STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285213	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Nebraska Lutheran Home	109 North 2nd Street Newman Grove, NE 68758

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 0689 Level of Harm - 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** 29638 LICENSURE REFERENCE NUMBER 175 NAC 12-006.09(I)(i). Based on record review and interview; the facility failed to identify causal factors and to revise and/or develop additional interventions for the prevention of ongoing falls for Resident 29 and falls with injury for Resident 135. The sample size was 5 and the facility census was 34. Findings are: A. Review of the facility Falls-Clinical Protocol with a revision date of 3/2018 revealed the facility was to review each resident's risk factors for falling and document in the resident's medical record. If the resident had a fall, staff were to identify possible causes within 24 hours of the fall. The facility would then identify pertinent interventions to try to prevent subsequent falls and then monitor and document the resident's response to the interventions. If the interventions were successful in fall prevention the approaches would be continued. Staff were to assess the need for changes on the approaches of the plan of care and develop additional approaches to prevent ongoing falls as needed. B. Review of Resident 135's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 7/19/24 revealed diagnoses of fractures, arthritis, osteoporosis, previous stroke, non-Alzheimer's dementia, anxiety, and depression. The MDS further indicated Resident 135 had: -moderately impaired cognition, -was dependent on staff for assist with eating/drinking, personal hygiene, dressing, bed mobility and transfers, -incontinence of bowel and bladder, and -experienced 2 or more falls with no injury, 2 or more falls with injury (except major) and 1 fall with major injury. Review of Resident 135's Progress Notes revealed the following: (continued on next page)

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
	285213	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Nebraska Lutheran Home	109 North 2nd Street Newman Grove, NE 68758

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 0689 Level of Harm - Actual harm Residents Affected - Few	-1/29/24 at 8:10 AM the resident had a witnessed fall in the resident's room. Resident 135 had fallen backwards when transferred by a staff member and was then lowered to the floor. Staff placed the resident in the lobby area for increased supervision and therapy was to assess the resident. -1/31/24 at 1:38 PM received orders for Occupation Therapy (OT) and Physical Therapy (PT) services. -1/31/24 at 9:10 PM the resident was found on the floor in front of the recliner in the lobby area. A new intervention was developed for a drug review due to increased confusion in the evenings. The Primary Care Provider (PCP) changed the resident's antidepressant medication to be given in the morning instead of the evening to minimize side effects. -2/27/24 at 1:00 PM the resident was found on the floor next to a chair in the resident's room. An immediate intervention to check the resident every 30 minutes for 8 hours was identified. Further review revealed no ongoing interventions and/or causal factors were identified related to the resident's fall. -2/27/24 at 2:55 PM revealed the resident was to be discharged from PT and OT due to goals met and resident had reached a plateau. -2/29/24 at 7:45 AM the resident was found on the floor in the resident's room. No causal factors were identified regarding the fall. The resident's medications were reviewed but no changes were made. -3/12/24 at 10:45 AM the resident was found on the floor of the resident's room. The resident had been lying in bed and stated a desire to get into the chair. A new intervention was developed to place non-skid strips next to the resident's bed. -4/11/24 at 4:00 PM the resident was found on knees on the floor. No causal factors were identified, and staff failed to revise current interventions or to develop new interventions to prevent further falls. -4/18/24 at 12:44 PM the facility visited with the family about the resident's behaviors and requested to move the resident to the Memory Unit. The family felt this would increase the resident's confusion and declined having the resident moved. -4/19/24 at 11:07 AM the resident was heard calling for help and was found on the floor in the resident's room. The resident had attempted to remove slacks and urinary incontinence brief. The resident, despite ongoing confusing was educated to use the call light to seek staff assistance. No further interventions were identified. -5/20/24 at 7:45 PM the staff heard a noise in the resident's room and found the resident sitting on the floor. The resident had been talking on the phone to family prior to the fall and fell when trying to hang up the phone. The resident was encouraged to call for assist as needed. The resident was screened by PT and orders were received for therapy to treat on 5/23/24. -6/18/24 at 3:23 PM the resident was discharged from PT as on 6/14/24 the resident was admitted to Hospice. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285213	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Nebraska Lutheran Home	109 North 2nd Street Newman Grove, NE 68758

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 0689 Level of Harm - Actual harm Residents Affected - Few	-6/24/24 at 8:15 PM the resident was found on the floor of the resident's room and was lying on right hip. Hospice was to bring a scoop mattress for the resident's bed. -7/14/24 at 9:00 PM the staff heard the resident screaming in their room and calling for help. The resident was found on the floor next to the bed and was assisted to the bathroom. No causal factors were identified, and the facility failed to revise current interventions or to develop new interventions to prevent further falls. The staff sent a note to the PCP regarding assessment for a possible fracture but did not receive a response. -7/15/24 at 9:20 AM the resident had been positioned in a wheelchair at a table in the lobby area. The wheelchair brakes had been locked. The resident attempted to move the wheelchair back away from the table and tipped over backwards in the chair. The resident was unable to bear weight with continued complaints of hip pain. At 10:30 AM the resident was transferred to the emergency room (ER) for assessment. -7/15/24 at 2:49 PM anti-tip bars were placed on the resident's wheelchair after returned from the ER with diagnosis of 2 pelvic fractures. -7/17/24 at 4:22 PM the resident was found on the floor beside the resident's bed. The resident's incontinence brief was partially removed and there was urine on the floor. Staff identified interventions to toilet the resident every 2 hours and to position the resident to the middle of the mattress. -7/18/24 at 2: 25 PM the resident was found on the floor next to the resident's bed. The resident had a scoop mattress and body pillow in the bed when staff had checked the resident 2 minutes prior to the fall. An intervention was identified for a fall mat to the floor next to the resident's bed. -7/19/24 at 10:00 PM the resident had passed away. An interview with Licensed Practical Nurse (LPN)-B on 9/12/24 at 9:57 AM confirmed the following: -2/27/24 at 1:00 PM after the resident's fall, the staff were to do 30-minute checks for 8 hours. No further interventions were developed to prevent further falls and no casual factors were identified. -2/29/24 at 7:45 AM the resident was found on the floor in the resident's room. No causal factors were indicated. Medications were reviewed but no changes were made to prevent further falls. -4/11/24 at 4:00 PM when the resident was found on their knees, no casual factors were identified, and no additional interventions were developed. -4/19/24 at 11:07 AM the resident was found on the floor of the resident's room with brief and slacks lowered. Education was provided to the resident regarding calling for assistance despite the resident's confusion and safety impairment. -6/14/24 the resident was admitted to Hospice. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285213	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Nebraska Lutheran Home	109 North 2nd Street Newman Grove, NE 68758

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 0689 Level of Harm - Actual harm Residents Affected - Few	-7/14/24 at 9:00 PM the resident was found on the floor of the resident's room. The resident had been restless earlier in the shift and had been positioned at the Nurse's Station for constant monitoring. The resident had complained of right hip pain and a facsimile was sent to the PCP regarding assessment for fracture of the resident's right hip. The facility again asked the family about moving the resident to the Memory Unit, but the family refused. -7/15/24 at 9:20 AM the resident had another fall when the resident tipped the wheelchair over backwards. The resident continued to complain of hip pain and was unable to bear weight. At 10:30 AM the resident was sent to the ER for evaluation. The resident was found to have 2 fractures of the resident's right pelvis. Anti-tip bars were placed on the resident's wheelchair upon return from the hospital and staff were instructed not to lock the wheelchair brakes when the resident was at the table. -7/17/24 at 3:25 PM the resident had another fall out of bed. The staff were educated to position the resident in the middle of the bed and to toilet the resident every 2 hours. -7/18/24 at 2:25 PM staff had checked on the resident who had been lying in bed with the scoop mattress and a body pillow. Two minutes later the resident was found on the floor. A fall mat was placed on the floor next to the resident's bed. -7/19/24 at 10:00 PM the resident passed away. C. Review of Resident 29's MDS dated [DATE] revealed diagnoses of non-traumatic brain dysfunction, Alzheimer's disease, depression, anxiety, and dementia. The MDS further indicated Resident 29 had: -severely impaired cognition, -behaviors which included resistance with cares, wandering and verbal behaviors directed toward others, -was dependent on staff for assist with personal hygiene, dressing, bed mobility and transfers, -incontinence of bowel and bladder, and -experienced 2 or more falls with no injury. Review of Resident 29's Nursing Progress Notes revealed the following: -1/13/24 at 4:10 AM the resident was on the bathroom floor and was incontinent of urine. Staff felt the resident had been awakened on safety rounds. New interventions were identified to have staff do rounds more quietly and to toilet the resident at least 2 times throughout the night. -1/14/24 at 10:11 PM the resident was found on the floor in the corridor. No causal factors were identified, and staff indicated an intervention for therapy to re-screen the resident even though the resident was currently on therapy caseload. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285213	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Nebraska Lutheran Home	109 North 2nd Street Newman Grove, NE 68758

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 0689 Level of Harm - Actual harm Residents Affected - Few	-1/15/24 at 8:00 PM the resident was found sitting on the floor of the resident's room. Family was concerned about a possible urinary tract infection (UTI) and new orders for a urinalysis. 1/18/24 a new antibiotic was ordered to treat the infection. -3/13/24 at 1:07 PM the resident was found on the floor next to the resident's bed. No causal factors were identified. The facility completed urinalysis which was negative, and therapy re-screened the resident but did not pick up for therapy. -5/14/24 at 11:28 PM the resident was observed seated on the floor in front of the recliner. Staff assisted the resident out to the commons area for closer supervision. Staff were to do frequent checks and encourage the resident to remain in the recliner in the commons area for supervision. In addition, a new order was received to increase the resident's Tylenol Arthritis to three times a day for pain control. -6/25/24 at 3:30 PM the resident was found sitting on the floor of the resident's room. The resident was assisted into the wheelchair and out to the common's area for closer supervision. Further review revealed no causal factors were determined and no additional interventions were identified. -6/26/24 at 2:22 AM the resident was found on the floor next to the resident's bed and in front of the wheelchair. The resident was incontinent of urine. A new intervention was developed for use of a pancake call light which was to be positioned on the right side of the bed. -6/30/24 at 3:10 PM the resident was lowered to the floor when became unsteady during assisted toileting transfer. Further review revealed no evidence current fall interventions were revised or new interventions developed. -8/6/24 at 2:29 PM the resident was found on the floor of the commons area next to the resident's wheelchair. The resident had attempted to stand and sat down on the floor. An intervention was put into place for one staff on the Memory Unit to always supervise the resident. -8/28/24 at 11:00 PM the staff entered the resident's room and witnessed the resident stand and then slide down to the floor. The resident was barefoot and had been incontinent of urine. An intervention was added to the resident's treatment sheet for the Charge Nurse to verify the resident was wearing gripper slippers when not wearing shoes. 9/8/24 at 5:47 AM the was found seated on the floor in the doorway of the resident's room. The resident was not wearing shoes or the gripper socks. Staff received written education regarding use of the gripper socks and the resident's bed was no longer to be placed in the lowered position but was to be placed at the height of the resident's wheelchair. During an interview pm 9/11/24 at 11:22 AM, LPN-B confirmed the following regarding fall prevention assessment and interventions for Resident 29: -1/14/24 fall at 10:11 PM there were no causal factors identified regarding the resident's fall. A screen went out to have therapy re-screen the resident despite already being on their case load. No further interventions were identified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285213	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Nebraska Lutheran Home	109 North 2nd Street Newman Grove, NE 68758

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 0689 Level of Harm - Actual harm Residents Affected - Few	-3/13/24 fall at 1:07 PM there were no causal factors identified. A urinalysis was completed and was negative. In addition, a therapy screen was completed but therapy did not pick the resident up for treatment. No new interventions were indicated to prevent further falls. -6/25/24 at 3:30 PM the resident was found on the floor of the resident' room. The resident was assisted into the wheelchair and then out to the common's area for increased supervision at the time of the fall. No causal factors and no further interventions were identified. -6/30/24 at 3:10 PM the resident fell when the staff were transferring the resident onto the toilet. There was no evidence current interventions were revised or additional interventions developed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285213	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Nebraska Lutheran Home	109 North 2nd Street Newman Grove, NE 68758

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 42360 Licensure Reference Number 175 NAC 12-006.09 Based on record review and interview, the facility failed to ensure Resident 4's antibiotic ointment use had an ordered duration to prevent potential adverse outcomes. The sample size was 5 and the facility census was 34. Findings are: A. Review of the facility undated policy Antibiotic Stewardship; revealed the following: -The facility's antibiotic stewardship program promoted the appropriate use of antibiotics and a system of monitoring to improve resident outcomes and reduce antibiotic resistance. -Antibiotic were prescribed for the correct indication, dose, and duration to appropriately treat the resident while attempting to reduce the development of resistant organisms or other adverse consequences or outcomes. Review of Resident 4's Minimum Data Set (MDS-federally mandated comprehensive assessment used to develop resident Care Plans) dated 6/21/24 revealed the resident took antibiotic medication. Further review revealed the resident received enteral (nutrition provided using the gut or tube feeding) nutrition. Review of Resident 4's Care Plan with a revision date of 7/17/23 revealed the resident had a feeding tube (tube inserted through the abdominal wall and into the stomach to provide nourishment) and staff were to change the dressing to the tube site daily, observe for signs and symptoms of infection and apply Bacitracin (antibiotic) ointment to the site twice daily every 3rd day. Review of Resident 4's Medication Administration Record (MAR) date August 2024 revealed the resident received Bacitracin Ointment starting 2/27/19 (5 and 1/2 years). During an interview on 9/11/24 at 10:41 AM the Director of Nursing confirmed the facility did not have an ordered stop date or duration of use orders for Resident 4's Bacitracin ointment. In addition, the ongoing use of an antibiotic without a defined duration or clinical rationale for continued use was not in accordance with the facility antibiotic stewardship policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285213	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Nebraska Lutheran Home	109 North 2nd Street Newman Grove, NE 68758

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 29638 LICENSURE REFERENCE NUMBER 175 NAC 12-006.12E1 Based on observation, record review and interview; the facility failed to provide safe storage of drugs and biological's as a medication cart was left unlocked and unattended, and medications were left unsecured in Resident 21's room. The sample size was 6 and the facility census was 34. Findings are: A. Review of the facility policy titled Medication Labeling and Storage with a revision date of 2/23 revealed the following: -the facility was to store all drugs and biological's in a safe, secure, and orderly manner; -the Charge Nurse was responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner, and -compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biological's were to be locked when not in use, and trays or carts used to transport such items were not to be left unattended if open or otherwise potentially available to others. B. Observations in Resident 21's room revealed the following: -9/9/24 at 8:30 AM a clear medication cup was observed lying on its side atop a blanket on the floor next to the resident's recliner. One pill (Plavix 75 milligram (mg) 1 tablet) remained in the cup. Further observation revealed the presence of 7 additional medications in the folds of the blanket (Amlodipine (used to treat high blood pressure) 5 mg 1 tablet, Isorbide (medication used to treat chest pain) 30 mg 1 tablet, Loratadine (used to treat allergies) 10 mg 1 tablet, Pantoprazole (used to treat heart burn) 40 mg 1 tablet, Eliquis (blood thinner) 2.5 mg 1 tablet, Guaifenesin (used to treat cough) 600 mg 1 capsule and Metoprolol (used to treat high blood pressure) 25 mg 1 tablet). Resident 21 confirmed the staff would leave the resident's morning medications in the resident's room as the resident preferred to take the medication with the breakfast meal. -9/10/24 at 8:38 AM the resident was seated in a recliner in the resident's room. Next to the chair on a table was a clear medication cup which contained the same 8 medications as the previous day. C. During an observation on 9/11/24 at 8:31 AM, the Medication Cart which was positioned outside of the dining room in the 300 corridor was left unlocked and no staff were observed in the immediate area. At 8:34 AM, Medication Aide (MA)-H returned to the cart. MA-H confirmed the cart had been left unlocked and unattended while the MA was in the dining room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285213	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Nebraska Lutheran Home	109 North 2nd Street Newman Grove, NE 68758

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. During interview on 9/11/24 at 3:09 PM, the Director of Nursing (DON) verified medications were to be stored inside the medication cart and the medication cart was to be always locked when unattended. In addition, Resident 21 had not been assessed and did not have an order for self-administration of medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285213	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Nebraska Lutheran Home	109 North 2nd Street Newman Grove, NE 68758

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 - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 29638 Based on record review and interview: the facility failed to submit their Payroll Based Journal (PBJ) data for quarter 3 of 2024 as required. This had the potential to affect all residents residing within the facility. The facility identified a census of 34. Findings are: A record review of the PBJ report from Centers for Medicare and Medicaid services (CMS) revealed the facility had failed to submit data for the third quarter (April 1 to July 30) in 2024. The PBJ report is a collection of staffing information and is a requirement of all long-term facilities to promote accountability and consistency. During an interview on 9/10/24 at 3:09 PM, the Provisional Administrator, revealed the facility did not know how to submit the required information and confirmed no information had been submitted.