STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255293	A. BUILDING _____ B. WING _____	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF SHELBY	1108 CHURCH STREET SHELBY, MS 38774

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and a Compliant Investigation (CI) with one (1) complaint, CI MS # 24203 at the facility from 5/19/24 through 5/22/24. The SA found the facility was in compliance related to misappropriation of property for CI MS #24203. No citations were written related to the CI. During the recertification survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation and cited F584, F641, F656, F693, and F851. The census at the time of the survey was 55 and the facility is licensed for 60 beds.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		6/27/24

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

Electronically Signed | 06/05/2024

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F 584	Continued From page 1 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review the facility failed to provide blinds or window coverings in good repair for one (1) of 60 resident rooms observed for a clean, comfortable, and homelike environment. Room 34. Findings Include: Review of the facility policy "Work Orders and Paging", effective September 1, 2014, revealed, "Purpose, To establish a productive procedure for communicating and coordinating the needs of the residents and employees from the Maintenance Department... Work Orders, TELS... is a Computerized Maintenance Management System (CMMS). Employees shall complete Work Orders	F 584	F584 1. The Resident in room 34 window blind was immediately replaced with new window blind on 05/20/2024 by the Maintenance Supervisor. 2. All Resident with window blinds in the center are at risk for the deficient practice. 3. The Director of Clinical Education educated nursing, therapy, housekeeping and dietary staff on 05/24/2024 on the purpose of TELS and submission of work orders on TELS. 4. A complete audit of all Resident's blinds	

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F 584	Continued From page 2 through TELS. When a verbal request for maintenance is received from center personnel, maintenance staff should request that a work order be submitted..." An observation of Room 34 on 5/19/24 at 1:00 PM, revealed the window blind had broken slats creating a 12 by six (6) inch opening on the right side through which the parking lot was visible. In an interview on 5/20/24 at 9:35 AM, with Certified Nursing Assistant (CNA) #1 she stated that if there was something broken in a resident's room, she would tell the maintenance staff. During an interview on 5/20/24 at 9:40 AM, with Registered Nurse (RN) #1 he stated that if broken equipment was found in the resident room, he would notify the maintenance staff either in person or by phone. On 5/20/24 at 10:00 AM, an observation of Room 34 and interview with the Maintenance man, he verified that the window blinds were broken creating and opening on the right side. The Maintenance man stated that staff are supposed to enter work orders in TELS, but usually they just tell him. He verified that he was not aware of the condition of the window blinds. On 5/20/24 at 10:07 AM, an interview and record review, with the Maintenance man, of work orders in TELS, revealed that there was no work order for the broken window blinds in Room 34. During an interview with the Administrator on 5/20/24 at 2:00 PM, she stated that staff usually notify the Maintenance man verbally or put maintenance needs on the 24-hour report. She	F 584	in the center was completed on 05/23/2024 by the Maintenance Supervisor and the Environmental Supervisor. This audit of all Resident's blinds will be performed by Maintenance Supervisor and the Environmental Supervisor daily for 30 days, weekly X 4 weeks and monthly X 3 months beginning on 06/03/2024/ The Administrator will pull the TELS task report weekly X 4 weeks and monthly X 3 months for input of repairs and to verify completion. All findings of concern and results of audits will be immediately addressed and reported to the Quality Assurance Performance Improvement committee on 6/26/2024, then monthly for the next 3 months.	

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F 584	Continued From page 3 verified that staff have not consistently been entering maintenance requests in TELS like they should.	F 584		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to accurately complete section P of the Minimum Data Set (MDS) for one (1) of four (4) residents residing in the facility with a wander alert bracelet. Resident #24 Findings Include: Review of the facility policy titled "RAI (Resident Assessment Instrument) Process Guideline" undated, revealed "Process: The CMS (Centers for Medicare and Medicaid Services) Long-Term Care Facility Resident Assessment User's Manual 3.0 will provide the framework and directions to completing the RAI process. All items in the MDS are to be coded per the instructions of the CMS Long-Term Care Facility Assessment User's Manual MDS 3.0". An observation of Resident #24, on 5/19/2024 at 12:16 PM, revealed she was sitting on the edge of the bed. A wander alert bracelet was observed on her left ankle. Record review of the "Order Summary Report" with active orders as of 5/20/24, revealed an	F 641	F641 1. Modification of Section P of Minimum Data set for resident #24 was completed and submitted on 06/07/2024 by the Registered Nurse Assessment Coordinator. 2. All Residents in the center with wander guards are at risk for the deficient practice. 3. The Nursing Home Administrator in-service the Registered Nurse Assessment Coordinator on 05/28/2024 on the submission of correct and accurate coding of the Minimum Data Set with emphasis place on Section P. 4. The Registered Nurse Assessment Coordinator and the Director of Clinical Education performed an audit and section P of Minimum Data Set for correct coding of wander guard use on 05/24/2024. This ongoing audit will be performed by the Registered Nurse Assessment Coordinator and the Director of Clinical	6/27/24

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F 641	Continued From page 4 order dated 7/03/2023, "Wanderguard to left ankle. Check placement and function ...." Record review of Resident #24's quarterly MDS with an Assessment Reference Date (ARD) of 5/3/2024, revealed in Section PO200 Alarms ...Wander/elopement alarm was coded as 0 indicating "Not used" during the MDS look back period An interview with the MDS Nurse on 5/20/2024 at 11:01 AM confirmed a data error was made on Resident #24's quarterly MDS and the wanderguard was not captured. An interview with the Director of Nursing (DON) on 5/20/2024 at 11:06 AM, revealed her expectations was for the assessments to be completed accurately by the MDS staff.	F 641	Education on weekly X 4 weeks effective 6/5/2024 and monthly X 3 months. The results of the audit will be submitted to the Quality Assurance Performance Improvement committee on 6/26/2024, then monthly for the next three months.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656		6/27/24

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F 656	Continued From page 5 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to implement a comprehensive care plan for a resident receiving an enteral feeding (Resident #1), and failed to develop a comprehensive care plan for a resident receiving antipsychotic medication (Resident #54) for two (2) of nineteen care plans reviewed.	F 656	F656 1. Resident #1 enteral feeding care plan was immediately corrected and updated on 05/24/2024. Resident #54 care plan addressing antipsychotic medication was completed on 06/01/2024. 2. All Residents in the center who	

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F 656	Continued From page 6 Findings Include: Review of the facility policy titled "Care Plans" with a revision date of October 2021 revealed, "Policy: Care plans will be developed for all patients and residents based upon the RAI (Resident Assessment Instrument) manual guidelines. Care plans are developed by the interdisciplinary team and revised as needed according to resident and patient status or change." This document was dated 5/21/24 and signed by the Licensed Nursing Home Administrator. Resident #1 Record review of Resident #1's care plan revealed, "Focus: (Proper name of Resident #1) has PEG (Percutaneous Endoscopic Gastrostomy) tube placed and is at risk for complications R/T (related to) feeding tube ...Interventions... every shift Jevity 1.5 @ (at) 65 ml/hr (milliliters per hour) x (times) 22 hours, 2145 kcal (kilocalories); 90g (grams) protein; and 2330 ml total fluid". An observation on 5/19/2024 at 12:25 PM, revealed Resident #1 lying in bed with his eyes closed. A bottle of Jevity 1.5 enteral feeding was hanging via feeding pump, which was turned off. An observation on 5/19/2024 at 3:15 PM revealed Resident #1 lying in bed with his eyes closed. A bottle of Jevity 1.5 enteral feeding was hanging via pump, which was turned off. On 5/19/2024 at 3:55 PM, in an interview with Licensed Practical Nurse (LPN) # 2 confirmed Resident #1's feeding pump was turned off.	F 656	receives enteral feedings and are on antipsychotic meds are at risk for the deficient practice. 3. The Nursing Home Administrator educated the Registered Nurse, Director of Nursing, the Director of Clinical Education, and the Assistant Director of Nursing on developing a comprehensive care plan on residents who receives enteral feedings and antipsychotics. A 100% audit conducted on 05/22/2024 by the Interdiscplinary Team on all residents receiving enteral feedings and antipsychotics. No other discrepancies were identified in the audit. 4. Director of Nursing, Assistant Director of Nursing, Assistant Director of Nursing, Registered Nurse Assessment Coordinator, and the Director of Clinical Education will continue to monitor and audit residents with enteral feedings and Psychoactive medications for updated and completion of comprehensive care plans. This audit will be performed weekly X 4 weeks effective 6/05/2024, then monthly X 3 months. The results of these audits will be submitted to the Quality Assurance Performance Improvement committee on 6/26/2024, then monthly for the next 3 months.	

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F 656	Continued From page 7	F 656		

On 5/21/2024 at 3:30 PM, in an interview with the Director of Nursing (DON) revealed the purpose of the care plan was to identify and focus on the resident's concern or problem and to develop interventions to resolve the problem. She confirmed that the facility did not follow Resident #1's care plan for the enteral feeding.

Resident #54

An observation of resident #54 on 5/19/2024 at 2:35 PM, revealed she could be heard hollering down the hallway. The resident was sitting in a wheelchair in her room and was confused, asking for the car keys and stated she was leaving to go to the store but did not want anyone to know.

Record review of the "Order Summary Report" with active orders as of 5/20/24, for Resident #54 revealed an order dated 4/22/2024, "Seroquel oral tablet 50 MG (milligrams) (Quetiapine Fumarate) Give 50 mg via PEG-Tube at bedtime for Mood Disorder".

Record review of the "Care Plans" for Resident #54 revealed a care plan was not developed for the antipsychotic medication Seroquel for mood disorder.

An interview with the Minimum Data Set (MDS) nurse on 5/20/2024 at 1:15 PM, revealed she was responsible for the care plans. She confirmed Resident #54 did not have a care plan developed for the antipsychotic medication Seroquel. She revealed a care plan should have been developed so that staff would know what care to provide.

An interview with the Administrator (ADM) on

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F 656	Continued From page 8 5/20/2024 at 1:32 PM, revealed antipsychotic medications should be care planned because they were high-risk medications and it would allow staff the knowledge to provide better care.	F 656		
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 §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, staff interview, and record review and facility document review, the facility failed to ensure a resident who received enteral nutrition received appropriate treatment and services, as evidenced by, the facility's failure to administer an enteral feeding according to the physician's order for one (1) of 11 residents with a	F 693	F693 1. Resident # 1 was immediately assessed by the Director of Nursing on 05/21/2024. 2. All Residents in the center who	6/27/24

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F 693	Continued From page 9 feeding tube. Resident #1 Findings Include: Record review of a typed document on facility letterhead, dated 5/21/24 and signed by the Licensed Nursing Home Administrator revealed, "Standards of Practice: The expectation set forth by (Proper Name of the facility) is that nurses comply with current standards of practice in terms of following physician's orders. This includes following orders for medication and enteral feedings." An observation on 5/19/2024 at 12:25 PM, revealed Resident #1 with his eyes closed lying in bed.. A bottle of Jevity 1.5 was hanging via pump, which was turned off. An observation on 5/19/2024 at 3:15 PM, revealed Resident #1 lying in bed with his eyes closed. A bottle of Jevity 1.5 was hanging via pump, which was turned off. An interview with Licensed Practical Nurse (LPN) #2 on 5/19/2024 at 3:55 PM, confirmed Resident #1's enteral feeding was turned off. Record review of the May 2024 MAR for Resident #1 revealed an order dated 3/12/2024, "Enteral feed one time a day turn feeding pump off" scheduled for 7:00 AM, signed as administered on the MAR, which indicated the resident was receiving this order. An additional order dated 3/12/2024 revealed, "Enteral Feed Order one time a day turn feeding pump on" scheduled for 1500 (3:00 PM) signed off as administered on the MAR, which indicated the resident was receiving this order.	F 693	receives Enteral tube feedings are at risk for the deficient practice. 3. The Director of Clinical Education educated nurses on 05/24/2024 on following Medical Director orders, administering enteral feedings as ordered with emphasis placed on the importance of not signing orders that are questionable. If any doubt or questions about an enteral order or any other orders, please notify MD for correct orders. Do no just click on the Medication Administration Record. 4. All new orders related to enteral feed will be reviewed by the Interdisciplinary team daily in the stand-up meeting to discuss enteral feeding orders and ensure the correct orders are documented and all feeding orders discontinued. This audit will be performed weekly X 4 weeks effective 6/05/2024, then monthly X 3 months. The results of the audit will be submitted to Quality Assurance Performance Improvement committee on 6/26/2024, then monthly for the next 3 months.	

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F 693	Continued From page 10	F 693		

Record review of the May 2024 Medication Administration Record (MAR) for Resident #1 revealed an order dated 5/7/2024, "Enteral feed order every shift Jevity 1.5 @ 65 ml/hr (milliliters per hour) x (times) 22 hours, 2145 kcal (kilocalories); 90g (grams) protein; 2330 ml (milliliter) total fluid" which was signed off on the MAR as administered, which indicated the resident was receiving this order.

During an interview with the Director of Nursing (DON) on 5/20/2024 at 8:45 AM revealed several weeks ago Resident #1 began not eating meals, and they increased his tube feeding. She revealed he was supposed to be receiving Jevity1.5 at 65 ML/HR (milliliters per hour) x (times) 22 hours. She confirmed the Jevity was not supposed to be off between the hours of 7:00 AM to 3:00 PM and stated the order should have been discontinued. The DON revealed an error was made by not removing the order from the resident's MAR. She revealed she took responsibility for the error because she put the new feeding order into the medical record and did not take out the other discontinued order. She confirmed weight loss could be a concern.

An interview with Registered Nurse (RN) #1 on 5/21/2024 at 9:02 AM, confirmed he was aware Resident #1 had two enteral feeding orders on the MAR. He revealed there was a problem with communication and the old order was not discontinued. He stated he had been turning the resident's feeding pump off at 7:00 AM and re-starting it at 3:00 PM daily, and confirmed he was signing both orders. RN #1 revealed he should have questioned the order and called the doctor for clarification and confirmed he should

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F 693	Continued From page 11 not sign a physician's order on the medical record that was not given. He revealed that the resident was at risk for dehydration, weight loss and malnutrition by not getting the appropriate enteral feeding. An interview with the Administrator (ADM) on 5/21/2024 at 9:48 AM, revealed the nurses should have questioned two different enteral feeding orders on the MAR. She revealed they should not have signed both orders as administered, and confirmed this was a standard of practice issue. She acknowledged Resident #1 was at risk for weight loss by not getting the correct enteral feeding order. During a telephone interview with the Registered Dietician (RD) on 5/21/2024 at 10:22 AM, confirmed Resident #1 was at risk for weight loss if he did not get the prescribed enteral feeding. Record review of the "Admission Record" revealed the facility admitted Resident #1 on 9/8/2019 with current medical diagnoses that included Alzheimer's Disease, Dysphagia, and Gastrostomy status.	F 693		
F 851 SS=F	Payroll Based Journal 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	F 851		6/27/24

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	255293	A. BUILDING _____ B. WING _____	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF SHELBY	1108 CHURCH STREET SHELBY, MS 38774

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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, 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.

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F 851	Continued From page 13 §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 interviews, record review and facility document review, the facility failed to submit accurate staffing information into the Payroll-Based Journal (PBJ) system for one (1) of four quarters reviewed. First quarter 2024 Findings Include: Record review of a typed document on facility letterhead, dated 5/21/24 and signed by the Licensed Nursing Home Administrator (LNHA) revealed "Staffing: It is the practice of (Proper name of the facility) to assure that adequate staffing is maintained to provide the necessary care and services for each resident. Staffing expectations are based on resident acuity and needs and may fluctuate based on the center population as identified in the facility assessment. The center conducts work force management meetings daily to discuss open positions, open shifts and call ins as related to patient needs. We continue to actively recruit staff offering various incentives." Record review of the "PBJ (Payroll-Based Journal) Staffing Data Report" revealed the facility submitted excessively low weekend	F 851	F851 1. A complete audit was performed 05/24/2024 by Administrator, Human Resource Director and the Workforce Manager on the Payroll Based Journal data that was submitted incorrectly to Centers for Medicare and Medicaid Services. Administrative assistant of the corporate office, Human Resource personnel and the work force manager notified of the incorrect data submission. 2. Diversicare of Shelby nursing home star rating and quality measures and all resident at the center are at risk for the deficient practice. 3. The Administrator educated by the Nurse Consultant on 05/22/2024 on submitting complete and accurate licensed nurse staffing data. 4. Licensed nurse staffing data will be reviewed during Daily Workforce Management meetings for accuracy. Administrator, Human Resource Director,	

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F 851	Continued From page 14 staffing data for the 1st quarter 2024 (October 1-December 31). An interview with Licensed Practical Nurse (LPN) #3 on 5/19/2024 at 12:45 PM, revealed she had witnessed staffing concerns on the weekend and stated "they mostly come from call in's." She revealed management did come in to work when someone called in. An interview with LPN #2 on 5/19/2024 at 12:50 PM, revealed she had witnessed staffing concerns on the weekend. She explained that when someone calls in on the weekend, they get on the phone and start calling staff to find help. She revealed they also notify the Workforce Manager so that she can start making calls. LPN #2 explained that management always helps and comes to work when someone calls in. An interview with the Administrator (ADM) and the Director of Nursing (DON) on 5/19/2024 at 3:30 PM, revealed they were not aware they had triggered for low weekend staffing. The ADM revealed they have a Workforce Manager who always ensured the facility met the minimum requirement or above. She stated they had never fallen below that minimum requirement. She revealed they do have frequent call-ins, but all management personnel come to work to fill positions, whether it be as an aide or a nurse. The ADM stated they all rotated and took call and were responsible for coming in if they were unable to find replacement staff when someone called in. The DON revealed that management personnel were all salaried and that corporate did not have a way to add them to the PBJ (Payroll-based Journal) because they did not clock in. The ADM explained that she had several	F 851	and the Workforce manager will audit licensed nurse staffing data weekly X 4 weeks effective 6/05/2024, then monthly X 3 months for accurate submission to Payroll Based Journal. The results of these audits will be submitted to the Quality Assurance Performance Improvement committee on 6/26/2024 for the next three months.	

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discussions with the facility Human Resource staff member and the Corporate Payroll staff and was told there was no way to add any hours for coming in and covering a shift for salaried individuals.

An interview with the Workforce Manager on 5/20/2024 at 2:32 PM, revealed she had worked in the staffing position for two (2) years. She revealed call in's were the biggest concern for staffing. She stated they have a staff member on call every day. She explained when a staff member called in, they had to call in to the person on call, and it was the on-call person's responsibility to call around and try to find a replacement. She revealed on the weekends, they call in to the facility and the floor nurses were responsible for calling the staff to find a replacement. The Workforce Manager explained the on-call person must work if they cannot find someone. She stated when management worked to fill a position, she always included them in her staffing numbers even though she knew Human Resources had told her that they were unable to add it to the payroll data. She confirmed this was an error in payroll data submission.

An interview with the ADM on 5/20/2024 at 3:15 PM, revealed she just hired two (2) aides and was looking to hire 2 more part-time. She stated the staff she has right now were willing to work extra and stay over to cover shifts. She revealed all management personnel come in to work to meet the staffing requirement when someone calls in. She explained she had reached out to the corporate office to notify them of the need to count salaried employees on payroll but was told they did not have a way to do it. She confirmed this was a payroll data error and would not

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F 851	Continued From page 16 accurately reflect the staffing numbers. An interview with Human Resources on 5/21/2024 at 9:40 AM, revealed she was responsible for completing payroll. She revealed once her information was entered into the payroll system, it went to the corporate office. She explained that the payroll system will not allow her to change the role of a salaried employee. She revealed that salaried employees' hours were pre-set in the system and could not be changed. An interview with the ADM on 5/22/2024 at 9:10 AM, revealed that the facility was without a payroll person for 4-5 months, and that would have been during the time the facility triggered for low weekend staffing. She revealed she hired someone in the middle of October 2023 to fill that position but the new hire still had to be trained. She explained that she and the Workforce Manager did payroll within that time frame. She revealed she was not familiar with payroll, but she had to step up and do what needed to be done. She acknowledged this likely caused some data errors with the accurate submission of the payroll-based Journal.	F 851		