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	345531	A. BUILDING _____ B. WING _____	C 10/07/2021

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NC STATE VETERANS HOME - SALISBURY	1601 BRENNER AVE, BUILDNG #10 SALISBURY, NC 28145

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E 000	Initial Comments An unannounced recertification and complaint survey was conducted on 10/04/2021 through 10/07/2021. The facility was found in complaince with the requirement CFR 483.73. Emergency Preparedness. Event ID # 1TZ11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 10/04/2021 through 10/07/2021. Event ID # 1TZ111. One of one complaint allegations was substantiated and resulted in F 550 defiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		11/4/21

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

Electronically Signed | 10/25/2021

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to treat a resident in a dignified manner, when a Nursing Assistant made disrespectful comments to a resident when the resident requested assistance with being toileted for 1 of 1 resident reviewed for dignity (Resident#29). The findings included: Resident #29 was readmitted to the facility on 4/16/20 and the resident ' s cumulative diagnoses included dementia, generalized weakness, history of falls, depression, stroke, anxiety, abnormal posture, difficulty in walking, syncope (temporary loss in consciousness caused by a fall in blood pressure) and collapse. Review of Resident #29 ' s most recent Minimum Data Set (MDS) revealed an annual	F 550	F550 This plan of correction contitutes a written allegation of compliance. Preparation and Submission of the plan of correction does not constitute an admission or agreement by the provider of the truths of the conclusion alleged or the corrections of the conclusion set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirements under state and federal law. The facility failed to meet CFR 483.10(a)(1)(2)(b)(1)(2) resident rights/exercise rights by failing to treat a Resident #29 in a dignified manner. The corrective action for resident #29 is the nursing assistant was immediately suspended and at the conclusion of the	

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F 550	Continued From page 2 comprehensive assessment with an Assessment Reference Date (ARD) of 5/17/21. The resident was coded as having moderately impaired cognition. The resident was coded as having had no hallucinations or delusions, no behaviors, and the resident was coded as requiring extensive assistance of one person for several activities of daily living (ADLs) including bed mobility, transfer (such as transfer from the bed to the wheelchair, dressing, toileting, and personal hygiene. The resident was coded as being frequently incontinent (7 or more episodes of incontinence, but at least one episode of continent voiding for urine and 2 or more episodes of bowel incontinence, but at least one continent bowel movement). Which indicated the resident did have the cognitive and physical ability for some continence. A review was completed of a Care Area Assessment (CAA) form for Resident #29 regarding Urinary Incontinence and dated 6/19/21. Documented under analysis of findings was information regarding the resident having been frequently incontinent, was taking a diuretic medication (a medication which increases urinary output), was at risk for a urinary tract infection and skin breakdown and received incontinent care from the facility staff on a routine and as needed basis. The resident ' s need for assistance with incontinence care and toileting were to be addressed in the resident ' s care plan. A witness statement by Nurse #1, dated 7/5/21, documented she had overheard Resident #39 ask Nursing Assistant (NA) #1 to help him go to the bathroom. The NA responded to the resident, if you don ' t use the bathroom it ' s gonna be some issues because you been saying this all	F 550	investigation said nursing assistant was terminated. 100% education for all staff was conducted on Resident Rights, Dignity, and the Abuse Policy for all affected veterans and resident #29. Education to be completed by 10/25/2021. Administrator or designee will utilize questionnaire to interview staff on the Residents Rights and Abuse Policy; 10 staff members per week x 4 weeks, 5 staff members x 4 weeks, then 2 staff members per week x 4 weeks. At this time, the Quality Assurance Performance Improvement committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 550	Continued From page 3	F 550		

day. The resident replied he really had to go and that he was sorry. The NA was then heard to mumble under her breath, you ' re going to sit your "a**" in there.

Review of a facility submitted investigation dated 7/9/21 revealed on 7/5/21 at 3:00 PM Nursing Assistant (NA) #1 was allegedly arguing with Resident #29 in the hallway and stated, if you don ' t use the bathroom it ' s gonna be some issues because you been saying this all day. The NA then proceeded to say, under her breath, "Sit your ass in there." The NA was suspended on 7/5/21 and the outcome of the investigation was NA #1 was terminated on 7/9/21.

Resident #29 ' s care plan, which had been most recently updated on 9/8/21, contained several problem areas related to the resident ' s continence and ADLs including the resident required assistance with transfer from the wheelchair to the bathroom commode, at risk for falls related to impaired mobility thus requiring a sit to stand transfer technique, the resident was receiving laxative and diuretic medications, a history of urinary tract infections (UTIs), required extensive assistance with ADLs and an approach was to encourage the resident to participate in ADLs to his ability, do not rush the resident, allow extra time to complete ADLs, provide extensive assistance with ADLs as needed, and regarding behavioral symptoms the resident was to be approached warmly and positively. Additionally, the resident had a problem area for the category of psychosocial well-being and the approach included to provide a calm and safe environment to allow the resident to express feelings.

An interview was conducted on 10/6/21 at 2:19

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F 550	Continued From page 4 PM with Nurse #1. She stated Resident #29 had asked NA #1 about going to the bathroom and the NA responded if the resident did not use the bathroom there were going to be issued because the resident had been making requests all day about going to the bathroom. She further stated the NA had then made a comment, under her breath, but loud enough the nurse could hear it, about how the resident could sit his a** in there. She said she felt like it was loud enough where the resident could have heard it and she said she could tell the resident was a little upset about the comment. She said the NA assisted the resident to the bathroom and provided care for the resident. She said she reported the NA using a cuss word to the Director of Nursing and she did not see the NA after that. On 10/7/21 at 10:21 AM the administrator was interviewed, and she said NA #1 was suspended immediately on 7/5/21 after she had made the inappropriate comment and was terminated on 7/9/21 because she felt the NA had treated the resident with poor customer service, poor judgement, used inappropriate language directed toward a resident, and that was not how the residents were to be treated. She said Resident #29 was interviewed regarding the event, however, due to the resident ' s short-term memory loss, he was unable to recall the comments which the NA had made. She explained it was unacceptable to make comments such as what NA #1 had made and the comment was said loud enough for another employee to hear it, she felt was not treating the resident with dignity and respect.	F 550		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		11/4/21

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F 684	Continued From page 5 § 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. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident, staff and Physician Assistant interviews, the facility failed to provide weekly skin assessments for 1 of 1 sampled resident reviewed for non-pressure related skin conditions, which resulted in a delay in treatment for skin breakdown (Resident #44). The findings included: Resident #44 was admitted to the facility on 03/01/17 with diagnoses that included in part, heart failure, hypertension, hemiplegia, chronic obstructive lung disease, atrial fibrillation and non-Alzheimer's dementia. The care plan for Resident #44 initiated on 04/30/20 documented that he had care areas for assistance with Activities of Daily Living (ADL's), risk for skin breakdown related to venous insufficiency and impaired mobility. An intervention initiated on 04/30/20 included to conduct weekly skin inspections. The care plan was last updated on 09/10/21. No interventions for treatment of skin breakdown for his lower legs were noted.	F 684	F684 This plan of correction constitutes a written allegation of compliance. Preparation and Submission of the plan of correction does not constitute an admission or agreement by the provider of the truths of the conclusion alleged or the corrections of the conclusion set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirements under state and federal law. The facility failed to meet CFR 483.25 Quality of Care by failing to provide weekly skin assessments for Resident #44 which resulted in a delay in treatment for skin breakdown. For resident #44 a skin audit was completed on 10/5/21 by the wound care nurse. Treatment orders obtained from in house Physician Assistant on 10/6/21. 100% skin audits were completed by licensed staff on 10/6/21 with no new areas noted. Clinical Competency Coordinator to complete 100% education with all licensed staff regarding weekly	

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F 684	Continued From page 6 Record review indicated Resident #44 was hospitalized from 08/11/21-08/25/21 for fluid overload. Hospital records were reviewed from the 08/11/21-08/25/21 visit. The wound care consultation from 08/23/21 indicated Resident #44's skin had a chronic dry cobblestone appearance to both lower legs. Review of Resident #44's Quarterly Minimum Data Set (MDS) from 08/30/21 indicated he was cognitively intact. Nurse #6 completed a weekly skin assessment on 09/01/21 for Resident #44. It was noted the resident's legs had normal color and turgor and had no alterations in the skin. An additional comment was added that he had bilateral discoloration of upper and lower extremities. The weekly skin assessment was not documented on 09/08/21. An interview with Nurse #2 was conducted on 10/07/21 at 11:02 AM regarding the missing 9/08/21 skin assessment and the leg wounds on Resident #44. She stated he had scabs on his legs when he returned from the hospital. Nurse #2 said she had not completed the skin assessment on 09/08/21 and did not know why. She noted she usually did not work on Wednesdays and it probably just slipped her mind or she may have gotten busy. A skin assessment was documented on Resident #44 on 09/15/21 by Nurse #6. Documentation noted the legs to be normal in color, with normal skin turgor and no alterations in the skin.	F 684	skin observations and the procedure of how to notify the wound care team in the event of any new areas of concern. This education to be completed by 10/25/21. Director of Nursing or appointed designee will conduct an audit of 100% weekly skin observations x 3 weeks, 75% weekly skin observations x 2 weeks, 50% weekly skin observations x 2 weeks. At this time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Refer to attachment Skin Observations.	

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The weekly skin assessments were not documented on 09/22/21 or 09/29/21.

Attempts to reach the nurse that was assigned to Resident #44's skin assessment on 09/22/21 and 09/29/21 was unsuccessful.

An observation of Resident #44's lower legs was conducted on 10/04/21 at 2:21 PM. The skin on both lower legs was very swollen, with areas of redness and multiple areas of black scabs noted bilaterally.

An observation of Resident #44's legs was done on 10/05/21 at 2:21PM with Nurse #2. The legs were red and swollen with numerous scabbed areas noted on his right and left legs.

An interview with Resident #44 was done on 10/05/21 at 2:21 PM regarding the sores on his legs. He stated he had those scabs since he returned from the hospital in August.

Nurse #2 was interviewed on 10/05/21 at 2:25 PM regarding the skin breakdown on Resident #44's legs. She stated the numerous scabbed areas were noted on the right and left legs and had been there since he returned from the hospital in August. She said she had not notified anyone of the scabs.

Wound Nurse #1 was interviewed on 10/05/21 at 2:41 PM regarding Resident #44. She stated she did not see the resident for wound care, and she had no wound care orders for him. She noted the nurses on the unit were responsible for the weekly skin assessments and they would notify her if new orders were received or if assistance

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was needed. The wound nurse said normally they would follow the resident if the scabbed areas were reported but those had not been reported to her. The wound nurse stated she had only been here for 2 months, but she had done a chart review and saw that Resident #44 had scabs on his legs early in 2021, and they had completed dressing wraps every other day until they had healed.

Resident #44 was observed on 10/06/21 at 9:19 AM outside in the smoking area, dressed and clean, and in a motorized wheelchair. It was noted in the area below his shorts, both of his lower legs were very red and swollen with numerous scabs.

Nurse #6 was interviewed on 10/06/21 at 2:45 PM. She stated she had cared for Resident #44 today, and on 10/04/21 but she had not looked at his legs either day for skin breakdown. The nurse stated she last assessed his legs on 09/29/21 and she had not noticed the scabs on both lower legs at that time.

The Director of Nursing (DON) was interviewed on 10/06/21 at 1:48 PM regarding the missing skin assessments on Resident #44. She stated they identified the problem with the skin assessments not being completed yesterday and were working to correct it.

A follow-up interview was done on 10/06/21 at 11:29 AM with Wound Nurse #1. She stated she had looked at Resident #44's legs last night after our discussion and made a skin assessment note. She said the Physician Assistant (PA) was contacted and she was waiting on the PA to evaluate the numerous scabs noted on bilateral

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lower extremities.

An interview was done with the PA on 10/06/21 at 1:36 PM regarding Resident #44's skin breakdown on his legs. She stated she had assessed the resident today and ordered bilateral zinc based gauze wraps for the scabs from his venous insufficiency.

An observation was done on 10/06/21 at 2:32 PM of Wound Nurse #1 applying zinc based gauze wraps to both of Resident #44's lower legs. There were at least 10 small areas with scabs on his right lower leg, and 3 pencil eraser size scabs on his left lower leg.

A follow-up interview was done with Nurse #2 on 10/07/21 at 10:25 AM regarding Resident #44. Nurse #2 stated she had assessed his legs either Monday 10/4/21 or last week sometime, and she had noticed the scabs present on Monday 10/4/21. She said his legs had been scabbed over for several weeks. She said he was in the hospital a long time in August 2021 and there were no scabs on his legs before he went to the hospital.

The Physician Assistant (PA) was interviewed on 10/07/21 at 11:04 AM regarding Resident #44 wounds on his legs and skin concerns. She stated the nurses were to do weekly skin assessments and she would expect to be notified of the scabs. She said if the areas were not treated, it could lead to more wounds and they could have been better if she had been notified. She stated he had a history of swelling and scabs on his legs, and usually the zinc gauze wraps helped, as they compressed the fluid and helped with the healing.

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F 684	Continued From page 10 The Director of Nursing (DON) was interviewed on 10/06/21 at 3:07 PM regarding the weekly skin assessments not being completed, or orders for interventions for skin breakdown on Resident #44. She stated she had been aware of skin assessments not being completed previously. She stated she expected weekly skin assessments to be done and the Physician or PA to be notified of concerns. The Administrator was interviewed on 10/07/21 at 11:15 AM about the weekly skin assessments not being done and the wounds on Resident #44's legs not being treated. She stated weekly skin assessments needed to be done, and she would expect the physician or PA to be notified of the scabs or skin changes for proper interventions. She stated there was no Process Improvement Plan (PIP) in place for wound care at the facility.	F 684		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and	F 693		11/4/21

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F 693	Continued From page 11 §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to separate the tube feeding syringe components stored for use, which creates the potential for bacterial growth, for one of one resident reviewed for tube feeding (Resident # 21). Findings include: Resident # 21 was admitted to the facility on 04/23/2021 with multiple diagnoses that included dysphagia and gastrostomy. The Minimum Data Set (MDS) quarterly assessment dated 08/02/2021 indicated Resident # 21received a tube feeding, received 51% or more of his total calories via tube feeding and more than 501 cubic centimeters of fluid via tube feeding. An observation conducted on 10/04/2021 at 11:45 AM revealed an unsealed clear plastic bag hanging on a tube feeding administration pole at the bedside of Resident # 21. Inside the clear plastic bag, a syringe was observed with the plunger fully depressed into the barrel of the syringe. The syringe appeared dry and clear of any moisture. An observation conducted on 10/05/2021 at 9:40	F 693	F693 This plan of correction contitutes a written allegation of compliance. Preparation and Submission of the plan of correction does not constitute an admission or agreement by the provider of the truths of the conclusion alleged or the corrections of the conclusion set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirements under state and federal law. The facility failed to meet CFR 483.25(g)(4)(5) tube feeding management/restore eating skills by failing to separate the tube feeding syringe components stores for use, which creates the potential for bacterial growth for resident #21. For resident #21 tube feed syringe was replaced. An audit was completed on 10/7/2021 on all residents potentially affected by the deficient practice no concerns were identified. Clinical Competency Coordinator completed 100% education for all licensed staff completed on proper storage and dating of equipment, which included storing of the plunger and syringe being stored separately. All education to be completed	

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	345531	A. BUILDING _____ B. WING _____	C 10/07/2021

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F 693	Continued From page 12 AM of the tube feeding equipment the hung on the tube feeding pole at the bedside of Resident #21 revealed the tube feeding syringe plunger was observed fully depressed into the syringe barrel with visible droplets of clear moisture at the tip of the syringe. During an observation of the tube feeding equipment on the tube feeding pole at the bedside of Resident # 21 on 10/06/2021 at 8:42 AM revealed that the clear bag dated 10/06/2021 contained a syringe with the plunger fully depressed into the syringe barrel. No visible moisture droplets were observed in the syringe or inside the unsealed storage bag. On 10/06/2021 an interview and observation the tube feeding pole Nurse #5 in the room of Resident # 21. The nurse revealed that she did store the syringe used for the tube feeding with the plunger fully depressed inside the syringe barrel and that she made certain to rinse the syringe completely prior to replacing it with the syringe plunger depressed into the syringe barrel. The nurse revealed that she was not aware that the syringe components were to be stored with the plunger and syringe barrel separated after use to allow the components to dry. An interview conducted on 10/07/2021 at 8:6 AM an interview was conducted with the Director of Nurses (DON) and the nursing home administrator (NHA). The DON stated the expectation was that the nurse was to replace the tube feeding syringe every 24 hours and store the syringe plunger and syringe barrel in a new dated clear bag and that after the syringe was used that it was to be rinsed and the 2 components stored separately in the same bag. The NHA stated that	F 693	by 10/25/21. Audit initiated on 10/18/2021 by Director of Health Services and is ongoing. Director of Nursing or designee will implement: 100% audit completed daily x 2 weeks, 75% audit completed daily x 2 weeks, 50% audit completed x 2 weeks. At this time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 693	Continued From page 13 she expected all tube feeding supplies to be changed every 24 hours and stored exactly as the DON stated.	F 693		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention	F 732		11/4/21

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F 732	Continued From page 14 requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to provide actual hours worked by nursing staff for 7 of 7 days reviewed for accurate nurse staffing hours and failed to provide staffing information at the beginning of the shift for 1 of 4 survey days. Findings included: 1. A review of the posted daily nursing forms for 9/19/2021 to 9/25/2021 revealed the nurse staffing hours were incorrect for 7 of 7 days: a. On 9/19/2021 the 7:00 am to 3:00 pm shift had 56 hours recorded for the Nurse Aides, but the actual hours were 59.75. The 3:00 pm to 11:00 pm shift had 16 hours recorded for Registered Nurses, but the actual hours were 8 hours, 16 hours recorded for Licensed Practical Nurses, but the actual hours were 25 hours, and 49 hours for Nurse Aides but the actual hours were 45.5 hours. The 11:00 pm to 7:00 am had 49 hours record for the Nurse Aides but the actual hours were 45.5 hours. b. On 9/20/2021 the 3:00 pm to 11:00 pm shift had 8 hours recorded for the Registered Nurses, but the actual hours were 12 hours, 24 hours recorded for the Licensed Practical Nurses, but the actual hours were 20 hours, and 45.5 hours for the Nurse Aides but the actual hours were 45 hours.	F 732	F732 This plan of correction contitutes a written allegation of compliance. Preparation and Submission of the plan of correction does not constitute an admission or agreement by the provider of the truths of the conclusion alleged or the corrections of the conclusion set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirements under state and federal law. The facility failed to meet CFR 483.35(g)(1)-(4) posting nurse staffing information by failing to provide actual hours worked by nursing staff for 7 of 7 days reviewed for accurate nurse staffing hours and failed to provide staffing information at the beginning of the shift for 1 of 4 survey days. No residents were effected. This deficient practice had no potential to harm any veteran. All RN supervisors were inserviced on how to accurately calculate nursing hours. CCC will check daily for accuracy daily x 3weeks, daily x 2 weeks, daily x 1 week. At this time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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c. On 9/21/2021 the 11:00 pm to 7:00 am shift had 32 hours recorded for the Nurse Aides, but the actual hours were 37.5 hours.

d. On 9/22/2021 the 7:00 am to 3:00 pm shift had 8 hours recorded for the Registered Nurses and the actual hours were 16 hours. The 3:00 pm to 11:00 pm shift had 24 hours recorded for the Licensed Practical Nurses and the actual hours were 23 hours and had 45.5 hours for the Nurse Aides, but the actual hours were 44.5. The 11:00 pm to 7:00 am shift had no hours for the Registered Nurses, but the actual hours were 8 hours.

e. On 9/23/2021 the 7:00 am to 3:00 pm shift had 16 hours for the Registered Nurses, but the actual hours were 8 hours and 16 hours for the Licensed Practical Nurses, but the actual hours were 24 hours.

f. On 9/24/2021 the 7:00 am to 3:00 pm shift had 56 hours recorded for the Nurse Aides, but the actual hours were 52.5 hours. The 3:00 pm to 11:00 pm shift had 32 hours recorded for the Licensed Practical Nurses, but the actual hours were 30 hours, and the Nurse Aides was recorded as 54 hours, but the actual hours were 36.5. The 11:00 pm to 7:00 am shift had 40 hours recorded for Nurse Aides, but the actual hours were 37.5.

g. On 9/25/2021 the 7:00 am to 3:00 pm shift had 28 hours recorded for Nurse Aides, but the actual hours were 37.5 hours. The 3:00 pm to 11:00 pm shift had 8 hours for Registered Nurse, but the actual hours were 20 hours, the Licensed Practical Nurse was recorded as 29 hours, but the actual hours were 12 hours, and the Nurse

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Aide was recorded as 52.5 hours, but the actual hours were 41.5 hours.

2. An observation on 10/4/2021 at 9:15 am of the Posted Nurse Staffing form in the front lobby of the facility revealed there was no date or the facility's resident census at the top of the form and the staffing information for each shift was blank.

An interview was conducted with the Nursing Supervisor on 10/7/2021 at 9:55 am and she stated the Supervisor for each shift was responsible for entering the staffing information on the staffing form each shift. The Nursing Supervisor stated the Nurses work 8 hours shifts and the Nurse Aides worked 7.5 hours per shift. The Nursing Supervisor did not know why the daily staffing sheet was not filled out on 10/4/2021. She stated the supervisors are required to take a nursing assignment at times and she felt that made it difficult to keep up with who had called out and to have time to update the form.

During an interview with the Scheduler on 10/7/2021 at 10:07 am she stated she was only responsible for completing the Nursing Schedule and did not update the Nurse Staffing forms. The Scheduler stated the Nurse Staffing forms are updated by the Nursing Supervisors.

An interview with the Administrator on 10/7/2021 at 10:32 am revealed the Nursing Supervisors were responsible for filling out the Nurse Staffing form each shift and ensuring it was accurate. The Administrator stated the Staff Development Coordinator should check the accuracy of the Nurse Staffing form each day.

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F 732	Continued From page 17 The Staff Development Coordinator was interviewed on 10/7/2021 at 10:55 am and stated she did not check the Nurse Staffing forms for accuracy, but she did check to see that they have been done. She stated she had not been told to check them for accuracy.	F 732		