STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155238	A. BUILDING 00 B. WING	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
YORKTOWN MANOR	2000 S ANDREWS RD YORKTOWN, IN 47396

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 21, 22, 23, 24, and 25, 2023. Facility number: 000143 Provider number: 155238 AIM number: 1002830890 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 3 Medicaid: 47 Other: 14 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 30, 2023.	F 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective September 8, 2023, to the Recertification and State Licensure Survey completed on August 21, 2023. We respectfully request a desk review for paper compliance.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility	F 0684		09/08/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Bailey	Administrator	09/08/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	failed to communicate with the medical director for a resident with hematuria (blood in urine) for 1 of 1 residents reviewed for urinary tract infection. (Resident 19). This deficient practice resulted in a delay of 10 days to schedule a doctor's appointment for the resident and 18 days before the resident was seen by a specialist. Findings include: Resident 19's clinical record was reviewed on 8/24/23 at 10:33 a.m. Diagnoses included Stage 4 chronic kidney disease, tubulo-interstitial nephritis (inflammation that affects the tubules of the kidneys and the tissues that surround them), unspecified hydronephrosis (a condition where one or both kidneys become stretched and swollen as the result of a build-up of urine inside them) and neuromuscular dysfunction of the bladder. A 6/15/23 annual Minimum Data Set (MDS) assessment indicated she was moderately cognitively impaired. She was incontinent of urine and bowel and was dependent on staff for toileting\. A current health care plan, revised on 8/1/22, indicated the resident was always incontinent of bladder and bowel, and was at risk for bleeding due to a prescribed anti-coagulant medication, apixaban 5 mg (milligrams) two times a day. A progress note, dated 5/21/23 at 9:29 p.m., indicated the resident had a moderate amount of bloody discharge with urinary incontinence. A progress note, dated 5/23/23 at 3:36 p.m., indicated the resident had a small amount of bloody discharge with urinary incontinence.		F 684 Quality of Care It is the practice of Yorktown Manor that residents receive treatment and care in accordance with professional standards of practice. · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 19 had an appointment with urology on 9/6/23 with a PCNL procedure to be scheduled by physician office. · How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents with condition changes have the potential of being affected by the deficient practice. The progress notes of all residents since survey exit were reviewed to identify any acute condition changes with no further findings. · What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The policy “Acute Condition Changes – Clinical Protocol” was reviewed by the IDT. An in-service was held with all licensed nurses on communication to the medical	

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	A progress note, dated 5/26/2023 at 4:38 p.m., indicated the resident had blood in urine with the amount of blood varied throughout the day. The description of the blood ranged from dark brownish tinged urine to bright red at times. Progress notes, dated 5/27/23, 5/28/23, 5/29/23, and 5/31/23, indicated the resident had moderate amounts of blood in her urine. The clinical record lacked indication of physician notification of the resident's hematuria. On 5/31/23 at 2:10 p.m., a call to urology was made and the resident was scheduled to see the doctor on 6/8/23 at 9:45 a.m. A progress note, dated 5/31/23 at 5:12 p.m., indicated the medical director was informed the resident had blood in her urine and was scheduled to see urology soon. Progress notes, dated 6/3/23 at 1:50 p.m. and 6/4/23 at 12:10 a.m., indicated the resident continued to have dark brown bloody sediment in her urine. On 6/7/23 at 3:17 p.m., she had a scant amount of blood in her urine. A progress note, dated 6/8/23 at 10:26 a.m., indicated the resident was diagnosed with hydronephrosis with stone(s) by urology and had received an order for a CT (computed tomography) scan. On 6/9/23 at 5:38 p.m., the CT was scheduled for 6/21/23 at 9:20 a.m.		provider when resident experiences an acute condition change and that follow up has been completed. A performance improvement tool has been developed to monitor resident changes in condition, that the medical provider was notified and follow up/treatment rendered if applicable. · How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A performance improvement tool has been initiated that randomly audits five (5) residents to identify condition changes, that medical provider was notified and follow up/treatment rendered if applicable. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting · By what date the systemic changes for the deficiency will be completed: 9/8/2023	

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	On 8/23/23 at 11:43 a.m., during an interview with LPN 15 , she indicated she did not know why Resident 19 had blood in her urine but that it happened on and off intermittently. The facility had not heard back from urology regarding the ongoing hematuria. She did not know why the condition had not been addressed by the urology doctor. The clinical record lacked contact or follow up with the urologist office until the ADON called them on 8/24/23. Review of a 6/21/23 CT report indicated it had been reviewed by the urologist on 7/21/23. During an interview with the DON on 8/25/23 at 9:17 a.m., she indicated the resident had been to urology in June. The CT scan indicated Resident 19 had kidney stones. Urology had never reviewed the CT scan. There had been an ongoing problem with getting a response from urology and the facility regularly had to wait on the doctor to address resident conditions. The problem with hematuria for Resident 19 had not been addressed because the facility was still waiting for urology to address the CT scan from June. A document titled "Acute Condition Changes - Clinical Protocol" was provided by the DON on 8/25/23 at 2:39 p.m. The document indicated the following: "...1) The physician will help identify individuals with a significant risk for having acute changes of condition during their stay; for example, an individual with an indwelling urinary catheter who has had recurrent symptomatic urinary tract infections, or someone with unstable vital signs or recurrent pneumonia...7) Before contacting a physician about someone with an			

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	acute change of condition, the nursing staff will collect pertinent details to report to the physician\...a) Phone calls to attending or on-call physicians should be made by an adequately prepared nurse who has collected and organized pertinent information, including the resident/patient's current symptoms and status...8) The nursing staff will contact the physician based on the urgency of the situation. For emergencies, they will call or page the physician and request a prompt response (within approximately one-half hour or less)...9) The attending physician will respond in a timely manner to notification of problems or changes in condition and status...a) The nursing staff will contact the medical director for additional guidance and consultation if they do not receive a timely or appropriate response...." 3.1-37(a)			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an			

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	unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.			
	Based on record review and interview, the facility failed to ensure a pharmacy recommendation was acted upon for 1 of 5 residents reviewed for unnecessary medications. (Resident 23) Finding includes: Resident 23's clinical record was reviewed on 8/23/23 at 10:02 a.m. Diagnoses included Alzheimer's disease, anxiety disorder, and psychotic disorder. A pharmacy recommendation, dated 9/26/22, indicated Zyprexa (an antipsychotic medication)	F 0756	F 756 Drug Regimen Review, Report Irregular, Act On It is the practice of Yorktown Manor that irregularities identified by the pharmacist during chart review are acted upon. · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The pharmacy recommendation for	09/08/2023

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	2.5 mg (milligram) every day for dementia with behaviors, was due for evaluation per federal guidelines. The physician had signed the document on 12/2/22, which was approximately two months following recommendation date. During an interview on 8/24/23 at 2:28 p.m., the DON indicated the September 2022 pharmacy recommendations were delayed being reviewed until early December 2022. The pharmacist had trouble with her computer. On 8/25/23 at 9:25 a.m., the DON provided email documentation regarding the September 2022 pharmacy recommendations. The emails indicated the following: a. On 9/26/22 at 3:49 p.m., the Pharmacy Consultant indicated she had been having some computer issues and had gotten behind this month. She was going to send the report later that night. b. On 9/26/22 at 5:43 p.m., the DON asked if the Pharmacy Consultant had sent the September recommendations and pharmacy report. c. On 9/26/22 at 6:22 p.m., the Pharmacy Consultant indicated the report was attached and apologized for the delay. d. On 10/11/22 at 6:38 p.m., the Pharmacy Consultant indicated she had been in the facility and had not seen the responses from September's recommendations and would look for them next month. e. On 10/12/22 at 6:21 a.m., the DON replied she had not received the September report. f. On 10/12/22 at 9:55 a.m., the Pharmacy Consultant forwarded her email message from 9/26/22 at 6:22 a.m. g. On 11/11/22 at 10:19 a.m., the Pharmacy Consultant requested confirmation that the		resident 23 was evaluated by the physician on 12/2/22. · How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents with pharmacy recommendations have the potential of being affected by the deficient practice. Pharmacy recommendations were reviewed on all residents to ensure they were acted on with no further findings. · What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The policy “Consultant Pharmacy Reports” was reviewed by the IDT. An in-service was held with all licensed nurses on the procedure for addressing recommendations. The pharmacist is completing a monthly report in the medical record entitled “Pharmacy Review” on all residents. A performance improvement tool has been developed to monitor that pharmacy recommendations were received each month and acted on timely. · How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A	

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	forwarded email send on 10/12/22 had been received. h. On 11/14/22 at 2:56 a.m., the DON indicated she had received the reports. A current facility policy, dated 11/20/21 and titled, "Consultant Pharmacy Reports," provided by the DON on 8/25/23 at 9:25 a.m. indicated the following: "...Procedures...B. Comments and recommendations concerning medication therapy are communicated in a timely fashion. The timing of these recommendations should enable a response prior to the next medication regiment review....C. Recommendations are acted upon and documented by the facility staff and/or the prescriber...." 3.1-25(i)		performance improvement tool has been initiated that randomly audits five (5) residents to ensure pharmacy recommendations were received and, if applicable, acted on. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting · By what date the systemic changes for the deficiency will be completed: 9/8/2023	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have			

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	access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to discard an expired insulin pen and to indicate a date opened on another insulin pen for 1 of 2 medication carts observed for medication storage. (300 Hall) Findings include: During observation of the 300 Hall medication cart on 8/25/23 at 12: 15 p.m., accompanied by LPN 8, the following was observed: a. A Lantus Solostar insulin pen (to treat diabetes) with an opened date 7/3/23. LPN 8 indicated the pen contained 140 units. b. A Humalog insulin Kwikpen (to treat diabetes) without an opened date. LPN 8 indicated the pen appeared to be full. During an interview at the time of the observation, LPN 8 indicated the Lantus Solostar pen was outdated and should have been destroyed after 30 days of the opened date. The Humalog Kwikpen lacked an opened date. The 300 Hall medication cart had two residents who received insulin. A current facility policy, revised August 2017 and titled "Diabetes: Injectable Medications,"	F 0761	F 761 Label/Store Drugs and Biologicals It is the practice of this facility to label drugs and biologicals in accordance with currently accepted professional standards and not use medications beyond the expiration date. · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The insulin pens that were outdated and lacked a date opened were destroyed. No residents were affected by the alleged deficient practice. · How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents who receive insulin in the facility have the potential to be affected by the alleged deficient practice. An audit was completed	09/08/2023

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	provided by the Administrator on 8/25/23 at 2:27 p.m., indicated the following: "...Humalog...Once opened, refrigerated or not, product must be used within 28 days....Lantus...once opened, refrigerated or not, product must be used within 28 days...." 3.1-25(o)		on all insulin pens/vials to monitor for expired medication or pens/vials that did not include date opened with no further findings. · What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The policy “Diabetes Injectable Medication” was reviewed by the IDT. An in-service was held with the licensed nursing staff on the policy. A performance improvement tool has been developed to monitor that insulin is properly labeled with the expiration date and destroyed when expired. · How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A performance improvement tool has been initiated that audits 5 residents on insulin weekly to ensure insulin is labeled with the date opened and has been destroyed if beyond the expiration date. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee for 5 residents weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance	

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			Meeting · By what date the systemic changes for the deficiency will be completed: 9/8/23	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure the dishwasher sanitization rinse cycle was tested and recorded to assure sanitary eating surfaces and to assure pureed food was prepared using the facility's recipe. This deficient practice had the potential to impact 64 of 64 residents who received meals from the facility kitchen.	F 0812	F 812 Food Procurement, Store/Prepare/Serve-Sanitary It is the practice of this facility to ensure food is prepared following the recipe and resident dishes are cleaned and sanitized. · What corrective action(s)	09/08/2023

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	Findings include: 1. During a kitchen observation on 8/21/23 at 9:41 a.m., accompanied by Dietary Aide (DA) 12, the dishwasher was cycled. She indicated the dishwasher was a low temperature washer and was tested each morning. DA 12 obtained some testing strips from the office and placed them in the rinse water. The result was 50 ppm (parts per million) and she indicated she thought that may be low and she would check. The staff had not recorded the testing results on any type of log. An observation of the test strips used by DA 12 indicated the strips had expired September 2022. During an interview on 8/21/23 at 10:14 a.m., DA 13 indicated she operated the dishwasher and had not tested the chemicals before. She indicated the cooks may test it in the morning, but she was unsure. A current facility policy, revised 5/20/19, titled, "Dish Machine Temperatures (Low Temperature Machines) and Sanitizer Testing," provided by the Administrator on 8/21/23 at 10:21 a.m., indicated the following: "...Guidelines...4. The sanitizer is also to be checked on the dish machine at each meal cycle using a chlorine test strip. The test is to be recorded during the rinse cycle on the first test run. ...This value is to be recorded on the Dish Machine Temperature and Sanitizer Monitoring Log...." 2. During an observation on 8/22/23 at 10:25 a.m., DA 10 prepared to puree lunch for 11 residents that required an altered textured diet. She placed the serving amount of the lunch entree of green beans, potato, and sausage in the food processor.		will be accomplished for those residents found to have been affected by the deficient practice: Test strips were immediately obtained for testing the sanitizer rinse cycle. Dietary Aides 12 and 13 were in-serviced on checking the expiration dates on testing strips and logging the results. Dietary Aide 10 was in-serviced on following the recipe for preparing pureed food. No residents were affected by the alleged deficient practice. · How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents that consume meals in the facility have the potential to be affected by the alleged deficient practice. An observation was completed on all staff that sanitize dishes and prepare pureed food to ensure proper procedure was followed with no further findings. The dietary manager reviewed stock to ensure items are available to prepare according to the recipe. · What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The policies “Dish Machine Temperatures and Sanitizer Testing and Policy: Standardized	

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	She added an amount of liquid from juices to the processor and blended. She added 5 1/2 pieces of bread to the mixture and blended. A review of the facility recipe for Pureed Sausage, Green Beans and Potatoes, provided by DA 10 on 8/22/23 at 10:35 a.m., lacked bread as an ingredient. The recipe indicated to use commercial thickener if the product needed to be thickened. During an interview at the time of observation, DA 10 indicated she had not reviewed the recipe. She had used bread as a thickener in the past and added it because there was bread to be served for lunch. She was unaware of the recipe to puree bread if served during a meal. A current facility policy, revised 7/2023, titled "Policy: Standardized Recipes," provided by the Administrator on 8/25/23 at 2:39 p.m., indicated the following: "...Standardized recipes are used when preparing menu items. Procedure:...3. Cooks are expected to use and follow the recipes provided...." 3.1-21(i)(3)		Recipes" were reviewed by the IDT. An in-service was held with the Food Service Director and dietary staff on the policies. A performance improvement tool has been developed to monitor that test strips are not expired for sanitizing, results are logged and recipes for pureed food are followed with food items needed to prepare being in stock. · How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A performance improvement tool has been initiated that audits 5 meals weekly to ensure pureed food is prepared according to the recipe, items are in stock for pureed food preparation, sanitation strips are not expired and results are logged. This Quality Assurance Audit Tool will be completed by the Food Service Director/Designee for 5 meals weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting · By what date the systemic changes for the deficiency will be completed: 9/8/23	

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F 0851 SS=D Bldg. 00	483.70(q)(1)-(5) Payroll Based Journal §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day			

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	(including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. Based on interview and record review, the facility failed to accurately report the Registered Nurse (RN) coverage hours into the Payroll-Based Journal (PBJ) system for the reported period of January 1, 2023 through March 31, 2023. This deficiency had the potential to affect 64 of 64 residents. Findings include: During a review of the facility PBJ Staffing Data Report, on 8/18/23 at 10:35 a.m., indicated the infraction dates for No RN Hours reported for the fiscal year quarter 2 (January 1- March 1, 2023). The following dates were listed: a. January 2023: 1/1, 1/2, 1/8, 1/14, 1/21, 1/22, 1/28, and 1/29. b. February 2023: 2/4, 2/11, 2/12, 2/17, 2/18, 2/25,	F 0851	F 851 Payroll Based Journal It is the practice of Yorktown Manor that a Registered Nurse is scheduled for 8 consecutive hours daily and hours are accurately reported into the Payroll Based Journal System (PBJ). · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Registered Nurse coverage for the dates listed is unable to be corrected. Adjustments in the system would not affect the star rating posted for the facility during	09/08/2023

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	and 2/26. c. March 2023: 3/4, 3/5, 3/9, 3/10, 3/11, 3/12, 3/13, 3/18, and 3/19. A record review, on 8/24/23 at 11:00 a.m., of employee time cards for January 2023 indicated a Registered Nurse (RN) was not scheduled for the following days: 1/1/23- 1/9/23 and 1/12/23-1/31/23; for February 2023 indicated a RN was not scheduled for 2/1-2/28/23 and for March 2023, indicated an RN was not scheduled for 3/1-3/21, 3/23, 3/24, 3/28, 3/29, and 3/31/23. During an interview with the Administrator, on 8/25/23 at 9:13 a.m., she indicated she had calculated the average resident census for the months in question at under 60 and the hours the DON had worked were reported. During a review of the current facility assessment tool, revised July 24, 2023 and provided by the Administrator on 8/24/23 at 10:00 a.m., indicated the average census was 62. During an interview with the DON, on 8/25/23 02:00 p.m., she indicated the facility assessment tool was up to date and she was under the impression the DON, who is an RN and was in the building, was enough to satisfy the requirement for the 8 hours of consecutive RN worked time. Human Resources sent payroll to a secondary party after she confirmed the punch in and punch times were correct. The secondary party sent the information into the PBJ system. The reported numbers were correct to the best of her knowledge and staffing was in accordance with regulations. On 8/25/23 at 1:00 p.m., a current policy, revised October 2017, titled Reporting Direct- Care		that time frame. · How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents that reside in the facility have the potential to be affected by the alleged deficient practice. Since March 2023, 5 Registered Nurses have been hired with 4 of these currently employed. An audit of PBJ reporting was conducted with no further findings. The facility continues to post ads for facility hiring of Registered Nurses. · What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The policy “Reporting Direct-Care Staffing Information” was reviewed by the IDT. An in-service was held with the nursing scheduler and Human Resources on the requirement for RN coverage and accurate reporting in PBJ. A performance improvement tool has been developed to monitor there is Registered Nurse coverage for 8 consecutive hours daily and it is reported correctly in PBJ. · How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A	

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	Staffing Information, was provided by the Regional Nurse Consultant and indicated the following: ".... Policy Interpretation and Implementation...11. Census data is reported each fiscal quarter and includes resident census on the last day of each month of the quarter...."		performance improvement tool has been initiated that audits (7) days weekly to ensure Registered Nurse coverage is scheduled as required and reported accurately in PBJ. This Quality Assurance Audit Tool will be completed by the Administrator/Designee 7 times weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting · By what date the systemic changes for the deficiency will be completed: 9/8/2023	