Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: _____ B. WING _____	R 04/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a Desk Review follow-up survey 4/09/20 and 4/13/20 to 4/16/20.	{D 000}	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in this statement of deficiencies or corrective actionreport; the Plan of Correction is prepared soley as a matter of compliance with state law.	
{D 270}	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION The Type A1 Violation was abated. Non-compliance continues. Based record reviews and interviews the facility failed to provide supervision for 2 of 4 sampled residents (Residents #1 and #2) experiencing frequent falls resulting in one resident sustaining a fractured pelvis (Resident #2) and one resident falling out of a wheelchair (Resident #1). The findings are: Review of the facility's Accident/Falls policy revealed: -When a staff finds a resident that had an accident/fall they are to send or call for help.	{D 270}	10A NCAC 13F. 0901 (b) Personal Care and Supervision All residents put on a 1hour supervision and accountability checklist. Resident Care Coordinator will review checklist daily for completion. Staff education will occur for Staff supervision and accountabilty checklist and Incident reporting by 4/24/2020 and ongoing. For any resident incident, the Increased supervision and accountability checklist will be increased to evry 30 minutes and the MD will be notified. We will re evaluate in 1 week for improvement/discontinuation of increased monitoring. For any second incidents, Increased supervision and accountability checklist will be increased to every 15 minutes for 1 week then reviewed for improvement/discontinuation. For any falls, a Fall risk assessment tool wil be completed. If 2 falls in a 4 week period occur, a therapy referral will be requested unless otherwise warranted.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sherry Jackson — TITLE: Executive Director — (X6) DATE: 5/12/2020

Reviewed and accepted 05/15/20 KHH

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{D 270}	Continued From page 1 -Staff were to evaluate the situation, call 911, and assess the resident. -If injury or accident was greater than first aid staff are to complete an Accident and Incident Report form within 48 hours. -Call/notify the resident's physician and responsible party. 1. Review of Resident #2's current FL2 dated 04/03/20 revealed: -Diagnoses included lewy body dementia, hyperlipidemia, degenerative joint disease. -Resident #2 was intermittently disoriented and was ambulatory with a walker. Review of Resident #2's Care Plan dated 11/05/19 revealed: -Resident #2 was sometimes disoriented, forgetful and needed reminders. -Resident #2 required extensive assistance with toileting, ambulation, bathing, dressing and grooming. -Resident #2 required limited assistance with eating and transferring. Review of Resident #2's Progress Note dated 01/31/20 revealed Resident #2 was found by a personal care aide (PCA) sitting on the floor. The resident was sent to the hospital. Review of Resident #2's Accident/Incident report dated 01/31/20 at 2:23am revealed a PCA found Resident #2 sitting on the floor beside her bed. The resident had lower leg injury. Review of the 01/31/20 hospital discharge summary report revealed Resident #2 had a fall that resulted in a pelvic fracture. Telephone interview with the PCA on 04/16/20 at	{D 270}		

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{D 270}	Continued From page 2 8:43am revealed: -She worked the third shift on 01/31/20, and when doing her rounds, she found Resident #2 on the floor. -She was not sure how Resident #2 ended-up on the floor. -Just before Christmas she noticed that Resident #2 had started to decline. -The resident was no longer able to do anything for herself. -She had to help Resident #2 get in and out of bed into her wheelchair. -Resident #2 no longer walked so she had to transfer the resident. -She checked on Resident #2 every thirty-minutes. -This was the first time Resident #2 fell on her shift. -She was not aware of other falls. -If she was walking the hall, she checked on Resident #2 more frequently than thirty-minutes. -The end of last year the Memory Care Unit Coordinator (MCUC) instructed staff to check Resident #2 every thirty-minutes because the resident's health had started to decline. -Before Christmas 2019, Resident #2 was able to stand and assist staff with dressing and toileting her. -Now staff had to do everything for Resident #2. -Resident #2 was total care because staff did everything for her. -Resident #2 had to be assisted from the bed to her wheelchair. -The resident was also assisted from the wheelchair to the toilet. -She was aware Resident #2 had another fall two to three weeks ago and was sent to the hospital. Telephone interview on 04/15/20 at 4:23pm with the MCUC revealed:	{D 270}		

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{D 270}	Continued From page 3 -A few days after the 01/31/20 fall Resident #2 was put on thirty-minute supervision checks. -The thirty-minute supervision checks required staff to check on Resident #2 every thirty-minutes. -When staff checked the resident, they were to ask her if she needed anything. -The facility's policy for toileting was every two hours. -The thirty-minute supervision checks were just for staff to lay eyes on the resident. -Resident #2 was also ordered physical therapy in February 2020 (unable to recall the exact date). -It was the facility's policy after a fall to monitor a resident's vital signs for 72 hours. -After the fall on 01/31/20 the electronic medical administration record (eMAR) should have documentation the resident vital were checked as part of the facility's fall protocol. Review of the January 2020 eMAR revealed there was no documentation Resident #2's vital signs were checked for 72 hours after the fall. Review of Resident #2's Progress Note dated 02/04/20 revealed Resident #2 was found sitting on the floor. The resident complained of toe pain but refused to go to the hospital. Review of Resident #2's Accident/Incident report dated 02/04/20 at 7:40am revealed Resident #2 was observed sitting on the floor on her bottom. Review of the facility's Increased Supervision and Accountability monitoring sheets revealed there was documentation Resident #2 was checked every thirty-minutes from 02/03/20 through 02/29/20. Review of the February 2020 eMAR revealed	{D 270}		

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{D 270}	Continued From page 4 there were documented vital sign checks from 02/04/20 through 02/07/20. Telephone interview on 04/15/20 at 4:23pm with the MCUC revealed: -On 02/04/20 the medication aide (MA) called her to come to Resident #2's room. -She witnessed Resident #2 sitting on the floor. -The resident complained of pain in her toe (unable to recall what toe). -Resident #2 refused to go out to the hospital. -A couple days after the fall on 01/31/20 she put in place thirty-minute checks. -No changes were made after the fall on 02/04/20. -Staff continued thirty-minute supervision checks. -Physical therapy started in February (unable to recall the exact date). -She was not sure if the resident was still getting physical therapy because all outside visitors had been stopped from entering the facility. Review of Resident #2's Progress Note dated 03/09/20 revealed Resident #2 was found on the floor and was sent to the hospital. Review of Resident #2's Accident/Incident report dated 03/09/20 at 8:53pm revealed the MA found the resident sitting on her buttocks on the floor beside her bed. Review of the 03/09/20 hospital discharge summary report revealed Resident #2 had a fall with no injuries noted. Review of the facility's March 2020 Increased Supervision and Accountability monitoring sheets revealed there was documentation Resident #2 was checked on every thirty-minutes from 03/01/20 through 03/31/20.	{D 270}		

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{D 270}	Continued From page 5 Review of Resident #2's March 2020 eMAR revealed there was no documentation Resident #2's vital signs were checked for 72 hours after the fall on 03/09/20. Telephone interview with the MA on 04/15/20 at 4:45pm revealed: -On 03/09/20, she worked the second shift. -It was 9:00pm or 10:00pm she was walking down the hall of the special care unit (SCU) and she observed Resident #2 in a sitting position on the floor. -Resident #2 was unable to tell her how she got on the floor. -She took the resident's vital signs and assessed the resident for injuries. -She called emergency medical responders and they helped Resident #2 off the floor. -Resident #2 was sent out to the hospital and returned the same night before midnight. -The hospital did not note any injuries. -Resident #2 was already on monitoring and supervision checks every thirty-minutes. -The thirty-minute supervision checks required PCAs to check and observe Resident #2 at least every thirty-minutes. -The MAs sometimes did the thirty-minute checks, but they were mostly completed by the PCAs. -The MCUC was assigned the thirty-minute checks. -The MCUC was the only person that could increase or decrease the thirty-minute checks. -Resident #2 had not been placed on checks less than every thirty-minutes. -In March (unable to recall the exact date) Resident #2 was moved to a room that was closer to the nurse's station.	{D 270}		

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{D 270}	Continued From page 6 Telephone interview with the MCUC on 04/15/20 at 4:23pm revealed: -In March 2020 (unable to recall exact date), but thought it was after the second fall in March 2020 Resident #2 was moved closer to the nurse's station. -It was the facility's protocol after a fall to monitor the resident's vital signs for 72 hours. -This should have been noted on the electronic medical administration record (eMAR). Review of Resident #2's Progress Note dated 03/23/20 at 11:04am revealed: -Resident #2 was observed lying on the floor by her bed. -The resident was holding her head. -The resident stated she fell and hit her head. -A bump was observed on the resident's head. -Resident #2 was sent to the hospital for an evaluation. Review of Resident #2's Accident/Incident report dated 03/23/20 at 7:15am revealed a PCA found Resident #2 lying on the floor holding the front of her head. Review of the 03/23/20 hospital discharge summary report revealed Resident #2's initial encounter was a fall. There were no injuries noted. Review of the facility's March 2020 Increased Supervision and Accountability monitoring sheets revealed there was documentation the resident was checked on every thirty-minutes from 03/01/20 through 03/31/20. Review of Resident #2's March 2020 eMAR revealed there was documentation Resident #2's vital signs were checked for 72 hours after the fall	{D 270}		

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{D 270}	Continued From page 7 on 03/23/20. Telephone interview with the PCA on 04/16/20 at 9:04am revealed: -When doing rounds at the beginning of her shift (after 7:00am) on 03/23/20 she found Resident #2 on the floor. -Resident #2 was holding her head. -She called the MA from the third shift to come and assist the resident. -Staff got Resident #2 off the floor and called emergency responders. -She usually worked the first shift and checked Resident #2 every thirty-minutes. -Resident #2 returned from the hospital the same day. -No instructions had been given to supervise Resident #2 more frequently than every thirty-minutes. -The MCUC had to tell staff to increase monitoring but that had not been done. Telephone interview on 04/15/20 at 4:23pm with the MCUC revealed: -After the fall on 03/23/20 Resident #2 continued being checked every thirty-minutes. -She had not considered increasing the checks. -She had not consulted with the Primary Care Provider (PCP) regarding other alternatives to keep the resident from falling. -After this fall the resident was moved closer to the nurse's station. -After the fall on 03/23/20 Resident #2 continued being checked every thirty-minutes. Review of Resident #2's Progress Note dated 04/08/20 at 3:48pm revealed: -A PCA observed Resident #2 on the floor beside her bed. -There was notation on the progress note the	{D 270}		

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{D 270}	Continued From page 8 actual date of the incident was 04/05/20 at 11:34pm. Review of Resident #2's Accident/Incident report dated 04/05/20 at 11:34pm revealed Resident #2 had a fall. Review of the facility's April 2020 Increased Supervision and Accountability monitoring sheets revealed there was documentation Resident #2 was checked every thirty-minutes from 04/01/20 through 04/05/20. Telephone interview on 04/15/20 at 4:23pm with the MCUC revealed: -On 04/08/20 a PCA reported to her Resident #2 was found on the floor. -The PCA reported the incident to her and she completed the incident report on 04/08/20 because the incident occurred on 04/05/20 which was a weekend. -After the fall on 04/05/20 no changes related to supervision of the resident were implemented. -Other than moving the resident closer to the nurse's station and thirty-minute supervision checks no other alternatives had been considered to prevent falls. -She had not considered increasing the supervision checks. -She had not consulted with the PCP regarding other alternatives to keep the resident from falling. -She was aware the PCP had ordered hospice three weeks ago for Resident #2. -She thought hospice would be able to assist with Resident #2's falls. -As of today's, date (04/15/20), hospice had not picked up Resident #2 as a client. -She had not considered systems to put in place until hospice got involved.	{D 270}		

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{D 270}	Continued From page 9 Telephone interview a physical therapist from the contracted Physical/Occupational therapy office on 04/16/20 at 10:12am revealed: -Resident #2 was picked up for Physical Therapy (PT) and Occupational Therapy (OT) in February 2020. -Resident #2 required maximum verbal cues due to cognitive deficit. -The resident exhibited limited activity tolerance due to cognitive deficit. -Resident #2 had dementia and required supervision to ensure safety with all ambulation due to fall risk. -Due to the resident's cognitive deficit she was unable to retain, recall and verbalize progress. -Resident #2 was discharged from PT on 03/25/20 and OT on 03/30/20. Telephone interview with Resident #2's PCP on 04/16/20 at 12:36pm revealed: -She was aware that Resident #2 had frequent falls. -Initially, she thought PT would help Resident #2 but due to the resident's diagnosis of dementia she could not retain anything taught by PT. -Due to the resident's dementia and age she was concerned the falls would happen more frequently. -After the resident's fall on 03/23/20 she ordered hospice in hopes they would provide systems to assist the facility with the resident's falls. -She was not aware that Resident #2 had a fall on 04/05/20. -She had not considered or consulted with the facility regarding what measures to put in place until hospice picked up the resident. Attempted telephone interviews on 04/14/20 at 1:19pm, 04/14/20 at 3:32pm, 04/15/20 at	{D 270}		

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{D 270}	Continued From page 10 11:54am, 04/16/20 at 10:15am, and 04/16/20 at 11:13am with Resident #2's family member was unsuccessful. Refer to telephone interview with the Memory Care Unit Coordinator (MCUC) on 04/16/20 at 9:43am. 2. Review of Resident #1's current FL2 dated 04/03/20 revealed: -Diagnoses included dementia, hypothyroidism, insomnia, allergic rhinitis, and major depressive disorder. -Resident #1 was constantly disoriented. -Resident #1 was non-ambulatory. Review of Resident #1's Care Plan dated 03/31/20 revealed: -Resident #1 had a wheelchair. -Resident #1 was totally dependent on staff for ambulation and needed extensive assistance with ambulation. -Resident #1 was always disoriented, had significant memory loss, and had to be directed. Review of Resident #1's Licensed Health Professional Support (LHPS) dated 04/03/20 revealed: -Resident #1 required 2 staff to assist with transfers. -Resident #1 required staff to push her wheelchair. Review of Resident #1's physician's orders dated 03/17/20 revealed an order for physical therapy (PT)/occupational therapy (OT) to evaluate and treat due to instances of sliding out of her wheelchair. Review of Resident #1's physician's orders dated	{D 270}		

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{D 270}	Continued From page 11 03/17/20 revealed an order to discontinue the PT/OT evaluation order due to Resident #1 receiving hospice services. Review of Resident #1's Resident Progress Notes dated 03/06/20 revealed: -A medication aide (MA) entered Resident #1's room to administer medication and found Resident #1 on the floor in front of her wheelchair shaking. -Resident #1 complained of pain in her neck and back. -Resident #1 was transported by emergency medical services (EMS) to a local hospital for evaluation. -There was no documentation of any increased supervision to be provided to Resident #1 to reduce falls. Review of an Incident and Accident Report for Resident #1 dated 03/06/20 revealed: -Resident #1 had an unwitnessed event in her room. -Resident #1 had no noted injuries. -Resident #1 was found on the floor shaking in front of her wheelchair and complained of pain. -Resident #1 was transported to a local hospital via EMS. -Resident #1's physician and responsible party were notified. -There was no documentation of any increased supervision provided to Resident #1 after her fall on 03/06/20. Review of Resident #1's hospital After Visit Summary dated 03/06/20 revealed: -Resident #1 was seen in the hospital emergency room due to a fall. -The diagnosis was a fall. -There were no injuries noted.	{D 270}		

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{D 270}	Continued From page 12 Review of a Mood/Behavior Monitoring and Communication form for Resident #1 revealed: -On 03/06/20, Resident #1's identified behavior was attempting to get out of her chair/bed. -The intervention was direct staff interaction. -Resident #1's behavior decreased after the intervention. -Resident #1 was moved closer to the nurse's station. Attempted telephone interview on 04/16/20 at 9:15am with the MA who documented the Resident Progress Note and Incident Accident Report dated 03/06/20 was unsuccessful. Review of Resident #1's Progress Notes dated 03/12/20 revealed: -Resident #1 slid out of her wheelchair onto the floor. -There was no documentation of any increased supervision provided to Resident #1 after her fall on 03/12/20. Review of the Incident and Accident Report for Resident #1 dated 03/12/20 revealed: -Resident #1 had an unwitnessed event and was found on the floor in her bedroom. -No injuries were noted and Resident #1 did not complain of pain. -Resident #1 was not sent out to the emergency room. -Resident #1's physician and responsible party were notified. -There was no documentation of any increased supervision provided to Resident #1 after her fall on 03/12/20. Review of a Mood/Behavior Monitoring and Communication form for Resident #1 revealed:	{D 270}		

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{D 270}	Continued From page 13	{D 270}		

-On 03/12/20, Resident #1's identified behavior was attempting to get out of her chair/bed.
-The intervention was direct staff interaction.
-Resident #1's behavior decreased after the intervention.
-Resident #1's physician and hospice provider were notified.

Telephone interview on 04/16/20 at 4:45pm with the MA who documented the Resident Progress Note and the Incident Accident Report dated 03/12/20 revealed:
-She did not observe Resident #1 when she slid out of her chair on 03/12/20.
-Resident #1 did not have any noted injuries and was not sent out to a local hospital.
-Staff was having a problem with Resident #1 sliding out of her wheelchair after she received her new wheelchair.
-Resident #1 sat a little higher in her new wheelchair than she did in the old wheelchair and slid out of her chair when she tried to touch her feet to the floor.
-The wheelchair leg rails were placed on the wheelchair to keep Resident #1 from sliding out. (She did not state when the leg rails were placed on the wheelchair.)
-She thought Resident #1 was placed on 30-minute checks after her fall on 03/12/20.
-The memory care unit coordinator (MCUC) was responsible for determining when a resident was placed on 30-minute checks and how long residents remained on 30-minute checks.

Review of Resident #1's Progress Notes dated 03/16/20 revealed:
-Resident #1 slid out of her wheelchair twice on 03/16/20.
-Resident #1 was added to the increased supervision checklist for 30-minute checks due to

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	HAL034093	A. BUILDING: _____ B. WING _____	R 04/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

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{D 270}	Continued From page 14 Resident #1 having an increase in sliding out of her wheelchair and being observed on the floor in the past week. -Thirty-minute checks were to start on second shift on 03/16/20 and would be ongoing. Review of the Incident and Accident Report for Resident #1 dated 03/16/20 at 4:30pm revealed: -Resident #1 had an unwitnessed event and was found in the hallway. -Resident #1 was observed on the floor after sliding from her chair. -No injuries were noted and Resident #1 did not complain of pain. -Resident #1 was not sent out to the emergency room. -Resident #1's physician and responsible party were notified. -There was no documentation of any increased supervision provided to Resident #1 after her fall on 03/16/20 at 4:30pm. Review of the Incident and Accident Report for Resident #1 dated 03/16/20 at 6:50pm revealed: -Resident #1 had an unwitnessed event in the day room. -Resident #1 slid out of her wheelchair onto the floor. -There were no noted injuries and Resident #1 did not complain of pain. -Resident #1 was not sent out to the emergency room. -Resident #1's physician and responsible party were notified. -There was no documentation of any increased supervision provided to Resident #1 after her fall on 03/16/20 at 4:30pm. Review of a Mood/Behavior Monitoring and Communication form for Resident #1 revealed:	{D 270}		

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{D 270}	Continued From page 15 -There was one entry on 03/16/20 at 4:00pm which documented Resident #1's identified behavior as wheeling around in chair. -The intervention was direct staff interaction. -Resident #1's behavior decreased after the intervention. -Resident #1's hospice provider was made aware. Telephone interview on 04/16/20 at 4:45pm with the MA who completed the Resident Progress Note and Incident Accident Reports dated 03/16/20 at 4:30pm and 03/16/20 at 6:50pm revealed: -She remembered Resident #1 sliding out of her wheelchair twice on 03/16/20. -Resident #1 did not have any injuries after either fall. -After her falls on 03/16/20, staff made sure Resident #1 was visible, placed leg rests in different positions, and placed Resident #1 on 30-minute checks. Review of the Increased Supervision and Accountability Checklist for Resident #1 revealed: -On 03/16/20, staff documented supervision of Resident #1 every 30 minutes from 7:00am until 6:00am. (According to Incident Accident Reports Resident #1's falls were documented as taking place at 4:30pm and 6:50pm on 03/16/20; The Progress Notes dated 03/16/20 documented the increased supervision checklist would begin on 03/16/20 on second shift.) -On 03/17/20 through 04/08/20, staff documented supervision of Resident #1 every 30 minutes from 7:00am until 6:30am. Telephone interview with Resident #1's hospice nurse on 04/15/20 at 12:10pm revealed: -Staff had contacted her regarding Resident #1's	{D 270}		

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{D 270}	Continued From page 16	{D 270}		

falls.
-She visited with Resident #1 on today, 04/15/20.
-When she visited, Resident #1 was usually in common areas where staff could see her.
-Resident #1 had received a new wheelchair through hospice services.
-She thought the facility had ordered PT for Resident #1 for truncal support.

Telephone interview with Resident #1's Responsible Party on 04/15/20 at 12:15pm revealed:
-Staff contacted him when Resident #1 slid out of her wheelchair.
-He did not know why Resident #1 was sliding out of her wheelchair.
-Resident #1 needed assistance with getting in and out of her wheelchair and her bed.
-Staff had not reported any injuries and he had not observed any injuries or bruising during his visits with Resident #1.
-He saw Resident #1 through a window at the facility on 04/14/20 and "she looked good."

Telephone interview with the MCUC on 04/15/20 at 4:20pm revealed:
-Resident #1 slid out of her wheelchair on 03/06/20, 03/12/20, and she had 2 falls on 03/16/20.
-After Resident #1 fell on 03/06/20, Resident #1 was moved into a room close to the nurse's station.
-After Resident #1 fell on 03/12/20, Resident #1 was moved back to her old room to see if her falls would decrease because staff thought she may have gotten confused about being in a new room.
-After Resident #1 fell on 03/12/20, staff checked on her every 30 minutes and laid her down between meals.
-Resident #1's received a new wheelchair on

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{D 270}	Continued From page 17 02/28/20 and Resident #1's feet were slightly off the ground in a seated position allowing Resident #1 to attempt to stand up. -She thought Resident #1's hospice provider was supposed to get Resident #1 a new wheelchair, but she thought they were unable to. -There was an order for PT for Resident #1, but it was discontinued due to her being on hospice services. Telephone interview with the Resident #1's physician on 04/16/20 at 12:23pm revealed: -She knew Resident #1 had increased falls. -She expected staff to notify her regarding falls, determine what caused the fall, and send residents out to the local hospital if they hit their head. -Resident #1's wheelchair could have contributed to her increase in falls along with a decline in health. -She did not know if staff could provide 30 or 15-minute checks for Resident #1 Refer to telephone interview with the MCUC on 04/16/20 at 9:43am. Telephone interview with the MCUC on 04/16/20 at 9:43am revealed: -When a resident had a fall, they were placed on 30-minute checks for a month and a half. -If a resident continued to have falls, the resident's 30-minute checks continued for another month. -She had never increased the frequency of safety checks for residents with multiple falls to every 15-minutes. -Before initiating or increasing supervision checks, she consulted with the resident care director to determine who needed to be placed on 30-minute checks and how long they should stay	{D 270}		

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{D 270}	Continued From page 18 on 30-minute checks.	{D 270}		

Petty Cash Receipt Sheet

Date _____ Time _____

Staff Receiving Money _____ Signature _____

Amount Given _____ Change _____

Department _____ Item Purchased _____

Attach Receipt

Petty Cash Receipt Sheet

Date _____ Time _____

Staff Receiving Money _____ Signature _____

Amount Given _____ Change _____

Department _____ Item Purchased _____

Attach Receipt