STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255097	A. BUILDING _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CENTER OF ABERDEEN	505 JACKSON ST ABERDEEN, MS 39730

(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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency conducted an annual recertification survey with a complaint investigation (CI) MS #23250 at the facility from 11/13/23 through 11/16/23. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA cited F561 related to resident rights, F644 related to coordination of Pre-Admission Screening (PASARR), F689 free of accident and hazards, and F851 related to inaccurate Payroll Base Journal submission. The facility was in compliance related to CI MS #23250 for resident neglect and no citations related to the complaint were cited. The census at the time of the survey was 91, and the facility held a license for 120 beds.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the	F 561		1/1/24

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

Electronically Signed | 12/04/2023

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F 561	Continued From page 1 facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review and facility policy review, the facility failed to honor a resident's choice to smoke cigarettes for one (1) of 17 smokers residing in the facility. Resident #45. Findings Include: Record review of the facility policy titled "Resident's Rights Policy" with a revision date of 11/23 revealed, "Every resident in this facility has the right to: ... 22. Use tobacco in accordance with applicable policies, rules, and laws..." An observation with interview on 11/13/23 at 3:30 PM, with Resident # 45, revealed him standing in the day room waiting to go outdoors to smoke. The resident revealed that the facility was punishing him because he was caught smoking in his bathroom. He stated they took his cigarettes away as punishment, and he was only allowed to use a vape pen. An interview with Resident # 45 on 11/14/23 at 8:35 AM revealed he was caught by staff smoking	F 561	On November 16, 2023 Director of Nursing (DON) performed a smoking assessment on resident #45 along with a Quality Assurance meeting to determine that resident #45 would resume smoking tobacco cigarettes under supervision. On November 16, 2023 the Medical Director provided an order for resident #45 to smoke tobacco cigarettes under supervision. November 16, 2023 resident #45 continued going outside but transitioned from a vapor cigarette to tobacco cigarettes per this resident's choice. The care plans for resident #45 was updated by DON on November 16, 2023 to reflect this resident's choice to smoke tobacco cigarettes. On November 27, 2023 the DON and Assessment Nurse performed smoking assessments on all smokers to evaluate current safety and preferences. All residents that smoke have the potential to be affected by this deficient practice. On November 16, 2023 facility initiated an emergency QA meeting to review all residents that smoke and	

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F 561	Continued From page 2 in his room. He stated, "I feel it's a punishment to take my cigarettes away." The resident stated, "You just don't know how hard it is to smoke all your life and then be told you can't." The resident voiced he desired to smoke, and he had told multiple staff members, but they will not allow it. An observation on 11/14/23 at 1:30 PM of the supervised scheduled smoke break revealed Resident #45 was provided a vape pen while all other residents were allowed to smoke cigarettes. An interview on 11/14/23 at 1:58 PM with the Director of Nursing (DON) revealed that Resident #45's smoking privileges had been taken away because he refused to follow the facilities rules related to the smoking policy. She stated that he was caught with cigarette butts and a lighter in his room on 7/14/23 and later was caught smoking in his room on 8/14/23. The DON revealed that Resident # 45 was told at that time that he could no longer smoke, since he could not follow the facility policy for smoking. She revealed that he was offered a nicotine patch, which he refused. She revealed the facility also offered to transfer him to another facility, but he wished to stay. The DON revealed she spoke with the resident on multiple occasions and explained that he could no longer smoke cigarettes due to not following the rules. She stated the facility decided the vape pen was the best option and to her knowledge he had been okay with not smoking. An interview with Resident #45 on 11/15/23 at 2:40 PM revealed it was not fair to allow other residents to smoke but not him. He revealed that the Director of Nursing (DON) told him he could work toward regaining his smoking privileges back, and he had done everything they had asked	F 561	have the potential to be affected by this deficient practice. On November 16, 2023 an in-service was initiated with staff members on the Smoking Policy and supporting Residents' choice. Beginning November 16, 2023 Nurse Case Manager and or Assessment Nurse will assess all smokers on admission, weekly for four-weeks, then monthly for three months and then quarterly to ensure all residents safety and their choice is reflected in the Smoking Assessment. The Nurse Care Manager and or Assessment Nurse will audit weekly for four weeks, then monthly for three months , and then quarterly thereafter to ensure that Smoking Assessments are performed and residents choice is honored . December 3, 2023, the Administrator or DON will report any concerns from the Plan of Correction to the Department Head Meetings weekly for four weeks and then monthly for three-months, then quarterly until substantial compliance is achieved with F561. The Quality Assurance Committee will begin meeting on December 18,2023 monthly for three -months and quarterly until substantial compliance is achieved with F561. If any concerns are identified with the current corrective action plan the Quality Assurance Committee will meet immediately and revise the corrective action plan as needed.	

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F 561	Continued From page 3	F 561		

and still could not smoke. He revealed that the DON suggested he use the vape pen, but that had not curbed his need to smoke cigarettes.

An interview with the Administrator (ADM) on 11/15/23 at 4:35 PM revealed they are a smoking facility and confirmed that Resident #45 was admitted to the facility as a smoker. The ADM confirmed that they had not tried any other interventions apart from revoking the resident's smoking privileges.

An interview on 11/16/23 at 8:03 AM with the Director of Nursing (DON) confirmed the facility had not done everything they could to honor Resident # 45's right to smoke cigarettes.

Record review of the Departmental Notes for Resident # 45 dated 8/14/23 revealed, "Resident has not followed the policy for smoking and will not be allowed to smoke..."

Record review of the Departmental Notes for Resident # 45 dated 9/20/23 revealed, "Resident has been asking frequently to go out to smoke. He cannot smoke due to not following the policy..."

Record review of the Face Sheet revealed Resident # 45 was admitted to the facility on 2/26/20 with medical diagnosis that included Heart Failure, Bipolar Disorder, Major Depressive Disorder, Chronic Obstructive Pulmonary Disease, and Anxiety Disorder.

Record review of the Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/05/23 revealed under Section C, a Brief Interview for Mental Status

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F 561	Continued From page 4 (BIMS) score of 15, which indicates Resident #45 was cognitively intact.	F 561		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review and facility policy review, the facility failed to submit a change in status referral for a level 2 PASRR (Pre-admission Screening and Resident Review) on a resident with a new mental diagnosis, new antipsychotic medication, and an inpatient psychiatric stay for one (1) of three (3) PASRRs reviewed. Resident #24. Findings include: Review of the Facility Policy "Pre-Admission	F 644	On November 30,2023 Social Services submitted a Level two Change in Status form for resident #24. On November 16,2023 Social Services and Interdisciplinary Team reviewed current census to identify any resident that needed a change in status referral for a level two Pre-Admission Screening and Resident Review (PASRR) Change in Status form based on new mental diagnosis, new anti-psychotic medication or inpatient psychiatric stay. All residents	1/1/24

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F 644	Continued From page 5 Screening PAS/PASRR (Pre-admission Screening/Pre-admission Screening and Resident Review)" with latest revision date of 09/23, revealed " ...A change in status referral for Level II Resident Review Evaluations Is Also Required for Individuals Who May Not Have Previously Been Identified by PASRR to Have Mental Illness, Intellectual Disability/Developmental Disability, or a Related Condition in the Following Circumstances: ... *A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a diagnosis of mental illness as defined under 42CFR (Code of Federal Regulations) 483.100 (where dementia is not the primary diagnosis). * A resident whose intellectual disability as defined under 42 CFR 483.100, or related condition as defined under 42 CFR 435.1010 was not previously identified and evaluated through PASRR. * A resident transferred, admitted, or readmitted to a NF (Nursing Facility) following an inpatient psychiatric stay or equally intensive treatment ..." Record review of Resident #24's "Diagnosis" list revealed a diagnosis of "Major depressive disorder, recurrent, severe with psychotic symptoms" with an onset date of 06/28/2022. Record review of "Physician Order List" of Resident #24 revealed an order dated 06/14/2022, "Evaluate and admit to Behavioral Health as indicated" and an order dated 06/28/2022, "Risperidone 0.5 mg tablet by mouth @ (at) bedtime". Record review of Resident #24's November 2023 Physician Orders revealed orders dated 06/28/22, "Bupropion HCL XL 150 mg tablet by mouth daily"	F 644	with a new mental diagnosis, new anti-psychotic medication or inpatient psychiatric stay have the potential to be affected by this deficient practice. On November 16,2023, Social Services and Admissions Coordinator was in-serviced by Quality Improvement Nurse on policy and procedure for Pre-Admission Screening PAR/PASRR. Beginning on November 27, 2023 Social Services or Admissions Coordinator will review current census in weekly Department Head Meeting to identity residents that need a change in status referral for a level two PASRR Change in Status form based on new mental diagnosis, new anti-psychotic medication or inpatient psychiatric stay. On December 4,2024 the Administrator or DON will report any concerns from the Plan of Correction to the Department Head Meeting weekly for four weeks and then monthly for three months and then quarterly until substantial compliance is achieved with F644. The Quality Assurance Committee will begin meeting on December 18,2023 monthly for three -months and quarterly until substantial compliance is achieved with F644. Social Services or Admissions Coordinator will perform weekly audits to ensure all change of status forms are submitted once weekly for one-month, monthly for three-months and quarterly thereafter. If any concerns are identified with the current corrective action plan the Quality Assurance Committee will meet immediately and revise the corrective action plan as needed.	

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F 644	Continued From page 6	F 644		

and "Cymbalta 60 mg capsule by mouth twice daily".

On 11/14/23 at 2:25 PM, an interview with Social Services, revealed that she was responsible for completing the "Level II Change in Status Request" forms and submitting them to (Proper Name for state designated authority) for any resident who went out to inpatient behavioral health and then (Proper Name for state designated authority) would let them know if it triggered for a Level 2 PASRR. She revealed that she failed to submit the status change information on Resident #24.

On 11/14/23 at 2:40 PM, an interview with Administrator confirmed that Resident #24 had a new diagnosis of Depression with Psychosis, had been to behavioral health and that the Status Change Form should have been submitted. The Administrator revealed that after this information was submitted, (Proper Name for the state designated authority) would have gotten back to the facility for further recommendations for services needed.

On 11/15/23 at 10:10 AM, an interview with Director of Nursing (DON) revealed that when a resident was sent out for behavioral health, a change of status form should be filled out and submitted. She revealed that this form should also be submitted if a resident had an order for a new or changed antipsychotic medication. The DON confirmed that Resident #24 had been sent out to behavioral health and came back with antipsychotic medications ordered and there had not been a change in status form submitted.

Record review of Resident #24's Face Sheet

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F 644	Continued From page 7 revealed an admission date of 03/22/21 with diagnoses including Metabolic Encephalopathy, and Major Depressive Disorder, recurrent, Severe with Psychiatric Symptoms. Record review of Resident #24's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 08/22/23 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.	F 644		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review and facility policy review, the facility failed to provide adequate supervision during smoke breaks to prevent residents from obtaining smoking paraphernalia and to maintain resident safety during smoke breaks for one (1) of 15 residents who smoke. Resident #45. Findings Include: Record review of the facility policy titled "Smoking Policies and Regulations" with a revision date of 10/22 revealed, "...Cigarette lighters and	F 689	n November 16,2023 Social Services and DON interviewed each resident that smokes and obtained verbal consent to search room for any smoking paraphernalia including resident #45. All residents that smoke have the potential to be affected by this deficient practice. On November 16, 2023 facility initiated an emergency QA meeting to review all residents that smoke and have the potential to be affected by this deficient practice. On November 16,2023 facility In-service initiated with staff to educate on the following: container designated to	1/1/24

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F 689	Continued From page 8 matches are not permitted in a resident's room and will be kept at the nurse stations. The facility will provide matches and will light cigarettes upon request in designated areas set aside for smoking. These areas will be monitored by designated staff..." Resident #45 An observation and interview on 11/13/23 at 3:30 PM, with Resident # 45, revealed him standing in the day room waiting to go outdoors to smoke. An interview with Resident # 45 on 11/14/23 at 8:35 AM, revealed he was caught by staff smoking in his room with cigarettes' butts and a lighter that he had confiscated during a supervised smoke break. An observation on 11/14/23 at 1:30 PM, of the supervised scheduled smoke break revealed two (2) staff members that dispensed the residents' cigarettes and provided assist with lighting for fourteen residents while leaving the smoke box open on the outdoor table. All outdoor tables had small, shallow circular ashtrays. An interview with Registered Nurse #1 on 11/14/23 at 1:50 PM, revealed they usually have two (2) staff members to supervise the smokers. She revealed that Resident # 45 had been caught smoking in his room a couple of times. An interview on 11/14/23 at 1:58 PM, with the Director of Nursing (DON) revealed that Resident #45 was safe with independent smoking when he was admitted to the facility, which meant he could smoke anytime in the designated area. She stated that he was caught with cigarette butts and	F 689	secure smoking paraphernalia must stay closed during smoke breaks and kept beside staff member(s) assigned to the monitoring of each smoke interval. Education also included that only one lighter will be kept in the container along with a focus on the Smoking Policy, supervision during smoke breaks, prevention of resident obtaining smoking paraphernalia and resident safety during smoke breaks. On November 15, 2023 the Smoking Policy was reviewed and signed by all residents that smoke and or Resident Representative (RR) including Resident #45. On November 16, 2023 all table top receptacles were removed from the designated smoke area. Beginning on November 16, 2023 Nurse Case Manager and or Assessment Nurse will assess all smokers on Admission and Quarterly to ensure all residents safety while smoking. November 16, 2023 Staff Development and or Director of Nursing (DON) will monitor smoke breaks daily for four-weeks, monthly for three- months and quarterly thereafter. On November 16, 2023 Admissions Coordinator and or Social Services will monitor all smokers to include room audits to ensure rooms are free of smoking paraphernalia for once weekly for four-weeks, once monthly for three-months and quarterly thereafter. December 3, 2023, the Administrator or DON will report any concerns from the Plan of Correction to the Department Head Meetings weekly for four-weeks and then monthly for three-months, then quarterly until substantial compliance is achieved with F689. The Quality	

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F 689	Continued From page 9 a lighter in his room on 7/14/23 and was caught smoking in his bathroom on 8/14/23, despite receiving supervised smoke breaks. She revealed Resident #45 confirmed that he took the cigarette butts during the supervised smoke break and stole a lighter out of the box that held the smoking supplies when the staff member turned her head. An interview with the Director of Nursing (DON) on 11/15/23 at 9:20 AM, revealed the facility had 15 residents that required smoking supervision. She revealed that they have two (2) staff members that supervise the residents' smoke breaks and stated they have adequate supervision. The Survey Agent inquired how Resident #45 could have got cigarette butts and a lighter inside the facility if he was adequately supervised, and she replied, "He waits until they turn their heads and sneaks and takes it." She confirmed that she had not tried any other interventions. She denied trying any one-on-one measures or staff education. She acknowledged, without adequate supervision, the resident could still potentially sneak a lighter or cigarette butts during the smoking times. An interview with Social Services on 11/15/23 at 4:20 PM, revealed that Resident #45 had been caught smoking in his room twice and he had been caught stealing used cigarette butts. An interview with the Administrator (ADM) on 11/15/23 at 4:35 PM, revealed they are a smoking facility and confirmed that Resident #45 was admitted to the facility as a smoker. She revealed they have adequate staff members outside with the resident to supervise during the smoking process. She revealed the facility had	F 689	Assurance Committee will begin meeting on December 18,2023 monthly for three -months and quarterly until substantial compliance is achieved with F689. If any concerns are identified with the current corrective action plan the Quality Assurance Committee will meet immediately and revise the corrective action plan as needed.	

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F 689	Continued From page 10 implemented increased monitoring during smoke breaks since Resident #45 was caught smoking in his room. She revealed that increased monitoring was defined as increased awareness by the staff since the smoking incident occurred. Record review of the Resident Incident Report for Resident # 45 dated 7/14/23 revealed, "Resident was found to be taking cigarette butts and lighter in his pocket-He stated that he was going to smoke in his bathroom until he was "caught". Resident is able to smoke independently at this time." Record review of the Resident Incident Report for Resident #45 dated 8/14/23 revealed, "Staff reports that residents room smelled of smoke. I went in and elder has been smoking in his bathroom. He had butts in his pocket. He stated he stole the lighter when the nurse had turned her head, he took the lighter. He also stated that he wanted to smoke independently so I smoked in my room." Record review of the Face Sheet revealed Resident # 45 was admitted to the facility on 2/26/20 with medical diagnosis that included Heart Failure, Bipolar Disorder, Major Depressive Disorder, Chronic Obstructive Pulmonary Disease, and Anxiety Disorder. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/05/23 revealed under Section C, a Brief Interview for Mental Status (BIMS) score of 15, which indicates Resident #45 was cognitively intact.	F 689		
F 851 SS=D	Payroll Based Journal	F 851		1/1/24

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F 851	Continued From page 11 CFR(s): 483.70(q)(1)-(5) §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 (including,	F 851		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255097	A. BUILDING _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CENTER OF ABERDEEN	505 JACKSON ST ABERDEEN, MS 39730

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F 851	Continued From page 12 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. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to submit accurate staffing data into the Payroll-Based Journal (PBJ) system for one (1) of two (2) quarters reviewed. Findings include: Record review of facility policy titled, "Entering Contract/Agency Hours for PBJ" dated 12/19, revealed, "Instructions for entering contractor/agency hours in prime view for PBJ reporting. PBJ = Payroll Based Journal - Mandated by CMS. Each location must collect time worked by 'contract' workers. The corporate	F 851	Root Cause Analysis (RCA) was conducted by the Interdisciplinary Team (IDT) on November 16, 2023 and based on findings the facility failed to submit accurate staffing data into the Payroll Based Journal (PBJ) system for one quarter. On November 16, 2023, the Administrator conducted a Quality Review of the facility process to ensure accurate submission of staffing data into the PBJ system to accurately record contractor/agency staffing hours. Residents have the potential to be affected by this alleged deficient practice. On November 16, 2023 an audit was conducted by the Administrator to ensure	

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F 851	Continued From page 13 office will submit at regular intervals. Information should be entered on a daily basis in Prime View." Record review of "Instructions For Verifying Hours in Prime View For PBJ Reporting - Administrators" dated 6/24/21, revealed, "PBJ = Payroll Based Journal - Mandated by CMS. The Administrator at each site is responsible for reviewing and approving hours in Prime View. This includes: Contract workers (these are entered each site on a daily basis). This is the main item you are checking." Record review of "PBJ Staffing Data Report CASPER Report 1705D FY (Fiscal Year) Quarter 3 2023 (April 1 - June 30)", revealed "Excessively Low Weekend Staffing - Triggered. Triggered = Submitted Weekend Staffing data is excessively low." During an interview on 11/15/23 at 3:25 PM, the Director of Nursing (DON) stated she was unsure why the Payroll Based Journal (PBJ) triggered for excessively low weekend staffing when the weekends were sufficiently covered with facility staff, agency staff, and with administrative staff working the floor. She felt that the problem could be from staff clocking in properly or with agency staff not being entered accurately. An interview with the Human Resource/Payroll Director on 1/15/23 at 3:35 PM, revealed the agency staff used paper records that they fill out for their shifts worked. She stated these forms were sent to the agency to be verified, then the agency returned an invoice to the facility with the agency staff hours worked and their rate of pay. She stated the Administrator then enters the	F 851	the facility process of entering accurate submission of staffing data into the PBJ system to accurately record contractor/agency staffing hours. On November 16, 2023, the Administrator and Human Resource/Payroll Director were educated by Regional Accountant on ensuring the facility process of entering accurate submission of staffing data into the PBJ system to accurately record contractor/agency staffing hours. Beginning on December 4, 2023, the Administrator will conduct Quality Improvement monitoring during the weekly Department Head Meeting of staffing data to ensure entering accurate submission of staffing data into the PBJ system to accurately record contractor/agency staffing hours weekly for four weeks and then monthly for three months and then quarterly until substantial compliance is achieved with F851. Administrator and or Human Resources will reconcile contract/agency sign-in time sheets with the working schedule to ensure accurate hours are reported to PBJ daily for four-weeks and weekly thereafter. The Quality Assurance Committee will begin meeting on December 18,2023 monthly for three -months and quarterly until substantial compliance is achieved with F851. If any concerns are identified with the current corrective action plan the Quality Assurance Committee will meet immediately and revise the corrective action plan as needed.	

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F 851	Continued From page 14	F 851		

information from the invoice into the PBJ system.

An interview with the Administrator on 11/15/23 at 4:10 PM, revealed she is reviewing the information for the quarter that triggered for low weekend staff. She stated she was reviewing the facility staff's clock-ins and the agency staff's paper documentation, and verifying this with video footage of each one working in the facility for specific dates. She stated the staffing was sufficient but she felt she failed to submit the agency staff into the system accurately which would have caused the discrepancy with the PBJ information.

On 11/16/23 at 8:05 AM, an interview with the Administrator revealed she was the person responsible for entering the staffing into the PBJ system. She confirmed that while reviewing the information entered, she determined there were occasions when the invoices from the staffing agencies were not received by the facility until after she had submitted the staffing information into the PBJ system, therefore the submitted information was not accurate for the facility's staffing. She confirmed that even though staffing was not a concern, the facility failed to provide accurate information into the PBJ system by not counting agency staff on all of the entries.