastasized. Resident #78 told the staff not to tell him he isn't going to get well, that's where he differs with her. Resident #78 told Staff A people like her were getting in his way stopping him from getting well. Staff A told Resident #78 he has every right to go home any time he wants, he can go home. Staff A reported to the resident the need to follow the Physician's order. Resident #78 stated the Physician's wrong that's why so many die from cancer is because they are in so much pain and your system worked against you. Staff A told Resident #78 he's not in pain. Resident #78 told her she was wrong.</p> <p>On 8/01/24 at 9:00 AM, the Administrator reported the facility terminated Staff A, LPN because of her comments to Resident #78.</p> <p>Review of the Suspension Pending Investigation Form dated 7/19/24, revealed Staff A, suspended pending further investigation started 7/19/24 and ended on 7/25/24 with Termination of employment.</p> <p>48452</p> <p>2. The MDS for Resident #13 revealed diagnoses of Parkinson's disease, psychotic disorder, PTSD, and delirium due to known physiological condition. The resident scored 10/15 on the Brief Interview for Mental Status (BIMS) which indicated moderately impaired cognition. It indicated the resident was dependent on staff for assistance with toileting hygiene, and required substantial to maximal assistance with toilet transfers.</p> <p>The resident's Care Plan, with an admitted [DATE], documented focus areas for high fall risk, impaired cognitive function due to Parkinson's disease, and risk for urinary tract infection with a prophylactic antibiotic.</p> <p>During an interview at 1:38 PM on 7/30/24 with Resident #13 she stated staff left her on the toilet for 20 minutes the night before (7/29/24). She stated an aide (Certified Nursing Aide, CNA) helped her to get to the bathroom and told her they would be right back, but were not. She added this was not the first time and it made her feel scared to go in there sometimes because she was not sure when they would come back.</p> <p>In an interview with Staff C, CNA at 10:01 AM on 8/1/24 about the resident she revealed that most of the time there was enough staff to answer call lights within 15 minutes and within 7 was preferred. She stated sometimes, if staff called in or if it was a busy time of day such as after meal times, it was a little impossible to get to them all because of the workload. She stated staying in a resident's room for supervision during toileting happened for some residents and not others, depending on their needs, and staff should not leave if a resident was a fall risk.</p> <p>During an interview with Staff B, Licensed Practical Nurse (LPN) on 8/1/24 at 10:16 AM she confirmed they try to answer call lights in 7 minutes, 15 at the most. She stated they did the best they could and most of the call light complaints she heard from residents were around meal times.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. The MDS for Resident #86 documented a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated intact cognition. Diagnoses included Urinary Tract Infection (UTI), hip and other fractures, anxiety, and depression. Section GG indicated the resident was dependent for toileting hygiene.</p> <p>Resident #86's Care Plan documented the resident had focus areas for fragile skin due to a skin graft, was at risk for falls, experienced pain related to fractures, and required the assistance of staff for toileting ADL (activities of daily living).</p> <p>On 07/29/24 at 01:03 PM during an interview in her room, the resident stated the staff were poor at answering call lights. She reported evenings and weekends it took up to 2 hours, and she knew because she had a clock on her wall above her TV. She stated call lights over 15 minutes happened on all shifts, and she had to have help because of the fractures she had. She stated this happened more often when there were not enough staff to provide care, usually because of call-ins. She knew this because aides would complain about it. The resident stated there was not consistency with anything and she was incontinent waiting for the bathroom more than once. This made her feel like the chair or the door. Not important.</p> <p>An interview with the Administrator on 8/1/24 at 10:25 AM confirmed staff were expected to answer call lights in 15 minutes. She stated she could not run a call light log report to check on resident concerns because the information could be altered so it might be inaccurate. She stated staff were trained on call lights as part of their orientation and it was discussed in meetings.</p> <p>A policy titled Answering the Call Light, revised March 2021, documented the purpose of the procedure was to ensure timely responses to resident's requests and needs. Steps included staff were to respond to the light and tell the resident the approximate time it will take to respond, if the resident's request required another staff member to notify the individual, and if aides were uncertain as to whether or not a request could be fulfilled to ask the nurse supervisor for assistance. The policy lacked documentation regarding time frames for response.</p> <p>48374</p> <p>4. The Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #4 scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS revealed medical diagnoses of acute osteomyelitis right foot and ankle, acquired absence of other right toes, and acute hematogenous osteomyelitis.</p> <p>On 07/30/24 at 08:57 AM The facility Administrator was queried on any reported concerns regarding two CNA's being rude or inappropriate with residents. The Administer advised she had one complaint on Staff G, CNA and Staff H, CNA and disciplinary action was completed with both of them. She advised both CNA's had a write-up for talking abrasive to a resident. The resident identified was Resident #4. As a result, all staff were trained on customer service and completed a review on abuse. Both Staff G and Staff H attended the training. The Administrator advised it is her expectation that all staff assist all residents regardless of who's responsibility it is.</p> <p>On 7/30/2024 at approximately 1:45 PM the Administrator provided the following documentation titled Internal Investigation Witness Statement:</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Witness Name: Staff G, CNA</p> <p>Interviewed by: Facility Administrator on 6/21/24. Phone interview</p> <p>Resident involved Resident #4</p> <p>Staff G stated that her and staff H went into the resident's room to answer the call light he asked for help. I told him you are independent, can you try?</p> <p>Witness Name: Staff H, CNA</p> <p>Interviewed by: Facility Administrator on 6/21/24. Phone interview</p> <p>Resident involved Resident #4</p> <p>Staff H reported I went in after Staff G to check and see if she needed help. I heard the resident say can you wipe me. Staff G replied can you try to wipe yourself and he responded never mind so we left the room.</p> <p>Witness Name: Resident #4</p> <p>Interviewed by: Facility Administrator on 6/21/24. In person interview</p> <p>Resident involved Resident #4</p> <p>The resident was interviewed pertaining to the grievance. Resident reported that he put his call light on for assistance. 2 CNA's entered the room. He asked for help with the bathroom. The resident stated that they told him you are independent, they asked me to try myself.</p> <p>On 7/30/2024 at approximately 1:45 PM the Administrator provided the following document titled Grievance/Concern Investigation Form</p> <p>Explanation: Resident #4 had his call light on in the bathroom to get help wiping himself and two CNA's came in and told him he was independent and left the room.</p> <p>Action and Follow-up: Staff education at stand-down. Staff had coaching in person</p> <p>On 7/31/24 at 4:50 PM During an interview with Resident #4 it was disclosed that two Certified Nursing Assistants (CNA), Staff G and Staff H had been rude to him. The resident advised the two CNA's walk around together and do everything together all of the time including assisting residents. The resident reported he was in the bathroom and he turned on his all light for assistance. The CNA's came in the room and he advised them he needed cleaned up and reportedly one of them, the resident was not sure which one, responded, what you can't wipe yourself anymore and turned around and walked out without assisting him. Resident #4 advised he went to management about the situation and feels it was resolved. He shared he believed one of the workers was dismissed. Resident advised he often says where is the CDR and when asked responded, the courtesy, dignity, and respect is lacking here.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 08/01/24 at 02:13 PM the Social Services Coordinator advised she was aware of the incident as the resident went to her with his concerns. She advised she filled out the grievance paperwork on behalf of the resident and submitted it to the Administrator. The Social Services Coordinator advised the resident told her that two CNA's answered his call light and reportedly told him you are independent and can probably do that yourself. The Social Services Coordinator shared she is aware that staff members were reeducated on resident care after this incident. She advised she has never seen any staff member being rude to any of the residents.</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>48452</p> <p>Based on resident interview, record review, staff interview, and policy review the facility failed to ensure residents were informed of new medications and participated in their own treatment plan for 1 of 3 residents reviewed (Resident #41). The facility reported a census of 84 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) for Resident #41 revealed diagnoses of cancer, anxiety, and heart failure. The resident scored 15/15 on the Brief Interview for Mental Status (BIMS) which indicated intact cognition.</p> <p>The resident's Care Plan documented a focus area dated 6/18/24 for poor impulse control related to getting medications or cares at an exact time frame. Interventions included analyze key times, places, circumstances, triggers, that help de-escalate behavior; administer medications as ordered; and document and give as many choices as possible about cares and activities.</p> <p>On 7/30/24 at 9:50 AM during an interview with Resident #41 she stated nurses were messing with her medications and did not tell her what they were for or why they were doing it. She stated it was tough, especially when they (the medications) made her feel different and she did not know why. She reported staff did not explain changes or what medication she was taking, just brought it to her and told her to take it.</p> <p>A document titled Care Plan Conference Signature page dated 1/30/24 did not include documentation of resident or power of attorney (POA) attendance.</p> <p>A Care Plan conference Progress Note dated 4/30/24 at 13:38 PM lacked documentation that the resident was invited to the conference, where medications were discussed.</p> <p>A Provider Encounter Note signed 5/29/24 at 4:49 PM documented the resident's brother was her power of attorney and the resident was currently 'decisional' which indicated the power of attorney had not been enacted.</p> <p>A social services note dated 7/5/24 documented the resident was cognitively intact with decision making skills.</p> <p>Progress Notes indicated the following medication and order changes with documented notifications to the power of attorney that lacked notification of the resident:</p> <p>5/29/2024 15:16 Order Note, Note Text: New order pharmacy GDR D/C Mucinex. POA notified</p> <p>6/25/2024 08:00 Order Note, Note Text: New order to change Senna to PRN and D/C scheduled</p> <p>POA notified</p> <p>(continued on next page)</p>

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>7/5/2024 17:13 Nurses Note, Note Text: Resident has been seen by NP today. New order: UA with culture and sensitivity if indicated. Change furosemide to 60 mg PO daily. POA notified.</p> <p>7/10/2024 19:13 Order Note, Note Text: Received new order to increase Coreg to 12.5 mg BID. Daily BP x 5 days. POA notified.</p> <p>7/20/2024 20:14 Order Note, Note Text: NP wrote order for CBC, Mag level, and BMP on next lab day; POA notified.</p> <p>An interview with Staff B, Licensed Practical Nurse (LPN) on 8/1/24 at 10:16 AM revealed that in most cases residents with high BIMS would have medication changes explained to them and a POA or family contact if the resident chose. She stated staff should discuss it with the resident. She stated residents say they don't know what they are taking 'all the time.' She indicated level of understanding was based on cognition and in some cases she had printed medication administration records or brought medication cards to explain.</p> <p>On 8/1/24 at 10:25 AM the Administrator stated she was aware this resident had a BIMS of 15 and reported her brother was involved in care conferences by resident choice, not because the POA was enacted. The Administrator confirmed she expected nursing staff to review care changes with residents with high BIMS.</p> <p>Dated 5/2023, the facility admission agreement section IV. Rights and Responsibilities of the Resident noted the resident had the right to be fully informed in a language that resident can understand of the resident's total health status including but not limited to medical condition.</p> <p>The facility's dignity policy, revised February 2021, documented each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feels of self-worth and self-esteem. Facility culture supported dignity and respect by honoring resident goals, choices, preferences, values, and beliefs.</p>		

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<p>F 0644</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48452</p> <p>Based on Minimum Data Set (MDS) review, Pre-Admission Screening and Resident Review (PASRR), staff interview, and policy review the facility failed to complete an updated PASRR evaluation for a resident with a new diagnosis for 1 of 1 residents reviewed (Resident #13). The facility reported a census of 84 residents.</p> <p>Findings include:</p> <p>The MDS for Resident #13 revealed diagnoses of Parkinson's disease, psychotic disorder, PTSD, and delirium due to known physiological condition. The resident scored 10/15 on the Brief Interview for Mental Status (BIMS) which indicated moderately impaired cognition.</p> <p>The resident's Care Plan, with an admitted [DATE], documented focus areas and interventions for PASRR, post traumatic stress disorder, behaviors and paranoia, cognitive function and decision making, hallucinations, and depression. The PASRR focus area indicated, on 7/9/21, the assessment was completed prior to admission to the facility.</p> <p>The PASRR Outcome, dated 7/7/21 indicated no Level II was required based on diagnoses of major depression, anxiety disorder, and panic disorder. It indicated there were no Neurocognitive disorders at that time, and there were no recent or current mental health symptoms. A section titled Ascend Outcome documented there was no evidence of a PASRR condition of an intellectual/developmental disability or a serious behavioral health condition. If changes occurred or new information refuted these findings, a new screen must be submitted.</p> <p>Resident #13's electronic health record Medical Diagnoses tab documented diagnoses of Parkinson's disease with dyskinesia with fluctuations dated 10/1/23, delusional disorders dated 11/3/23, and delirium due to known physiological condition dated 3/15/24.</p> <p>An email dated 8/1/24 at 12:24 PM from the Administrator indicated the facility did not have a policy for PASRR completion, they just followed the regulation.</p> <p>An interview with the Administrator on 8/1/24 at 1:43 PM determined she reviewed the PASRR website and the only documentation of a completed assessment for this resident was in 2021.</p>		

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>48452</p> <p>Based on Payroll Based Journal (PBJ) Data, schedule review, staff interview, and policy review the facility failed to submit payroll data for agency staff during the second quarter of the current fiscal year. The facility reported a census of 84 residents.</p> <p>Findings include:</p> <p>A document titled PBJ Staffing Data Report for Fiscal Year 2024 Quarter 2 (January 1 - March 31) documented the facility triggered for one star staff rating and excessively low weekend staffing.</p> <p>On 7/30/24 at 1:00 PM the Administrator provided staff schedules for the month of March. These documented hours worked by nurses, certified medication aides, and certified nursing aides for three shifts each day and included the name of the on-call staff. The documentation also included both facility and agency staff.</p> <p>During an interview with the Administrator on 7/31/24 at 3:22 PM she stated the PBJ data submitted by the facility did not include agency staff. She acknowledged this impacted the data the Centers for Medicare and Medicaid Services had for the facility and stated the facility would have to look into it.</p> <p>A policy titled Reporting Direct-Care Staffing Information (PBJ) revised October 2017 documented direct-care staffing information included staff hired directly by the facility, those hired through an agency, and contract employees.</p>		