STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165432	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Living Senior Campus	2421 Lutheran Drive Muscatine, IA 52761

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on clinical record review, facility policy review, resident representative interview and staff interview, the facility failed to ensure residents and/or their representatives were fully informed of the risks and benefits of taking psychotropic (medications that affect thought processes or behaviors) before the resident started taking the medication and when changes occurred for 2 of 5 residents (Residents #3 and Resident #47) reviewed for unnecessary medications. The facility reported a census of 117 residents.Findings include:1. Review of the Minimum Data Set (MDS) assessment, dated 12/10/25, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated intact cognition. The MDS identified the resident did not display any behaviors and had signs and symptoms of minimal depression. The list of diagnoses included depression, anxiety, bipolar disorder and an intellectual disability. The MDS indicated the resident medications prescribed in the high-risk classes of antipsychotic, antidepressant and antianxiety. Review of the electronic health record (EHR) Clinical Resident Profile section, dated 2/11/26, revealed the resident had a durable power of attorney (POA) for health care and financial decisions. Review of the EHR revealed the following Physician Orders: a. Clonazepam (an anti-anxiety medication) 0.5 milligrams (mg), 1 tablet by mouth 2x daily for generalized anxiety disorder. Start date: 1/03/25. Review of the February 2026 Medication Administration Record (MAR) revealed this order continued with no changes. b. Trazadone (an antidepressant) 25 mg one-half tablet (12.5 mg) 2x daily as needed (PRN) for agitation. Start date: 11/24/25. Discontinue date: 1/27/26. c. Lamictal (a mood stabilizer): 1. 25 mg - 1 tablet daily for behaviors for 2 weeks from 12/17/25 to 12/21/25, and renewed on 12/21/25 until discontinue date of 2/5/26. 2. 50 mg -1 tablet daily for behaviors from 12/17/25 to 12/21/25, and renewed 12/31/25 with discontinue date of 2/5/26. d. Buspirone 10 mg – 1 tablet three times a day, started on 10/28/25 changed to 15 mg – 1 tablet three times a day on 12/16/25. Review of the clinical record revealed a lack of documentation that facility staff had explained the risks and benefits of taking the above medications to the resident and/or the resident's representative in advance of the medications starting or being changed. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/9/26 at 9:47 AM, the POA for Resident #3 reported facility staff called frequently to notify of medication changes, but did not tell her what the medications were being used for, or the risks and benefits of the medications. During an interview on 2/11/2026 at 10:25 AM, Resident #3 reported he took medications to treat diabetes. The resident was able to confirm he took medications to treat mood, but denied having any problems with his mood. Resident #3 did not know what medications he took, or the risks and benefits of taking his medications. During an interview on 2/11/2026 at 10:28 AM, Staff D, Licensed Practical Nurse (LPN), stated if the physician ordered a new psychotropic medication, or if there was a change made to a psychotropic medication, the nurse notified the resident and family, did teaching with both the resident and family on the new or changed medication and documented this information on a psychotropic medication consent form. During an interview on 2/11/2026 at 10:33 AM, Staff C, Assistant Director of Nursing (ADON) explained nursing staff made sure the family was aware of new and changed psychotropic medication orders. Staff C reported they completed a consent form with the POA, and that they could obtain the consent over the phone, but they needed two nurses to hear the consent. Staff C reported nursing staff notified the POA for Resident #3 when he had medication changes and staff completed the medication consent form with the POA. During an interview on 2/11/2026 at 11:41 AM, the Director of Nursing (DON) explained that Lamictal was a mood stabilizer, and she did not consider Lamictal a psychotropic medication. The DON explained that nursing staff should be doing a consent form for any new medication that was classified as an antidepressant, antianxiety or antipsychotic. The DON explained they just recently found out nursing staff needed to obtain a new consent for any dose or medication change. 2. Review of the MDS assessment, dated 11/25/25 for Resident #47 identified an admission date of 11/17/25. A BIMS score of 15 out of 15 indicated Resident #47 cognition intact. The list of diagnoses included depression and diabetes mellitus. The MDS indicated Resident #47 prescribed medications in the high-risk classes of antipsychotic, antianxiety, and antidepressant medications. Review of Resident #47's Care Plan, revised on 1/6/26, revealed a Focus area to address the use of high-risk medications which included the resident's psychotropic medications. Interventions included, in part Review medication for potential side effects with resident and/or person in charge of healthcare decisions for informed consents. Review of Physician Orders revealed the following medications with a start date of 11/17/25, and discontinuation date of 12/22/25. a. Aripiprazole (atypical antipsychotic) 2 mg tablet, give 1 tablet by mouth in the morning. b. Buspirone (anti-anxiety)7.5 mg tablet, give 1 tablet by mouth three times a day c. Escitalopram (antidepressant) Oxalate 20 mg tablet, give 1 tablet by mouth in the morning. Review of the EHR revealed a consent form for the use of psychotropic medications dated 9/9/25. The EHR lacked a consent form the above medications prescribed on 11/17/25. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/11/26 at 12:04 PM, the Director of Nursing (DON) acknowledged the consent dated 9/9/25 is a previous admission for the resident. The DON stated a new consent from the current psychotropics prescribed should have been reviewed with the resident/and or representative upon her readmission in November. The facility policy, titled Unnecessary Medications, last revised May 2025, directed in part.Follow the requirement of residents' right to be fully informed of, participate in, or decline treatment before initiating or increasing a psychotropic medication. The informed consent must include information related to the benefits, risks, and alternatives for medications, including any black boxed warnings.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, facility policy review, family, resident and staff interviews, the failed to make repairs of damaged flooring and walls in a timely manner for 2 of 4 (Resident #53 and Resident #81) resident rooms sampled; and failed to dispose of an empty cleaning spray bottle from 1 of 4 (Resident #81) resident rooms. The facility reported a census of 117 residents.Findings include:1. Review of the Minimum Data Set assessment for Resident #53, dated 1/28/26, revealed the resident admitted to the facility on [DATE]. The Brief Interview for Mental Status (BIMS) score of 8 out of 15 indicated a moderate cognitive impairment. The list of diagnoses included dementia. The MDS indicated Resident #53 required substantial/maximal assistance for transfers, and repositioning. Review of the electronic health record (EHR) revealed Resident #53 resided in their current room since 12/19/24. During an observation on 2/5/26 at 8:42 AM, a fist sized area with a dent and crack noted on the wall above the head of the resident's bed. An area on the wall behind the resident's recliner appeared to be have previously patched. A family member of Resident #53 present in the room. The family member stated the area on the wall above the resident's bed had been dented and cracked since the resident moved in to the room over a year ago. The family member stated they did request a repair be made to a larger hole which had been behind the resident's recliner. They stated the facility did make that repair. 2. Review of the MDS assessment for Resident #81, dated 1/28/26, revealed a BIMS score of 15 out of 15 which indicated intact cognition. The MDS indicated Resident #81 had clear speech, could make self-understood to others and understood others. The MDS indicated Resident #81 dependent for transfers and positioning. Review of Resident #81's Care Plan, last revised 1/23/26, revealed the resident dependent on staff for transfers with a Hoyer lift (type of mechanical lift), bed mobility, lower body dressing, showering and toilet hygiene. During an observation on 2/4/26 at 2:45 PM, a gouge noted on the floor of the residents room, located on the right side of the bed and measured approximately a quarter of an inch deep and 2 to 3 feet long; a piece of trim noted missing from the wall near the entrance of the bathroom; black marks noted on the lower part of the wall by the entrance to the bathroom; and a board approximately 2 feet by 6 inches by 1 and a half inches noted lying flat on the floor between the head of the residents bed and the wall on the left side. During an interview, Resident #81 stated the board had been laying on the floor for about 2 months and had been attached to the wall by his bed. Resident #81 stated the floor in the room had been tore up for about the same amount of time. The resident stated the facility staff were aware of the board on the floor, and he thought maintenance was waiting for the approval to fix the floor. During an observation on 2/9/26 at 12:54 PM, Resident #81 in his room working with the Restorative Aide. A spray bottle labeled Cleaner noted to be on the floor under the bed frame near the head of the bed. The spray bottle noted to be in the same location during observations on 2/10/26 at 11:40 AM. At 11:40 AM, the resident stated the housekeeping staff had yet to clean his room, and usually do so around noon. During an interview on 2/10/2026 at 10:30 AM, the Maintenance Director stated he received repair needs for resident rooms submitted by staff through an electronic system, or by a phone call. He stated not all requests were entered into the electronic system. The Administrator stated all staff have access to the electronic system, and are to utilize this system to turn in repair requests to maintenance. The Maintenance Director reported he walked the halls, but did not go into the resident room unless he was aware that a repair was needed. The Maintenance Director reported the only pending repair he had for a resident's room was to add a handle bar to assist a resident getting in and out of bed. During an interview on 2/10/2026 at 12:45 PM, Staff G, Certified Medication Assistant/Certified Nursing Assistant stated if she noticed that something needed repaired in a resident's room, she would enter a request in the computer for maintenance to repair it.During an interview on 2/10/2026 at 12:46 PM, Staff I, Licensed Practical Nurse (LPN), (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she puts the need for repairs in resident rooms or equipment needs in the computer or calls Maintenance to notify them of the needs. During an interview on 2/10/26 at 12:55 PM, Resident #81 stated housekeeping staff cleaned his room a short while ago. The empty spray bottom remained in the same location on the floor near the head of the resident's bed. During an interview on 2/10/2026 at 1:00 PM, Staff J, Housekeeping, stated she cleaned the floors and picked up trash in each of the resident's rooms as part of her daily housekeeping duties. Staff J confirmed she had already cleaned Resident #81's room.Review of the undated facility policy, titled Housekeeping and Cleaning Policy, revealed, in part, Repairs: Promptly fix cracks, peeling paint, or broken fixtures .daily cleaning of .Resident rooms: Dust surfaces, empty trash, clean bathrooms (toilets, sinks, showers), mop floors, disinfect high-touch areas.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, clinical record review, facility policy review and staff interview, the facility failed to ensure staff completed hand hygiene and utilized Enhanced Barrier Precautions in an attempt to prevent the transmission of infections during resident care for 3 of 8 (Resident #2, Resident #3, and Resident #91) residents reviewed for infection control. The facility reported a census of 117. Findings include:1. Review of the Minimum Data Set (MDS) assessment for Resident #2, dated 12/10/25, revealed a list of diagnoses which included traumatic brain injury, seizure disorder and quadriplegia. The MDS indicated Resident #2 utilized a feeding tube (a surgical opening in the abdominal wall for the delivery of nutrition, hydration and medications) and a tracheostomy (a surgical opening in the throat to provide an alternate airway for breathing). Review of the Care Plan for Resident #2, revised 2/8/26, revealed a Focus area to address Enhanced Barrier Precautions (EBP) for trach and PEG tube (a type of feeding tube). The Intervention directed Enhanced Barrier Precautions are to be used with the following care activities (specify): - Dressing - Bathing/showering - Transferring - Providing hygiene Changing linens - Changing briefs or assistance with toileting - Caring for devices Trach, PEG Tube. Review of Physician Orders revealed an order, start date 11/20/25 to Cleanse G-tube site with normal saline. Cover with split gauze and secure with paper tape. Daily and PRN (as needed). During an observation on 2/5/26 at 9:24 AM, Staff K, Licensed Practical Nurse (LPN) provided feeding tube care to Resident #2. Staff K explained she could not get the feeding machine flow to work and needed to disconnect the lines to the machine and start over. Staff K performed hand hygiene with an alcohol-based hand rub and donned gloves. Staff K did not don a gown. Staff K disconnected the feeding tubing, feeding formula container and the flush bag, and emptied contents of bags into the bathroom sink. Staff K then removed her gloves, obtained a new container of feeding formula, wrote the date on the container and hung the bag on the IV pole. Without completing hand hygiene, Staff K donned gloves, filled the flush bag with water, and reconnected all tubing to the feeding pump. Without wearing a gown, Staff K sanitized her hands, applied gloves, primed the lines, and opened the port to the residents PEG tube and connected the feeding tube to the port. During an observation on 2/5/26 at 3:06 PM, while wearing a gown and gloves, Staff L, Certified Nursing Assistant (CNA) transported Resident #2 on a shower bed from the shower room to his room. Staff M, CNA, donned a gown and gloves, and took a mechanical lift into the resident's room. Staff M closed the residents door. At 3:19 PM, Staff L, CNA and Staff M, CNA both wearing gowns, exited the resident's room and moved the mechanical lift and shower bed out of the resident's room. Staff M, CNA, removed her gown in the hallway. Staff L, CNA, wore the gown down the hallway, through the common/TV area to the soiled utility room. During an observation on 2/05/2026 at 3:26 PM, Staff K, LPN, sanitized her hands with an alcohol-based rub, unlocked the medication cart, removed a carton of liquid protein and poured it into a cup. Staff K then punched out a Metoclopramide 10 milligram (mg) tablet and prepared to crush the tablet. After crushing the tablet, Staff K mixed the medication in with the liquid protein. Staff K then obtained a vial of Duoneb (Ipratropium/Albuterol 0.5-2.5 mg/milliliters (ml) nebulizer treatment), and took . Staff K locked the medication cart and took the cup with the liquid protein, medication and vial of Duoneb to Resident #2's room. Staff K entered Resident #2's room and placed a pair of gloves, a graduated cylinder, syringe and placed them on the bedside table. Without performing hand hygiene, Staff K then donned gloves. Without wearing a gown, Staff K used an electronic vitals machine to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	take the residents blood pressure, pulse and oxygen saturation vitas. She also used a stethoscope to listen to Resident #2's lungs. During cares, Resident #2 periodically coughed through the trach opening. Without completing hand hygiene, Staff K changed gloves and moved the trach humidifier machine and the nebulizer cart closer to Resident #2. Without donning a gown, Staff K prepared and started the Duoneb treatment. Staff K reported the resident had a history of coughing out sputum from trach. Staff K then leaned over the resident to reposition him and his pillow. Staff K raised the head of his bed up, removed her gloves, sanitized her hands with an alcohol-based rub, and re-gloved. Staff K then added tap water to the graduated cylinder, and positioned the resident to administer the medication and liquid protein. Without donning a gown, Staff K completed hand hygiene, re-applied new gloves, checked for stomach content residual and then delivered the 30 mL flush. Staff K then administered the medication/liquid protein via the feeding tube, and completed another 30 mL flush. Staff K then removed her gloves and completed hand hygiene During an interview on 2/10/26 at 3:15 PM, the Infection Preventionist stated staff providing cares to residents on EBP should wear a gown and gloves. She explained personal cares, wound care, and care for medical devices such as a feeding tube and trach required EBP. The Infection Preventionist stated hand hygiene should be done before entering a resident's room, before gloving, in between glove changes and after removing gloves. The Regional Nurse and Director of Nursing (DON) stated staff received infection control education during initial orientation, quarterly for handwashing, as needed and during annual competency skills. 2. Review of the MDS for Resident #4, dated 12/19/25 revealed a list of diagnoses which included amputation, end-stage renal disease, diabetes mellitus, morbid obesity, and non-pressure chronic ulcer of other part of right foot with fat layer exposed and identified an open lesion on the foot related to a surgical wound with wound care and application of dressings. Review of the Care Plan, updated 6/23/25 revealed the following Focus areas and associated Interventions: a. Enhanced Barrier Precautions, date initiated 10/8/25. Enhanced Barrier Precautions are to be used with the following care activities (specify): - Dressing - Bathing/showering - Transferring - Providing hygiene Changing linens - Changing briefs or assistance with toileting -Caring for wounds. b. Skin Integrity.I have a surgical wound to my right foot where I had 3-4-5th toes amputated, dated initiated 6/23/25. Ensure medications and treatments are completed as ordered. Review of Physician Orders revealed the following: a. Betadine solution dampen gauze wring out so not soaking wet, apply betadine dampened gauze to wound cover with dry gauze secured with roll gauze and tape wrap with ace loosely. Start date: 2/5/26. During an observation on 2/10/26 at 10:36 AM, Staff K, LPN gathered supplies for wound care and entered Resident #4's room. An orange sign for Enhanced Barrier Precautions noted to be posted on the resident's door. A yellow multipocketed holder stocked with Personal Protective Equipment (PPE) which included gloves, gowns, masks and alcohol-based hand rub (ABHR) hung over the door of the resident's room. Without wearing a gown, Staff K put on a pair of gloves and placed a pillow under Resident #4 right knee and calf. She then removed the dressing applied to the resident's foot. Staff K then removed gloves and put on clean gloves without completing hand hygiene. Staff K then used (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clean gauze and spray wound cleanser to cleanse the wound. Staff K removed gloves and applied ABHR prior to putting on clean gloves. Staff K applied a betadine solution-soaked gauze pad to the wound, removed gloves and put on clean gloves without first completing hand hygiene. Staff K then covered the betadine-soaked pad with a dry gauze pad and wrapped the residents wound with a roll of gauze, followed by wrapping the area with an ace wrap. Staff K disposed of waste in the trash, washer her hands and left the residents room with the trash. During an interview on 2/10/26 after the wound care observation, Staff K, LPN stated she was not aware of EBP for Resident #4 and stated she did not wear a gown during wound care. Staff K also stated she did not complete hand hygiene between glove changes for two of the three times she changed her gloves. During an interview on 2/11/26 at 12:04 PM, the DON stated Resident #4 had EBP in place due to his wound. She stated her expectation is for staff to follow EBP protocol of wearing a gown and gloves during wound care, and to complete hand hygiene between glove changes. The Enhanced Barrier Precautions signage posted on Resident #4's door provided the following instructions: Everyone must: Clean their hands, including before entering and when leaving the room. Providers and Staff must also: Wear gloves and a gown for the following High-Contact Resident Care Activities: Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy, Wound Care: any skin opening requiring a dressing. The EBP signage contained the U.S. Department of Health and Human Services Centers for Disease Control and Prevention (CDC) logo on the bottom left of the sign. 3. Review of the MDS for Resident #91, dated 11/29/25 revealed diagnoses of stroke, diabetes mellitus, and morbid obesity. The MDS identified the risk for developing pressure injuries but did not identify a pressure ulcer. Review of the Physician Orders revealed an order, dated 1/26/26 for coccyx wound. Cleanse the area apply triad cream, and cover with Mepilex (a brand name) foam dressing every day shift and PRN (as needed) when soiled. During an observation on 2/10/2026 at 11:10 AM, Staff A, Registered Nurse (RN) donned a gown, washed her hands and applied gloves. Staff A then placed the foam dressing package, cotton swabs, multiple clean 4x4 gauze, a tube of Triad cream and a spray bottle of wound cleaner onto a chair which had appeared dirty and had a white substance scattered onto the seat cushion. Staff A cleaned Resident #91with wet wipes and as she disposed of the gloves and wipes, the wound cleaner bottle got knocked on the floor. Staff A washed her hands, re-gloved and tucked the clean depend under Resident #91, touching the resident's buttocks with her gloved hands. Staff A then picked up the wound cleanser bottle off the floor and sprayed the contents directly onto the wound and a 4x4 gauze that was used to cleanse the wound. Without completing hand hygiene and changing gloves, Staff A picked up a cotton swab from the chair, opened the Triad ointment tube and applied the ointment onto the swab, and then applied the ointment to the open wound. Staff A opened the foam dressing package and attempted to put her gloved hand into her pocket to find a marker. Staff A then placed the opened foam dressing onto the chair, removed a glove, retrieved the marker from her pocket. Staff a then wrote the date and her initials onto the foam dressing and then applied the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dressing to the wound. Staff A then washed her hands and removed the trash. During an interview on 2/10/2026 at 12:30 pm, Staff B, Assistant Director of Nursing (ADON) stated she had worked at this facility for 20 years and the expectation was for the nurse to follow doctor orders and complete the treatment properly. Staff B stated her expectation was for a nurse to use a barrier on a clean surface when completing wound treatments and follow infection control protocols. Staff B stated the staff used clean towels as barriers. Review of the facility's policy, titled Handwashing, reviewed April 2025, revealed Policy statement which declared, in part The facility requires staff to wash their hands after each direct resident contact, for which Handwashing is indicated by accepted professional practice . As per recommendations from the CDC guidelines. Alcohol-based hand sanitizers are the most effective products for reducing the number of germs on the hands of healthcare providers. Alcohol-based hand sanitizers are the preferred method for cleaning hands in most clinical situations. The Procedure section directed, in part .Alcohol based hand sanitizer should be used: Immediately before touching a patient; Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; Before moving from work on a soiled body site to a clean body site on the same patient; After touching a patient or the patient's immediate environment; After contact with blood, body fluids, or contaminated surfaces; Immediately after glove removal. Review of the facility's policy, titled Enhanced Barrier Precautions, reviewed 10/25/25, revealed, in part .Use of Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities .Precautions, including use of gown and gloves, will be used during any high contact resident care activities to include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care (central line, urinary catheter, feeding tube, tracheostomy/ventilator) or use and wound care. Face protection may also be included when performing activity with risk of splash or spray.

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, facility record review, staff interview, and facility policy review, the facility failed to ensure the Daily Staffing posting contained required information and posted daily/seven days a week. The facility reported a census of 117 residents. Findings include: An observation on 2/9/26 at 1:20 PM, revealed the facility posted the Daily Staffing information at the receptionist desk inside the main entrance. The current posting, dated 2/9/26 did not identify the resident census or indicate the actual hours required for each nursing staff type (Registered Nurse (RN), Licensed Practical Nurse (LPN), or Certified Nursing Assistant (CNA)).During an interview on 2/9/26 at 3:00 PM, the Director of Nursing (DON) stated the resident census and the actual hours worked for the RN, LPN, and CNA were not completed on the form for 2/9/26.A review of the Daily Staffing postings for the last 30 days (1/10/26 through 2/826) revealed the data to indicate the daily resident census and actual hours worked by each nursing category left blank.During an interview on 2/9/26 at 4:25 PM, Staff O, Scheduling and Staffing Manager, stated she is responsible to complete and post the Daily Staffing information. She explained she started her position in March 2025 and worked Monday through Friday. Staff O stated on Monday's she completes the Daily Staffing information for Saturdays and Sundays. Staff O stated she does not post the information on the weekends, and is unsure who is responsible to post the form. During an interview on 2/10/26 at 11:08 AM, the Director of Human Resources stated he started his position in April 2025. The Director stated the Daily Staffing forms did not include the actual hours worked by nurses and they were not posted on Saturday and Sunday. During an interview on 2/10/26 at 11:30 AM, the Administrator stated the Daily Staffing forms were not completed with the resident census and the actual hours worked for nurses, and the information had not been posted over the weekend. The undated facility policy titled Posting of Nurse Staffing Hours directed staff to post daily up-to-date nurse staffing information for residents, families, visitors, and staff to review that included: current date, resident census and total number of nursing staff and actual hours worked.