STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165450	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Estates of Toledo	403 Grandview Drive Toledo, IA 52342

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42441 Based on clinical record review, resident interview, staff interviews, and community members interviews, the facility failed to treat a resident with dignity and respect for 1 of 2 residents reviewed for dignity (Resident #33). The facility reported a census of 43 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #33 revealed a Brief Interview for Mental Status (BIMS) of 14 out of 15 indicating intact cognition. The MDS further documented diagnoses including acute and chronic respiratory failure. Review of Physician Orders for Resident #33 revealed an order for full code/cardiopulmonary resuscitation (CPR) dated [DATE]. The Care Plan for Resident #33 revised [DATE] revealed the resident had an Iowa Physician Order for Scope of Treatment (IPOST) in place and requested a CPR/full code order. The Care Plan further revealed a goal that the resident will have the requested code status honored during the facility stay. Review of Progress Notes dated [DATE] at 2:05 PM documented by the Director of Nursing (DON) revealed she had been called to Resident #33's room and she told the resident you need to go to the hospital and as she was finishing her sentence both the police officer and the Emergency Medical Technician (EMT) told her it was not her decision to make. The DON further documented the resident was a full code and he needed to go to the hospital because his oxygen level was low and with him being a full code, he needed to go to the hospital or change his code status. During an interview [DATE] at 10:48 AM the DON revealed on [DATE] Resident #33 had contacted 911 himself and that he had a habit of doing that. Revealed 911 then contacted the facility and facility staff requested the ambulance come here as the resident wasn't doing well. The DON further revealed she wanted Resident #33 to go to the hospital to get treatment and stated that is how you have to speak to these guys. The DON denied telling the resident he had to change his code status if he stayed at the facility. (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
	165450	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Estates of Toledo	403 Grandview Drive Toledo, IA 52342

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview [DATE] at 2:06 PM, Resident #33 stated on [DATE] prior being transferred to the hospital he asked the DON why she was again asking him about his code status as they had already talked about it. Resident #33 stated it made him feel small when she brought up his code status again that day prior to being transferred. During an interview [DATE] at 9:23 AM, Staff E, Certified Nursing Assistant (CNA) revealed she had been in Resident #33's room on [DATE] when the EMTs and a police officer were present. Staff E stated one of the EMTs wanted report so Staff F, CNA went to get the DON. Staff E stated the DON reported the resident was being sent out because he wouldn't change his code status and the EMT said we cannot take him if he does not want to go. Staff E stated after the DON had told Resident #33 you have to change your code status or leave, the EMT told the DON to leave the room and when she did not want to leave, the police officer said the resident was now under the care of the EMTs and the DON left the room. During an interview [DATE] at 9:55 AM, Staff F, CNA revealed she was in Resident #33's room on [DATE] with the 2 EMTs and the police officer. Staff F stated when the DON came into the room she stated the resident was getting shipped out because he wouldn't change his code status and told the resident we can't have you here if you don't change your code status. Staff F further stated she felt like the DON was giving Resident #33 an ultimatum in regards to changing his code status or going to the hospital. During an interview [DATE] at 12:13 PM, Staff G, CNA revealed she had been in Resident #33's room when the EMTs and the police officer were present on [DATE]. Staff G stated the resident made it clear that he didn't want to go to the hospital and the DON didn't give him an option, she gave him an ultimatum that she didn't want him there if he didn't change his code status from full code to DNR. Staff G further stated the DON left the room after an EMT asked her to leave and she felt the DON could have been more professional during the situation. On [DATE] at 1:37 PM, the Administrator revealed the facility did not have a specific policy related for Resident Rights however the information was located in the facility admission packet. Review of the facility's undated admission packet revealed the resident has a right to a dignified existence and the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. During an interview [DATE] at 11:16 AM the Administrator revealed it is an expectation residents are treated with dignity and respect.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165450	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Estates of Toledo	403 Grandview Drive Toledo, IA 52342

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42441 Based on observation, clinical record review, and staff interview, the facility failed to notify the physician of a hospital transfer for 1 of 1 residents reviewed for hospitalization (Resident #33) and failed to follow physician orders related to oxygen for 1 of 12 residents reviewed (Resident #20). The facility reported a census of 43 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #33 revealed a Brief Interview for Mental Status (BIMS) of 14 out of 15 indicating intact cognition. The MDS further documented diagnoses including acute and chronic respiratory failure. The Care Plan for Resident #33 revised 3/29/23 documented the resident had altered respiratory status and difficulty breathing and directed staff to monitor for respiratory distress and report to the medical director as needed including decreased pulse oximetry (blood oxygen saturation) and confusion. Review of Progress Notes for Resident #33 revealed on 9/1/24 at 1:47 PM, the Director of Nursing (DON) documented the resident was only oriented to self at the time and his pulse oximetry was 78% on 2 liters of oxygen. The DON further documented the resident was being transferred to the emergency room (ER) on an emergency basis due to vital signs and drastic change in mental cognition. Clinical record review revealed Resident #33 transferred to the hospital on 9/1/24. The clinical record lacked documentation related to physician notification of the transfer. During an interview 11/21/24 at 8:10 AM the Administrator revealed there was not a policy in regards to physician notification as the expectation is to follow regulations. During an interview 11/21/24 at 10:48 AM the Administrator revealed it is an expectation the provider would be notified if a resident was being transferred to the hospital and if it was an emergent situation, the physician would be notified immediately following the transfer. The Administrator acknowledged the physician had not been notified when Resident #33 was transferred to the hospital on 9/1/24. 48886 2. The MDS, dated [DATE], documented Resident #20 had a BIMS score of 14 out of 15, indicating intact cognition. The MDS further documented the resident had diagnoses to include progressive neurological conditions, multiple sclerosis, anxiety disorder, depression, and post traumatic stress disorder. Review of the electronic health record (EHR) for Resident #20 revealed an order for 2 liters (L) of oxygen PRN (as needed) for saturations below 90% and anxiety, with a start date of 3/15/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165450	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Estates of Toledo	403 Grandview Drive Toledo, IA 52342

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation 11/18/24 at 2:45 PM, Resident #20 had her oxygen set at 4 liters, resident was in bed with her oxygen on and in use. During an interview 11/18/24 at 2:45 PM, Resident #20 stated she has not observed staff to change the tubing or the water in the canister/humidifier. During an observation 11/19/24 at 2:45 PM, Resident #20 had her oxygen set at 4 liters, the resident was in bed with her oxygen on and in use. During an observation 11/20/24 at 3:03 PM, Resident #20 had her oxygen set at 4 liters, the resident was in bed with her oxygen on and in use. The tubing had a date of 11/17 and a gallon of distilled water was next to the oxygen machine was a date of 11/15/24. During an interview 11/20/24 at 3:05 PM, Resident #20 stated she had her oxygen on most of the time, she said it is rare that she does not have her oxygen on. She said sometimes it might fall off while she is sleeping. Review of the treatment administration record (TAR) from March of 2024 to November of 2024 for Resident #20 lacked documentation of the administration of oxygen. The TAR did not reflect any dates the resident received oxygen, including the dates the resident was observed to have her oxygen on: 11/18/24, 11/19/24 and 11/20/24. The TAR further lacked documentation the tubing was changed. During an interview 11/20/24 at 3:25 PM, the Administrator and Director of Nursing (DON) stated the oxygen for Resident #20 is a PRN order for anxiety, not for respiratory concerns. The Administrator stated the facility started on the 6th of November using hard charting for the oxygen/nebulizer tubing changed every Saturday during the 3rd shift, this used to be documented on the TAR. The Administrator acknowledged this was not documented on the TAR for Resident #20 prior to November 6th. The Administrator also acknowledged the TAR does not reflect when the resident was using the oxygen. The Administrator and DON acknowledged the order for the resident's oxygen was for 2 L PRN for anxiety, and were unaware the resident was receiving oxygen at 4 L. The Administrator stated an expectation the order is followed and the resident should not receive oxygen at 4 L, or above the ordered 2 L. The Administrator stated an expectation the physician's orders be followed, the TAR should reflect when the resident receives the oxygen, and there should be documentation as to when the tubing is changed. During an interview 11/20/24 at 3:30 PM, the DON stated she went to Resident #20's room and her oxygen was set at 4 L, she moved this down to 2 L. During an interview 11/21/24 at 8:30 AM, the Administrator stated a conversation took place yesterday with the hospice nurse who stated they thought an order had been written for resident to be on 2-4 L oxygen PRN for anxiety, comfort, and oxygen saturation under 90. The Hospice team had been setting resident's oxygen at 4 L when they were here for visits. During an interview 11/21/24 at 10:46 AM, the Administrator stated the facility does not have a policy on following physician orders, they follow professional standards.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165450	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Estates of Toledo	403 Grandview Drive Toledo, IA 52342

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 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. 50874 Based on observation, policy review and staff interviews the facility failed to ensure the dish machine reached manufacture guideline temperature to clean dishes and touched ready to eat food with bare hands causing potential cross contamination of food for 1 out of 1 meal observed. The facility reported a census of 43 residents. Findings include: In the course of the initial brief tour of the kitchen on 11/18/24 at 9:51 AM, observed an American Dish Service (ADS) National Sanitation Foundation Machine Model Series AF-3D(S)/AFC-3D(S) low temperature dish machine. There was a placard in the upper left above the rinse aid prime switch that revealed the wash/rinse minimum temperature to be 120 degrees fahrenheit. The Dishwashing Record High Temperature log for the month of November 2024 posted on the wall approximately 4.5 feet from the dish machine revealed the following temperatures recorded three times per day: Wash Rinse Wash Rinse Wash Rinse 11/1/24 -100 110 106 120 100 115 11/2/24 -110 120 100 110 105 120 11/3/24 -Blank Blank Blank Blank 108 120 11/4/24 -124 118 120 122 Blank Blank 11/5/24 -120 100 120 Blank 106 115 11/6/24 -120 100 120 Blank Blank Blank 11/7/24 -130 100 130 Blank 110 120 11/8/24 -Blank Blank Blank Blank Blank Blank 11/9/24 -Blank Blank Blank Blank 120 120 11/10/24-Blank Blank Blank Blank Blank Blank 11/11/24-112 122 Blank Blank Blank Blank 11/12/24-120 100 120 Blank 122 122 11/13/24-120 100 120 Blank 115 Blank 11/14/24-120 80 120 Blank 104 110 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165450	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Estates of Toledo	403 Grandview Drive Toledo, IA 52342

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/15/24-Blank Blank Blank 122 104 110 11/16/24-Blank Blank 114 120 Blank Blank 11/17/24-Blank Blank Blank Blank 120 130 11/18/24-112 Blank During an observation on 11/18/24 at 9:53 AM, observed Staff A, Dietary Aide operating the dish machine. Staff A, Dietary Aide revealed she was unaware of the type of dish machine the facility had. Staff A, Dietary Aide revealed the wash temperature is to reach 80? and the rinse temperature is 120 degrees fahrenheit. She acknowledged she was unsure what temperature the dish machine was to be at and just wrote down whatever the gauge read. The dish machine gauge revealed a temperature of 128 degrees fahrenheit. During an interview on 11/18/24 at 9:57 AM, Staff B, Dietary Manager revealed the dish machine is a low temperature chemical sanitation machine requiring a minimum temperature of 120 degrees fahrenheit for the wash/rinse cycles. Staff B, Dietary Manager tested the dish machine with an Ecolab Chlorine test strip and revealed a 100 part per million (PPM) hypochlorite concentration. Staff B, Dietary Manager acknowledged there were many areas left blank on the November 2024 Dishwashing Record High Temperature log. She further acknowledged many recorded temperatures were below the manufacture guidelines of 120 degrees fahrenheit. The facility failed to operate the dish machine at the manufacture guidelines to properly clean/sanitize the dishes. In an interview on 11/19/24 at 11:32 AM, the Consultant Dietitian revealed that she comes monthly to audit the kitchen for food service safety. The Dining Registered Dietitian Kitchen Inspection on 10/31/24 at 2:00 PM documented the log for the dish machine was partially filled out but does have holes. The Consultant Dietitian revealed the facility had been using the wrong log to record wash and rinse temperatures and provided the proper form to the Dietary Manager and Administrator. Observed operation of the dish machine on 11/19/24 at 12:19 PM with Staff B, Dietary Manager. The temperature gauge on the dish machine revealed wash cycle temperature of 124 degrees fahrenheit, rinse cycle temperature of 128 degrees fahrenheit and chemical strip revealed 50 PPM. The ADS Install Manual, AF-3D-S/AFB Series, Revision 4.5, April 28, 2021 on page 2 #3 documented water heaters must provide the minimum temperature of 120 degrees fahrenheit required by the machine. The recommended temperature range for optimal performance is 130-140 degrees fahrenheit. Review of the facility Cleaning Dishes/Dish Machine Policy dated 2021 revealed prior to use, proper temperatures and/or chemical concentrations and machine function should be verified. For low temperature dishwasher spray type dish machines using chemicals to sanitize the wash temperature is 120 degrees fahrenheit. Sanitization is 50 PPM. The policy failed to list the temperature for the rinse cycle. Review of the Dish Machine Temperature Log policy dated 2021 revealed staff will record dish machine temperatures for the wash and rinse cycles at each meal. The facility missed 47 opportunities to record wash/rinse temperatures and on 27 opportunities recorded temperatures below the manufacture guidelines. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165450	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Estates of Toledo	403 Grandview Drive Toledo, IA 52342

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During continuous observation on 11/19/24 at 11:39 AM, observed Staff C, [NAME] facing the steam table holding a bun in her bare hands. Staff C, [NAME] opened the bun and placed it on a plate sitting on the steam table. Observed an additional 3 plates with open buns on the steam table. Observed Staff C, [NAME] grab cheese slices from a plate to the right of the steam table with her bare hands, placing 1 slice of cheese on each open bun. Staff C, [NAME] proceeded to grab tongs and place a hamburger on each of the 4 open buns. Staff C, [NAME] placed the tongs in the steam table pan on the stove. Staff C, [NAME] placed the top of the bun on each hamburger with her bare hand. Staff C, [NAME] grabbed the handle of a scoop and placed a serving of peas on each of the four plates. Staff C, [NAME] held the top of the bun with her left hand, using a knife with her right hand to quarter each of the hamburger sandwiches. After sectioning one burger she would place the plate on cart that was to her left and then proceeded to do the same until all four plates were on the cart. The cart was taken to the dining room and served to the 4 residents. Observed Staff D, [NAME] with gloved hands place bread on the griddle. Staff D, [NAME] with right gloved hand place a hamburger on the griddle using tongs. Staff D, [NAME] turned and using the same gloved hands took two slices of cheese, placed one on the hamburger and the other on one of the bread slices on the griddle. Staff C, [NAME] looked at the cheese slice on the bread and using her left bare hand picked up the cheese and replaced it on the bread slice on the griddle. Staff D, [NAME] using the same gloved hands picked up a spatula and placed the bread slice from the griddle on top of the bread slice with the cheese. Staff D, [NAME] with his left gloved hand held the top of the grilled cheese sandwich while using a spatula with his gloved right hand to place the grilled cheese sandwich on a plate. Staff C, [NAME] placed her left bare hand on top of the grilled cheese sandwich holding the edges then used her right hand cut the sandwich in half diagonally with a knife. The plate was placed on a cart and taken to the dining room to be served. During an interview on 11/19/24 at 11:49 Staff C, [NAME] acknowledged touching the hamburger buns, cheese, and grilled cheese sandwich with her bare hands. Staff D, [NAME] acknowledged touching the cheese and the grilled cheese sandwich with the gloved hands that came in contact with other potentially contaminated surfaces. Staff C, [NAME] revealed that she normally wears gloves but had been instructed not to wear gloves that day. On 11/19/24 at 11:50 AM Staff B, Dietary Manger acknowledged she observed Staff C, [NAME] touching the hamburger buns and cheese with her bare hands. Review of the facility General Food Preparation and Handling policy dated 2021 revealed bare hands should never touch ready to eat raw food directly. Disposable gloves are a single use item and should be discarded after each use. The policy further stated that food should be prepared and served with clean tongs, scoops, forks, spoons, spatulas, or other suitable implements to avoid manual contact of prepared foods. Staff C, [NAME] and Staff D, [NAME] failed to use proper food handling procedures for the meal service observed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165450	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Estates of Toledo	403 Grandview Drive Toledo, IA 52342

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 - Potential for minimal harm Residents Affected - Some	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 48886 Based on the Center for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report (April 1st to June 30th) review, facility staffing assignments review, and staff interviews, the facility failed to submit accurate staffing data for the PBJ Staffing Data Report. The facility reported a census of 43 residents. Findings include: The PBJ Staffing Data Report run date of 11/13/24 triggered for excessively low weekend staffing for the fiscal year 3rd quarter, April 1st to June 30th of 2024. Review of Facility Daily Assignment Sheets and daily posting for the infraction dates reflected the facility had adequate weekend staffing according to their census and facility assessment equation for staff required. During an interview 11/21/24 at 12:32 PM, the Administrator stated an uncertainty as to why the facility triggered for low weekend staffing, stating a corporate human resources (HR) employee submits the PBJ data. Starting in October of this year, the HR employee has sent her an email prior to submitting to PBJ if he notices low RN coverage, and it is usually because they forgot to add in agency staff or the Director of Nursing (DON) or Assistant Director of Nursing (ADON), who also fill in for hours given their lower census if someone does not come in for work. The administrator sent an email to corporate HR to see if they might have an idea why they triggered for low staffing. During an interview 11/21/24 at 1:24 PM, the Administrator stated she received an email from corporate HR. During the fiscal year 3rd quarter, only 3 days of agency staffing were submitted: 5/26 (Sunday), 5/27 (Monday) and 6/9 (Sunday). The Administrator stated this would not accurately reflect the amount of agency staff and believes this is why it would have triggered for low weekend staffing. The Administrator stated they are accurately reporting to PBJ currently. The facility does not have a policy on submitting to PBJ.