STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255118	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Meridian	4728 Highway 39 North Meridian, MS 39301

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 50921 Based on record review of resident council minutes, facility policy review, and interviews conducted during the Resident Council meeting, the facility failed to promptly resolve grievances related to condiments and call light response times for 12 of 12 Resident Council members. This failure has the potential to affect 87 residents. Cross Reference F725 Findings Include: A review of the facility's Resident Rights and Protections Under State and Federal Law dated 2022 indicates, You have the right to voice grievances and recommend changes . to representatives . and The nursing home must try to resolve the issue promptly. A review of the facility's Customer Concern (Grievance) Policy, effective date July 2018, indicates, Support residents' right to voice concerns . and ensure after receiving a concern, the center actively seeks a resolution ., and Customer concerns will have a prompt response . A record review of the Resident Council meeting minutes dated October 16, 2024, and November 20, 2024, confirmed residents raised concerns about the lack of condiments. On 05/18/25 at 12:30 PM, an observation of the dining room revealed baked potatoes served to residents with no salt or pepper packets on the trays to season the potatoes. No salt and pepper shakers were observed on the tables. On 05/18/25 at 12:55 PM, the State Agent observed Resident #52 having lunch in Styrofoam to-go containers. The resident's lunch consisted of slices of roast beef, carrots, baked potatoes, and a cookie. No condiments were noted on the tray. On 05/18/25 at 01:00 PM, during an interview with a Certified Nursing Assistant (CNA), she confirmed that she assisted Resident #52 with lunch and noted the resident had no condiments on her tray, including butter, salt, or pepper. She explained that she went to the kitchen and was informed there was no butter or salt and pepper. She further explained that the dietary manager had announced over the intercom that all meals would be served in Styrofoam to-go containers due to only two kitchen staff working that day. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/19/25 at 1:30 PM, the Resident Council met with the State Agent to discuss concerns raised by residents regarding the quality of care, staff responsiveness, food service, and general facility practices. Resident #14 stated that they pay too much money not to receive basic condiments such as salt, pepper, and butter. Residents reported that no condiments were provided the previous week. Resident #14 stated they were told the absence of condiments was due to milk being wasted on condiment boxes during delivery, and others were told the dietary department was operating on a budget. Resident #32 and Resident #68 reported that call lights often take up to 20 minutes to be answered. Resident #62 stated that during the 11:00 PM to 7:00 AM shift, call lights can go unanswered for up to 30 minutes. Residents alleged that during this shift, staff are often on their personal phones when calls come in and do not respond promptly. Resident #39 shared that she has had to call the facility using her personal phone to be connected to the nurses' station to request assistance because CNAs either took an excessive amount of time to respond or did not respond at all. Resident #14 confirmed similar issues during the day shift, stating that it takes a long time for CNAs to respond to call lights. Resident #68 stated that CNAs sometimes answer a call light only to say they will return but never come back. Resident #72 reported that CNAs often turn off the call light, say they will come back, and by the time they return, she has forgotten what she needed. Resident #39 confirmed that her call light has remained unanswered for more than 30 minutes on multiple occasions. Resident #68 reported that last month, she called 911 for an ambulance because her call light had been ignored for an extended period. On 05/19/25 at 2:46 PM, during an interview, the Ombudsman reported that during her routine visits and rounds at the facility, Certified Nursing Assistants (CNAs) are frequently not present or visible on the units. She stated that when she visits to speak with residents or follow up on areas of potential noncompliance, nurse aides are consistently difficult to locate. On 05/20/25 at 9:27 AM, during an interview conducted with the Social Services Director, she explained that grievances can be submitted by residents through various channels. She shared that common grievances often involve food preferences, response times to call lights, and missing personal items. Once a grievance form is completed, it is forwarded to the appropriate department. For example, concerns related to call lights are directed to the Director of Nursing (DON), who may then coordinate with Human Resources if necessary. She acknowledged that call light response times tend to be slower during breakfast and lunch tray pass because CNAs are actively engaged in meal service. On 05/20/25 at 9:43 AM, during an interview with the Activities Director, she confirmed that call light responsiveness has been an ongoing issue within the facility. She reported that while the problem may be resolved for a period, typically about a month, it often recurs. She stated that she documented the issue as a grievance and submitted it to the nursing department. On 05/21/25 at 9:00 AM, during an interview with the District Manager of Dietary (DMD), she revealed that the truck comes on Wednesday of every week and that last week, she was told something had spilled over the condiments on the truck, and the condiments had to be rejected. The DMD stated that staff could have gone to get condiments from the store so residents could have condiments during meals. She also stated that salt and pepper shakers were on the carts for residents during tray pass. The State Agent did not observe salt and pepper shakers on the trays or in the dining hall during lunch tray pass. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/21/25 at 11:35 AM, during an interview with the Dietary Manager (DM), she revealed that the condiments on the week's delivery appeared to have spilled milk or ice cream on the box. Although the condiments were sealed inside the box, she rejected the items and sent them back to the provider. The DM admitted to having run out of condiments. The State Agent informed the DM that, according to Resident Council members, the lack of condiments had been documented as an ongoing issue since October and November 2024, and residents reported they also did not have condiments the prior week.

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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. 50921 Based on observations, staff interview, record review, and facility policy review, the facility failed to provide a comfortable, homelike environment in the resident rooms for three (3) of 32 rooms on the North Unit. Findings include: A review of the facility's Resident Rights & Quality of Life Policy, Policy#CC-20, effective March 13,2020 indicated: The patient or resident has the right to . receive services in a center environment that is safe, clean, and comfortable . On 05/19/25 at 10:43 AM, the State Agent (SA) observed exposed sheetrock surrounding the air conditioner in room N2. On 05/21/25 at 10:05 AM, during a room tour and interview with the Maintenance Supervisor, rooms N2, N4, and N8 were observed to have exposed wall areas near the door and air conditioner, chipped paint, and exposed metal on the bottom corner of walls. The Maintenance Supervisor stated that the damage in room N8 occurred while moving a bed and confirmed that all identified areas were in need of repair. Also, on 05/21/25, during an interview with the Maintenance Supervisor, the SA reviewed maintenance work orders from April to May 2025. The review revealed no documented requests for repairs in room N2 room N4, or room N8. The Maintenance Supervisor admitted that more repair requests are communicated to him verbally during rounds than are formally documented.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48181 Based on record review, staff interviews, and facility policy review, the facility failed to assure accurate coding of the Minimum Data Set (MDS) related to discharge status (Resident #90) and an anticoagulant medication (Resident #14) for two (2) of 23 residents sampled. The scope/severity for F641 was increased to E because this tag was cited on the last annual recertification survey 1/25/24. This represents a pattern of deficiency. Findings Include: A review of the facility's policy, MDS and Care Plans, dated August 2019, revealed, .MDS will be developed and maintained per RAI (Resident Assessment Instrument) Guidelines. A record review of the Centers for Medicare & Medicaid Services (CMS) Resident Assessment Instrument (RAI) 3.0 Manual, dated October 2019, revealed, .Completion of the RAI . The RAI process has multiple regulatory requirements . (1) the assessment accurately reflects the resident's status . Resident #90: A record review of the Admission Record revealed the facility admitted Resident #90 on 03/06/25 with diagnoses including fractured femur. A record review of the clinical record revealed Resident #90 had an order with an end date of 03/22/25 to Discharge home . A record review of the Discharge Summary, dated 03/17/25, revealed Resident #90 would transfer home . A record review of the facility's Notice of Transfer or Discharge revealed that on 03/19/25 the resident was discharged from the facility to home. A record review of the Discharge MDS with an Assessment Reference Date (ARD) of 03/19/25 revealed Resident #90 was coded as discharged to a Short-Term General Hospital. On 05/19/25 at 3:41 PM, in an interview with the Social Services Director (SSD), she acknowledged making an incorrect entry regarding Resident #90's discharge status. The SSD noted it was a simple mistake and confirmed she is responsible for ensuring her sections of the MDS are coded correctly. She affirmed that the importance of having accurate information on the MDS is for proper billing and stated she will be more careful to verify the accuracy of information. On 05/19/25 at 3:43 PM, in an interview with Registered Nurse (RN) #1, she acknowledged the discrepancy in the MDS, which listed the resident's discharge status as Short-Term General Hospital. RN #1 confirmed it is the responsibility of the discipline that coded their section to assure accuracy before submitting the MDS. She stated the MDS is used for reimbursement, and it is important to include accurate information. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/19/25 at 3:47 PM, during an interview with the Director of Nursing (DON), she stated the MDS nurse is responsible for ensuring the MDS contains accurate information. The DON emphasized the importance of accurate MDS coding to ensure proper billing and stated she expects the MDS nurse to verify information before submission. Resident #14: A record review of the Admission Record revealed Resident #14 was admitted on [DATE] with diagnoses including seizure. A record review of the Quarterly MDS with an ARD of 02/11/25 Section N revealed Resident #14 was taking an anticoagulant. A record review of the physician's orders and the electronic Medication Administration Record (MAR) for the month of February 2025 revealed there were no anticoagulant medications ordered or administered to Resident #14 during the lookback period. On 05/21/25 at 12:00 PM, during an interview, RN #1 explained she was not working in February 2025 and the MDS nurse responsible at the time was no longer employed at the facility. After reviewing Resident #14's physician's orders and MAR, RN #1 confirmed there was no indication the resident was on an anticoagulant medication and that the MDS must have been coded in error. On 05/21/25 at 3:24 PM, in an interview with the Administrator, she acknowledged the discrepancies related to discharge status and medication administration on the MDS. She stated that the discipline completing each section of the MDS is responsible for assuring its accuracy. The Administrator explained that accurate MDS coding is necessary to reflect the true picture of the resident's needs and acuity of care. She stated she will provide training to staff on MDS coding expectations.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 43283 Based on observations, interviews, record reviews, and facility policy review, the facility failed to revise a care plan for a resident no longer requiring the use of a lift for transfers for one (1) of 23 resident care plans reviewed (Resident #14). Findings include: A review of the facility's policy, MDS and Care Plans, dated August 2019, revealed, .MDS will be developed and maintained per RAI (Resident Assessment Instrument) Guidelines. A review of the RAI 3.0 Operations Manual dated October 2019 revealed, .Planning for Care: Individualized care plans should address strengths and weakness .Individualized care plans should be based on an accurate assessment of the resident's self-performance and the amount and type of support being provided to the resident . A record review of Resident #14's Comprehensive Care Plan revealed a care plan with a revision date of 05/15/25 stated, .I have a physical functioning deficit with transfers and require assistance of 1 to two (2) staff as needed . with interventions listed as Hoyer Total Lift Large (Green) Sling and Invacare Total Lift Large (Green) . During an observation and interview on 05/18/25 at 11:41 AM, the State Agency (SA) observed Resident #14 sitting up in his wheelchair in the hallway. Resident #14 complained that the staff would not let him use the large bathroom in the hallway. He stated he could not get in and out of the bathroom in his room and had difficulty getting on the toilet. He reported he could transfer himself but did need assistance, although it took staff a long time to come and help. On 05/19/25 at 12:10 PM, during an interview with Certified Nurse Aide (CNA) #3, she explained Resident #14 is very independent and will do everything for himself. He is to be assisted with transfers but will not wait or even ask for assistance. She stated he requires assistance from one (1) staff member with transfers. On 05/19/25 at 12:25 PM, the SA observed Resident #14 returning to his room with two (2) staff members. During an interview with the Therapy Director, she explained the resident was recently discharged from therapy but was referred back due to his complaint about not being able to use his bathroom. Resident #14 was discharged from therapy with no problems using the bathroom in his room and was walking 10-15 feet with assistance. Resident #14 wheeled himself into the bathroom without concerns, stood, and used the assist bar on the wall. No concerns were noted with the transfer with therapy staff providing contact guard assist. On 05/19/25 at 2:00 PM, during an interview with Registered Nurse (RN) #2, she explained Resident #14 requires assistance from one (1) staff member, but the resident will not call for assistance. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/19/25 at 2:30 PM, during an interview with the Therapy Director and record review, she confirmed Resident #14 was discharged from therapy back in February 2025 with stand-by guard assistance. Prior to therapy, the resident could not walk or transfer. She confirmed through a record review of Resident #14's PT (Physical Therapy) Discharge Summary that the resident was contact guard assist with transfers. On 05/21/25 at 12:00 PM, during an interview with RN #1, she explained the facility uses ongoing care plans and updates them daily by reviewing physician orders. She stated she uses physician orders and assessments to complete the Minimum Data Sets (MDS) and care plans. She reviewed Resident #14's care plan and confirmed the resident had a care plan for a lift. She uses the lift evaluation to complete the care plan, and the last lift evaluation completed for the resident was from 11/24, which indicated the resident required a lift. She confirmed she was unaware that the resident was no longer using a lift but acknowledged there were no current orders for a lift. The care plan had not been revised accurately to reflect the individual's current needs. On 05/21/25 at 12:45 PM, during an interview with the Assistant Director of Nursing (ADON), she confirmed Resident #14 does not require a mechanical lift. She stated she expects all care plans to be updated according to current resident assessments. On 05/21/25 at 12:55 PM, during an interview with the Administrator, she confirmed she expects all care plans to reflect an accurate assessment of each resident and be revised according to the RAI guidelines. A record review of Resident #14's Admission Record revealed the facility admitted the resident on 02/23/24 with the diagnoses of Other Seizures, Anxiety Disorder, Unspecified, Delusional Disorders, and Personal History of Traumatic Brain Injury. A record review of Resident #14's Order Summary Report with active orders as of 05/20/25 revealed orders for OT clarification: OT to treat patient three (3) times a week times 2 weeks with therapeutic exercise, therapeutic activity, self-care training, and group to increase safety and independence with functional tasks active on 05/19/25. No orders were noted for a mechanical lift. A record review of Resident #14's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/13/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Section GG revealed the resident required partial/moderate assistance with toilet transfers. A record review of Resident #14's PT Discharge Summary revealed dates of service from 01/23/25 through 02/26/25, with discharge at CGA (contact guard assist) for transfers on 02/26/25.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 37415 Based on observation, interviews, and facility policy review the facility failed to ensure sufficient nursing staff were available to meet the care needs of residents during a shift change on three (3) of six (6) resident halls, as evidenced by the facility having one (1) Certified Nurse Aide (CNA) available during the transition from day shift to evening shift, while three nurses remained at the nurse's station, and five (5) resident call lights were observed activated for approximately 30 minutes without response. Cross Reference F565 Findings include: A review of the facility's Staffing Policy revealed it is the practice of (Proper Name of Facility) to assure that adequate staffing is maintained to provide the necessary care and services for each resident. Staff expectations are based on resident acuity and needs and may fluctuate based on the center population as identified in the facility assessment. The center conducts workforce management meetings daily to discuss open positions and call-ins as related to patient needs. The facility continues to actively recruit staff, offering various incentives. On 5/20/25 at 2:30 PM, the State Agency observed several lights sounding on the North Wing. One light was on in North A Hall, two call lights were sounding in North B Hall, and two call lights were sounding in North C Hall. The State Agency also observed three nurses at the nurse's station-one sitting and two standing-reporting to the oncoming shift. No one answered the call lights. No CNAs were observed on the floor until 2:45 PM. At that time, CNA #8 arrived for the evening shift on the North Unit and began answering call lights. Resident #11 was heard saying, Will someone please help me? Upon entering the room, the resident stated her call light had been on for 30 or 40 minutes and that she needed help. On 5/20/25 at 4:10 PM, CNA #2 confirmed there were no CNAs on the floor at 2:55 PM. She also stated she answered the call lights in Rooms N12 and N19. CNA #2 said she did not know where the other CNAs were but confirmed that nurses were present at the nurse's station when call lights were sounding. CNA #2 added that CNAs should notify nurses before leaving the floor and that she had just been informed that CNA #9, scheduled for the North Hall, was sent home on administrative leave at 2:45 PM. On 5/20/25 at 4:30 PM, during an interview, the Assistant Director of Nursing (ADON) stated she did not know where the CNAs were and was unaware that the Administrator had sent CNA #9 home on administrative leave until the State Agency asked about the unanswered call lights on the North Hall around 3:00 PM. On 5/21/25 at 8:00 AM, Licensed Practical Nurse (LPN) #3 confirmed there were no CNAs on the floor at 2:30 PM on 5/20/25. She was unaware that CNAs had left the floor until the State Agency asked to speak with them. She also did not know how long they had been gone. LPN #3 stated CNAs are supposed to report off to the nurses before leaving or going home but often fail to do so. She said administrative staff are aware that CNAs often leave without notification. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/21/25 at 8:10 AM, LPN #1 confirmed she was one of the cart nurses on North Hall during the day shift. She stated she did not know CNA #9 had been sent home on administrative leave and that the CNAs had not informed her they were leaving. On 5/21/25 at 9:00 AM, CNA #4 confirmed she was assigned to North C Hall. She stated she went outside to dump her barrel before the shift change and did not inform nurses she was leaving the hall. On 5/21/25 at 9:15 AM, CNA #1 confirmed she was assigned to North A Hall and also did not inform the nurses she was leaving the hall. She explained she went to dump her barrel before the next shift. She did not think to notify the nurse and was unaware CNA #9 had been placed on administrative leave. CNA #1 said the hall is often short-staffed. She stated, We try to do the best we can with what we have. On 5/21/25 at 9:30 AM, CNA #6 stated CNAs do not perform walking rounds to explain care to the oncoming shift. She said dayshift CNAs are often gone before the evening shift arrives. CNA #6 confirmed only one evening shift CNA was on the floor when she arrived. On 5/21/25 at 11:00 AM, CNA #8 confirmed she clocked in at 2:25 PM on 5/20/25. When she arrived on North Hall, call lights were sounding, and no CNAs were on the hall. She observed three nurses at the nurse's station. CNA #8 stated she normally worked as the transportation aide on dayshift but had been working evenings due to staffing shortages. She also confirmed seeing CNAs #4 and #5 outside. On 5/21/25 at 11:30 AM, LPN #2 confirmed she was at the nurse's station at 2:30 PM on 5/20/25 receiving report from LPN #1. She stated that CNAs do not conduct walking rounds and that the dayshift CNAs were not on the hall when she arrived, which she did not know until asked by the State Agency. She said she would have helped with call lights if she had known and acknowledged that nurses struggle to assist due to CNA shortages. On 5/21/25 at 12:00 PM, the Administrator confirmed she informed CNA #2 around 2:50 PM that CNA #9 had been placed on administrative leave, which left the North Hall down one CNA. She stated she was unaware the other CNAs were not on the hall. The Administrator acknowledged the facility is actively working to increase staffing and confirmed that available shifts are posted for staff to pick up as needed.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48181 Based on observation, interview, and facility policy review, the facility failed to store food and maintain food quality in accordance with professional standards for food safety related to overly ripe produce and improperly stored foods and unlabeled items during one (1) of three (3) kitchen observations. Findings include: A review of the facility's policy, Food Storage: Cold Foods revised ,d+[DATE], revealed, .Procedures .2. All perishable foods will be maintained at a temperature of 41 degrees F or below . On [DATE] at 10:35 AM, during an observation and interview of the kitchen with the Dietary Manager (DM), refrigerator #3 revealed a plastic storage container containing 14 overly ripe cucumbers with white slimy rind, soft and pliable to the touch, and liquid formed at the bottom of the container. A further observation of the pantry revealed one (1) opened bottle of yellow mustard with the manufacturer's instructions Best if used by date of [DATE]; one (1) opened gallon-sized bottle of soy sauce with the manufacturer's instructions to Refrigerate after opening for quality; 19 overly ripe oranges with green and white bio-growth on the rind; and one (1) overly ripe apple containing a brown soft spot with the interior of the apple exposed. The Dietary Manager acknowledged the overly ripe produce and improperly stored pantry items and stated it is her responsibility to make sure the food is not expired and is stored properly. The DM stated she did not examine the produce that day as she had intended and confirmed the risks of having overly ripe food in the kitchen. The DM noted that going forward she will do a regular check of the produce and pantry items to assure freshness. The DM affirmed that the dietary staff are in-serviced once a month on food safety, which includes lectures and tests. On [DATE] at 02:30 PM, in an interview with the Administrator, she acknowledged the overly ripe produce and improperly stored foods. The Administrator stated it is the responsibility of the DM to monitor the food supplies for proper storage and spoilage and stated her expectation is that the DM will get a system of organization to stay on top of monitoring food safety.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255118	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Meridian	4728 Highway 39 North Meridian, MS 39301

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 37415 Based on interviews and Certification and Survey Provider Enhanced Reports (CASPER) reporting data review, the provider failed to ensure their Payroll Based Journal (PBJ) (information of the staffing hours for the appropriate care of the residents) had been corrected before submitting to the Centers for Medicare and Medicaid Services (CMS) for one (1) of four (4) quarters reviewed. Findings include: Review of the provider's CASPER reporting data revealed the facility triggered for excessively low weekend staffing for one (1) of four (4) quarters: October 1, 2024 - December 31, 2024. Review of the facility's Monthly Schedule dated October, November, and December 2024 revealed the Director of Nursing (DON) worked as supervisor on October 26 and 27, November 3, and December 14 and 29, 2024. She worked on the floor as a nurse on November 5 and December 29, 2024. Review of the facility's Monthly Schedule dated October, November, and December 2025 revealed the Assistant Director of Nursing (ADON) worked as supervisor on October 6 and 19, November 3, 14, 16, and 17, and December 1 and 29, 2024. The ADON worked on the floor on October 5, 12, 13, and 29, November 22, and December 29, 2024. During an interview on 5/19/25 at 11:00 AM with the Director of Nursing (DON), she explained she did not know the facility triggered for low weekend staffing in the first quarter. The DON said she and the Assistant Director of Nursing (ADON) work when the nursing staff is low. The DON revealed that both are salaried employees and were not clocking in and out during the first quarter. The DON said they just started clocking in and out within the last two (2) weeks. The DON also said the only proof they have that they worked is the assignment sheets, where they wrote themselves in. This is not included in the daily Payroll Based Journal. During an interview on 5/19/25 at 11:15 AM with Certified Nursing Assistant (CNA) #2, she revealed she is responsible for the schedule for the nurses and CNAs. CNA #2 stated that if the staff members work a different shift or work beyond their routine shift, she goes into the system and corrects the information. If the staff works on the floor but normally performs other jobs, she changes the code to reflect the correct position the staff worked that day. The corporate office is responsible for sending in the PBJ. During an interview on 05/20/25 at 09:00 AM with the Administrator, she explained she was not aware the facility triggered in the first quarter of 2025 for excessively low weekend staff. The staffing coordinator corrects the staff punches daily. This goes directly to the corporate office. The Administrator confirmed the facility just started two (2) weeks ago a new process requiring all salaried employees to clock in and out when they work on the floor. During an interview with the Director of Payroll, he explained he has not received anything from CMS showing that the facility triggered for excessively low staff for the first quarter. The Director said the PBJ was accepted.