STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. Building B. Wing	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Living Community of St. Peter	1907 Klein Street St Peter, MN 56082

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure a process for residents and resident representatives to file grievances anonymously, when R22, R23, R35, R45, R46, and R63 voiced they were not aware of how to submit a grievance or an anonymous process to submit a grievance. This had the potential to affect all 67 residents in the facility. Findings include:R22's quarterly Minimum Data Set (MDS) dated [DATE], indicated R22 was cognitively intact.R23's quarterly MDS dated [DATE], indicated R23 had moderately impaired cognition, R35's quarterly MDS dated [DATE], indicated R35 was cognitively intact.R45's quarterly MDS dated [DATE], indicated R45 was cognitively intact.R46's annual MDS dated [DATE], indicated R46 was cognitively intact.R63's annual MDS dated [DATE], indicated R63 was cognitively intact.On 1/13/26 at 11:32 p.m., during a facility tour with social services (SS)-B director concern forms were observed on each unit, however no confidential collection box was present. SS-B confirmed there were grievance forms in the designated areas accessible to all residents and stated grievance forms could be turned in to staff or placed under my door. SS-B confirmed there was no confidential grievance box and confirmed he did not know of anywhere forms could be placed securely for anonymous submission.On 1/13/26 at 12:08 p.m., the administrator stated residents could complete concern forms located on the units and may give them to any staff member. The administrator stated they thought there was a box to place the concerns forms on each wing and after a tour of the facility the administrator confirmed there was no confidential receptacle available for grievance submission. The administrator stated they expected one to be present so residents could voice concerns.On 1/13/26 at 1:05 p.m., during the resident council meeting, residents R22, R23, R35, R45, R46, and R63 stated they were not aware of any method to submit concerns anonymously. All residents reported they would talk to someone if they wanted to file a grievance. None of residents stated they were aware of a process to file a grievance anonymously. Residents reported they were unsure whether forms existed and, if so, how they should be turned in.Facility Concerns, Grievances Policy dated 9/17/19, indicated: Purpose: To create an environment where resident and customer concerns are solicited and readily resolved.Policy: A resident/customer/resident representative has the right to voice grievances and concerns without discrimination or reprisal and without fear of discrimination or reprisal. The term voice concerns is not limited to a formal, written grievance process, but may include a resident's verbalized concerns to staff. Concerns and grievances can be made anonymously.The community views customer concerns as a primary method to learn of and meet customer expectations. In keeping with this belief, staff is trained to obtain and respond to resident/resident representative customer concerns.The social worker/grievance officer /designee checks the confidential container daily; removes the completed forms, logs the concern, and routes the copy to the staff responsible to acknowledge, investigate, and resolve the concern.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview and document review, the facility failed to follow Centers for Disease Control (CDC) guidelines for appropriately implementing measures to prevent the spread of infection when the facility failed to ensure signage was posted for visitors and staff regarding visiting when ill, hand hygiene and respiratory management, and failed to follow infection control practices while washing resident personal laundry. This practice had the potential to affect all residents residing in the facility.Findings include:INFECTION CONTROL SIGNAGEDuring observation on 1/12/26 at 9:45 a.m., no signs were posted at facility entrance doors to encourage visitors and staff to follow respiratory hygiene, cover their cough, stay home while sick, or sanitize hands prior to visiting. In addition, no facemasks or hand sanitizer were available at the main entrance.Review of current CDC guidelines from the CDC website on 1/13/26, indicated for prevention of transmission of viral respiratory infections in long term care, facilities should provide instructions and post visual alerts at the entrances to healthcare facilities reminding patients, visitors, and staff to tell healthcare personnel about any symptoms of respiratory infection, visitors should be encouraged to defer non-urgent routine visits until they have recovered, wear a mask in the facility if they have any respiratory symptoms, clean their hands after having contact with respiratory secretions, practice respiratory hygiene and cough etiquette. Healthcare facilities should ensure the availability of materials for adhering to respiratory hygiene and cough etiquette at facility entrances, including facemasks and alcohol-based hand sanitizer.LAUNDRYDuring observation and interview on 1/13/26 at 10:39 a.m., laundry assistant (H-A) placed soiled laundry into facility washing machine. H-A was not wearing a gown while touching resident laundry. Resident personal laundry was in contact with H-A's clothing. H-A stated she washed all resident personal laundry for the facility. H-A stated she sometimes wore a gown but did not wear one today. H-A stated her gown was being washed and she did not have any disposable gowns available in the laundry room.During observation and interview on 1/13/26 at 2:11 p.m., H-A was observed carrying resident clean laundry to resident's room while holding the laundry against her shirt. H-A was wearing the same shirt she wore while handling resident soiled laundry without a gown. H-A stated she did not normally carry clean resident clothing up against her own clothing. H-A stated that could cause the clean laundry to become contaminated and could be an infection control issue.During interview on 1/13/26 at 2:41 p.m., registered nurse (RN)-E also known as infection preventionist stated the facility should have signs, masks, and hand sanitizer at the entrance to the facility to prevent infection in the facility and promote proper infection control practices and was not sure why they were not there. RN-E further stated she could understand why a gown should be worn when handling soiled laundry and asked if it should be a cloth or disposable gown. RN-E stated handling soiled laundry without a gown and then handling clean laundry could be a cause for spread of infection. RN-E stated she would work with H-A to get her some gowns.During interview on 1/13/26 at 3:35 p.m. director of nursing (DON) stated she was made aware of the lack of signage, masks, and hand sanitizer and had already made sure they were put by the entrance. DON further stated she was not aware H-A had not been wearing a gown when handling soiled laundry and would have expected her to be wearing a gown for infection control purposes.Facility Infection Prevention and Control Program policy dated 8/30/23, indicated the infection prevention and control program exists to assure a safe, sanitary, and comfortable environment for residents and personnel. It is designed to help prevent the development and transmission of disease and infection. In addition, personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

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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 - Few	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 observation, interview and document review, the facility failed to ensure a gradual dose reduction (GDR) or a clinical justification of psychotropic medications was documented for 1 of 5 residents (R8) reviewed for unnecessary medication and were taking psychotropic medications. Findings include: R8's annual Minimum Data Set (MDS) dated [DATE], indicated R8 was sometimes understood and sometimes understands. R8 had severe cognitive impairment, and no mood or behavioral issues. R8 required maximal/substantial assistance with activities of daily living and is dependent on staff with transfers. R8 does not walk. R8's medication used included antipsychotic, antidepressant, antianxiety, anticonvulsant, anticoagulant and diuretic. R8's care plan dated 1/6/26, indicated use of psychotropic drug including antidepressant, antipsychotic, benzodiazepine (used to treat anxiety). Medications managed by psychiatry. Interventions included attempt a gradual dose reduction as indicated. R8's Physician Order Report dated 1/12/26, included the following psychotropic medications: aripiprazole (antipsychotic) 15 milligram (mg), 1/2 tablet orally once a morning for major depressive disorder, single episodedesvenlafaxine succinate (antidepressant) extended release 100 mg oral once a morning for major depressive disorder, single episodealprazolam (antianxiety) 0.25 mg orally twice a day for anxiety. Consultant Pharmacist Recommendation to Physician dated 7/2025, indicated R8 had been taking aripiprazole 7.5 mg every day since 9/23 without a GDR. Could we attempt a dose reduction to perhaps 5 mg every day to verify this resident is on the lower possible dose. The response was left blank. R8's provider note dated 8/12/25, by nurse practitioner (NP)-G indicated most recent PHQ-9 score was 0 indicating no depression. The progress note did not include a pharmacy request for gradual dose reduction (GDR), deferral to psychiatry to address the request or rationale to continue current psychotropic medications. R8's medical record review indicated R8's last documented behavioral issue was 6/1/25, when R8 was upset with nursing assistant (NA) yelling get out, get out and don't come back. R8's progress note dated 10/7/25 at 3:53 p.m., by social services (SS)-A indicated observations completed with no delirium noted and no changes. R8's psychiatry note dated 10/9/25, included last AIMS score (abnormal involuntary movement scale used to evaluate movements for patients taking neuroleptic medications {antipsychotic} was 4 (indicates severe abnormal movements), up one point from previous. Consultant Pharmacist recommendation to physician dated 11/2025, indicated R8 had been taking desvenlafaxine 100 mg every day since 9/23 without a GDR. Could we attempt a dose reduction at this time to verify this resident is on the lowest possible dose. The resident has been taking alprazolam 0.25 mg twice a day since 4/24 without a GDR. Could we attempt a dose reduction to perhaps 0.25 mg at bedtime to verify this resident is on the lower possible dose. R8's progress note dated 12/12/25, by nurse practitioner (NP)-D included R8 has severe cognitive impairment without depression as recent PHQ-9 (depression scale) score was 0. Orders and plan included depression screening was reviewed. The progress note did not include pharmacy request for gradual dose reduction (GDR), deferral to psychiatry to address the request or rationale to continue current psychotropic medications. R8's AIMS observation report indicated on 12/29/25 at 2:41 p.m. registered nurse (RN)-F completed the observation with a score of 4, which was unchanged. R8's progress note dated 1/5/26 at 1:50 p.m., by social services (SS)-A indicated R8 was intermittently dozing off, requiring gentle physical redirection to maintain engagement. R8 reported no mood concerns. During observation and interview on 1/12/26 at 4:09 p.m., R8 was sitting in chair in her room with the television on. R8 answered yes and no questions. R8 denied any side effects from her medications and denied any anxiety or depression at this time. On 1/13/26 at 12:53 p.m., pharmacist (P)-F indicated that GDR's are important, they aren't urgent needing to be done immediately but they do need to be addressed by a provider at the next visit to ensure resident is on the lowest possible dosage of medication. On 1/13/26 at 2:10 p.m., RN-E, also identified as case (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	manager, stated the local provider wants these requests sent to the psychiatry office but she never receives an answer back from them. RN-E stated in 10/2024, psychiatry, family and medical provider agreed to continue the medications and not attempt a GDR but confirmed a GDR has not been discussed since that time. RN-E stated she had not attempted to reach psychiatry with 7/25 and 11/25 requests. RN-E stated the local provider should have seen the GDR request at the 12/25 visit but the medical record lacked evidence the provider saw the request or deferred to psychiatry. On 1/13/26 at 3:40 p.m., the director of nursing (DON) stated she would expect pharmacy recommendations to be addressed within the next month of the recommendation but sometimes it can take longer if it is deferred to psychiatry. The DON stated if psychiatry isn't responding to facility requests, she should be notified so it can be addressed and a note should be present in the medical record indicating attempts to reach psychiatry. Attempt made to reach NP-D and psychiatry without success. Facility Psychotropic Medication Use policy dated 9/7/23, included: Psychotropic medications are given upon a medical provider order. The nursing associates collaborate with the medical provider to ensure the lowest possible dosage is given for the shortest period of time and are subject to gradual dose reductions and re-reviewPsychotropic medications are ordered by the medical provider to treat a specific condition as diagnosed and documented in the medical record.Gradual Dose Reduction (GDR) begins within the first year in which a resident is admitted with or is newly prescribed a scheduled psychotropic medication. GDR is attempted in two separate quarters (with at least one month between the attempts), unless clinically contraindicated and documented by the medical provider. Contraindications may include:The continued use is in accordance with relevant current standards of practice and the medical provider has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder; orThe resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility and the medical provider has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.The IDT team monitors the resident condition and target behaviors for efficacy of the medications and any clinically significant adverse consequences. Documentation will reflect implementation of the above.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure follow-up of ordered diagnostic testing, review by the provider, or notification to the resident and/or family regarding results of an x-ray for 1 of 1 resident (R23) reviewed for pain. Findings Include:R23's quarterly Minimum Data Set (MDS) dated [DATE], indicated R23 had moderately impaired cognition, required partial/moderate assist for chair to bed transfer, sit to stand transfer, and toilet transfer; required substantial assistance with lower body dressing and toileting hygiene and diagnoses included Non-Alzheimer's Dementia and depression.R23's care plan dated 11/27/25, indicated experience pain/discomfort related to osteoarthritis; monitor for nonverbal indicators of discomfort such as restlessness, anxiety, change in ADL (activity of living) ability, guarding, or impaired cognition.R23's order history dated 1/6/26, indicated on 1/6/26 radiology right ankle, right foot. R23's progress note dated 1/7/26 at 2:04 p.m., indicated called on status of x-ray, x-ray company stated that they don't have coverage today for this area and tech will be out tomorrow to do.R23's x-ray result dated 1/8/26 at 11:18 p.m., indicated no acute bone abnormality. On 1/12/26 at 12:17 p.m., R23 was observed seated in her wheelchair in her room and stated she had an x-ray last week on Thursday for right leg pain and had not heard back regarding the results.On 1/12/26 at 6:00 p.m., R23 stated she still had not received x-ray results, did not know who to ask, and had not been followed up with. R23 verbalized ongoing right foot pain and uncertainty about her walking ability due to the pain.On 1/13/26 at 8:06 a.m., nurse practitioner (NP)-E stated R23 reported right foot pain the prior week and an x-ray had been ordered. NP-E confirmed she had not been contacted by the facility regarding x-ray results.On 01/13/2026 at 8:40 a.m., licensed practical nurse (LPN)-A stated R23 had an x-ray last week, and they thought R23's x-ray results came back showing a bone spur and did not know if the resident or family had been informed. LPN-A reviewed the electronic medical record and confirmed there was no documentation of receipt of results or notification to the provider or family.On 1/13/26 at 8:43 a.m., registered nurse (RN)-A, known as the nurse manager, stated she was not sure if R23's x-ray results had been received. RN-A confirmed progress notes did not show results or notifications and stated they would need to find out more information.On 1/13/26 at 11:27 a.m., RN-A stated the x-ray results were located that morning after calling the x-ray company. RN-A acknowledged this was not the first time x-ray results had not been received or had been misplaced. RN-A confirmed no documentation existed showing staff reviewed or communicated the results. RN-A stated she expected the resident and family to be notified and confirmed this was not reflected in the record. RN-A stated a delayed receipt could be a problem if something serious. RN-A described the facility's usual process: the physician orders the x-ray, the facility calls the x-ray vendor, and results are faxed to the facility to be reviewed, with nursing responsible for notifying the resident, family, and provider.On 1/13/26 at 11:50 a.m., during a follow-up interview, LPN-A stated during shift report she was told that R23 had completed an x-ray last week and that a bone spur was identified. LPN-A confirmed there was no documentation showing the x-ray results were communicated or acted upon. LPN-A stated she expected a progress note documenting review and notification. LPN-A described routine practice: reports print on the fax machine, nursing staff check the fax tray, and either provide the results to RN-A and notify the resident, family, and provider. LPN-A stated results are then placed in the provider folder for review unless urgent, in which case staff should call immediately.On 1/13/26 at 12:57 p.m., the director of nursing (DON) stated that when x-ray results are received by fax, nursing staff are expected to review them and notify the provider immediately if urgent, and if non-acute, notify the provider on the next business day. The DON stated she would expect staff to have addressed R23's x-ray results prior to today (1/13/26) and confirmed there should have been documentation reflecting review, follow-up, and notification. The DON stated the facility received x-ray reports both via the physical fax and email and nursing is responsible to ensure results are (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	routed and acted upon.Facility Change in Condition, Resident Examination and Evaluation Facility Policy dated 11/10/25, indicated document symptom(s), assessment, observations, resident/resident representative, and medical provider notification.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a new intervention was followed to prevent further falls for 1 of 2 resident (R51) reviewed for fall with major injury.Findings include:R51's face sheet printed 1/13/26, indicated diagnoses of femur fracture, dementia, muscle weakness, and unsteadiness on feet.R51's annual Minimum Data Set (MDS) dated [DATE], indicated moderately impaired cognition, no upper or lower extremity impairment, use of walker, partial/moderate assistance with upper and lower body dressing, supervision with personal hygiene, independent with transfers, independent with walking 150 feet.R11's care plan dated 12/8/25, indicated at risk for falls due to diagnoses, impaired mobility, weakness, impulsivity, poor safety awareness, history of fall with left hip fracture-tripped over equipment in the hallway while ambulating independently. Provide with an environment free of clutter. Due to constant ambulating around the unit and history of sticking to pattern when walking fall was unavoidable. Since event resident ambulating per usual.Facility progress note documented by registered nurse (RN)-B dated 12/5/25, indicated R51 found on the floor in the hallway lying of left side. R51 stated he had been on the way to the bathroom and got caught up on something. Note further indicated R51's walker became caught on vitals machine, had been against the wall in the hallway. R51 attempted to back up after the walker became caught and subsequently fell. R51 had left hip and upper leg pain with left knee appearing externally rotated. R51 transferred to emergency department and diagnosed with left femur fracture.Facility progress note documented by RN-C dated 12/8/25, indicated R51 returned from hospital following left hip repair.Facility event note documented by RN-B dated 12/5/25, indicated R51 fell in hallway, landed on left side. Following the event, the fall was determined to be related to an environmental hazard combined with R51's cognitive impairment. A vitals machine had been positioned along the hallway wall in R51's usually walking path, causing his walker to become caught and resulting in loss of balance. Resident is highly ritualistic and the presence of a new object in his customary route disrupted his established routine and contributed to the incident. Environmental hazard removed and to be kept in alternate location.During observation on 1/12/26 at 4:15 p.m., R51 was on his bed in his room. A vitals machine on wheels was plugged in along the wall in the hallway directly outside his room.During observation on 1/13/26 at 8:23 a.m., R51 was seated in dining room. Vitals machine was plugged into the wall in the direct path to his room.During interview on 1/13/26 at 8:57 a.m., RN-D stated she was unaware the vitals machine was not supposed to be plugged in near R51's room. RN-D stated she worked five days per pay period and may have missed the message about that intervention. RN-D further stated fall interventions were normally place in a binder at the nurses' station or told in report.During interview on 1/13/26 at 9:02 a.m., nursing assistant (NA)-A stated she was aware of fall interventions for R51 and that the vitals machine should not be in the hallway. NA-A stated she did not know where to find new fall interventions but knew to ask the nurse if anything changed after a fall. NA-A stated communication was poor at the facility.During interview on 1/13/26 at 9:04 a.m., NA-B stated she was unaware of specific interventions for R51 but knew that new fall interventions were put in a binder at the nurses' station and staff had to initial to indicate they had read them.During interview on 1/13/26 at 9:08 a.m., RN-E also known as case manager stated the vitals machine should not have been in the hallway because that was determined to be the cause of his fall and could cause more falls for R51 or other residents. RN-E further stated R51 was not walking as much as he used to after his fall but could improve and be at risk again for falls. R51 stated fall interventions were put in a binder at the nurses' station for staff to review and sign off on. R51 showed the binder and that the fall intervention for removing the vitals machine from the hallway had not been put in the binder. RN-E could not find a sign off sheet to show staff had been made aware of the new intervention after the fall.During interview on 1/13/26 at 3:35 p.m., director of (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing (DON) stated she expected fall interventions to be followed and staff to be made aware of new fall interventions to prevent additional falls.Facility Integrated Fall Management policy dated 9/23, indicated residents are assessed for their risk of falls upon admission, significant change, and quarterly. Residents with risk for falling will have interventions implemented through the resident centered care plan. Post fall the environment of the fall is evaluated for possible contributing factors and addressed. The interdisciplinary team reviews the fall and may implement additional interventions. Documentation of the above is completed.

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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, interview and document review, the facility failed to ensure required nursing staffing information, specifically registered nurse (RN) hours, were posted for residents, staff and visitors. This had the potential to affect all 67 residents residing in the facility and their visitors.Findings include:During an interview on 1/13/26 at 11:13 a.m., nursing staffing was reviewed with the director of nursing (DON) who stated there was a licensed nurse on duty 24/7 and at least one registered nurse (RN) on duty for eight consecutive hours each day. During an observation on 1/13/26 at 11:35 a.m., the daily staffing posting, located on the wall next to the entrance to the administrative offices was reviewed. It was not clear by the information posted there had been an RN on duty. Information listed on the posting included the various nursing position, hours worked and number of staff. For 1/13/26, the daily staffing posting indicated: DAY SHIFT: 6:00 a.m. to 6:30 p.m.LN/RN - 1RN - 0RN/LPN/TMA - 3TMA - 0TMA - 0NAR - 6NAR - 2EVENING SHIFT: 2:00 p.m. to 10:30 p.m. RN - 0LPN/RN - 3TMA -1NAR - 4NAR/TMA - 2NAR - 0NIGHT SHIFT: 6:00 p.m. to 6:30 a.m.RN - 0LPN/RN/TMA - 1LPN/RN - 2TMA - 0NAR - 2NAR - 2Each shift listed RN several times, either singularly, or along with LN, LPN, TMA. Each time RN was listed singularly, the number of staff indicated was zero. During an interview on 1/13/26, at 11:38 a.m., together with the DON, the staffing coordinator (SC)-B and the health information coordinator (HIC)-C looked at the posting. They agreed, one could not tell if there had been an RN scheduled to work that day. HIC-C stated she was responsible for the form and for filling it out and would make the necessary changes to reflect individual RN hours. In addition, SC-B admitted she did not adjust the form for staff absences due to call outs or illness.Nursing staffing posting forms were reviewed for the prior months of November and December 2025, and for January 2026, verifying an RN was not identified as working nor were staffing adjustments noted. Nursing staff schedules were reviewed for October, November, December 2025, and January 2026, which indicated there had been at least one RN scheduled to work each day. Facility Posting of Nursing Hours policy with review date of 9/20/22, indicated the purpose was to provide the number of direct care associates available during any given shift. At the beginning of each shift, the number of licensed nurses, including registered nurses (RN), licensed practical nurses (LPN) and licensed vocational nurse (LVN) and the number of unlicensed nursing associates - certified nursing assistants (CNA), directly responsible for resident care would be posted in a prominent location that was accessible to residents and visitors and in a clear and readable format. Schedule would be amended as schedule changed. Shift staffing information would be recorded for each shift. The information included the facility name, the date for which the information was posted, the resident census at the beginning of the shift for which the information was posted, twenty-four hour shift schedule, the shift for which the information is posted, the type (RN, LPN, LVN, or CNA) and category (licensed or non-licensed) of nursing staff working during that shift, the actual time worked during that shift for each category and type of nursing staff, total number of licensed and non-licensed nursing staff working for the posted shift.