STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255161	A. BUILDING _____ B. WING _____	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC BALDWYN NURSING FACILITY	739 4TH STREET SOUTH BALDWYN, MS 38824

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification along with complaint investigation (CI MS #25852 and CI MS #26236) at the facility from 1/6/25 through 1/9/25. 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 F550, F584, F641 and F851 during the survey. The SA found the facility was not in compliance for CI MS #25852 for environment and cited F584. The SA found the facility in compliance for CI MS#26236 related to mold in the building. The census at the time of the survey was 103 with a license for 107 beds.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		2/15/25

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

Electronically Signed | 01/20/2025

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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, and facility policy review, the facility failed to honor a resident right to vote in the 2024 election for one (1) of 23 sampled residents. Resident #72 Findings Include: Review of the facility policy titled "Resident Rights: Participation in Groups and Activities of Choice" with a review date of 2/12/24 revealed under, "Procedure:... Residents should be encouraged to exercise their rights to vote in local, state, and national elections." An interview with Resident #72 on 1/8/24 at 8:11 AM revealed she had lived at the facility for over a year and did not get to vote this past election.	F 550	1. On 1/9/2025 resident number 72 was spoken with about her rights to vote as required by the Social Services Director. 2. All residents have the potential for the same deficient practice. All residents were rounded on starting 1/9/2025 and completed this date (1/9/2025) to ensure that all residents were honored in their right to vote by the Baldwyn Administrative Leadership. The Social Services Director will continue to ask and document the resident wishes on admission. 3. All social services employees (activities department) will be in-serviced starting by 1/14/25 by the Social Services Director and completed by 2/15/2025. This will be to ensure all residents will be honored in	

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F 550	Continued From page 2 She explained that she was registered to vote in a different county and had waited for the staff to bring her the necessary forms to complete, but no-one ever did. She revealed she always voted in the past, and it was important for her to continue to do so. An interview with Social Services (SS) on 1/8/24 at 10:10 AM revealed she did not go room to room and speak with the residents individually regarding their desire to vote in the past election. She explained that she spoke with some residents in a resident council meeting and told them, if they wanted to vote, they needed to come talk to her. She revealed Resident #72 did not tell her that she wanted to vote and confirmed that she should have directly spoke with the resident regarding her wishes and acknowledged this was the resident's right to participate and cast her vote. An interview with the Administrator (ADM) on 1/8/24 at 10:43 AM confirmed the facility should have spoken with Resident #72 regarding her desire to vote and ensured she was able to vote. Record review of the "Face Sheet" revealed the facility admitted Resident #72 on 11/29/23. Record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/27/24, revealed under, section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #72 is cognitively intact.	F 550	their right to vote. 4. The activities department started rounds on 1/9/2025 with all residents to ensure they are honored in their right to vote. The Social Services Director and/or Activities Director will audit/round (5) residents weekly for one month (January), then every two weeks for one month (February), once monthly (March) to ensure all residents will be honored in their right to vote. The Activities Director will screen and document all new admissions and their wishes as it pertains to voting to help ensure each resident is honored. The results based from verbal exit from the State Survey Team will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee on 1/28/2025. These rounds/results along with the written statement of deficiencies report (CMS-2567) were up for review at our QAPI follow-up meeting on 1/28/2025. Recommendations from this committee will be reviewed on the (1/28/2025) QAPI Meeting and on-going for the next 2 scheduled quarterly QAPI meetings (April 2025 and August 2025) to ensure solutions are sustained.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		2/15/25

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F 584	Continued From page 3	F 584		

§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.

§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

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F 584	Continued From page 4 sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and facility policy review, the facility failed to provide a clean, safe, and homelike environment as evidenced by bugs in ceiling lights, walls and ceiling in disrepair, blind slats broken and bent, broken wood molding, unclean air/heating unit and floors for six (6) of 67 rooms in facility. Findings include: Record review of facility policy titled, " Resident Rights: Dignity and Respect", dated 2/12/24, revealed, "To provide the kind of care to our residents that should maintain and enhance their dignity, individuality, and quality of life by the following treatment. ... a living environment that is safe, clean, and comfortable". During an initial observation on 1/6/25 at 12:10 PM, room A-12 was noted to be in disrepair and had multiple areas of the room that had paint missing on the walls. Several areas of the room were observed that included an area by door measuring approximately eight (8) inches x 6 inches, an area near the bathroom counter measuring approximately four (4) inches x five (5) inches, and other smaller areas scattered around the room that were all missing paint. Approximately 15 dead bugs were observed in the ceiling light fixture and multiple water stains were covering most of the ceiling tiles. The wood molding on the center of the wall approximately shoulder high behind the resident's headboard was broken with a sharp point protruding from the wall surface. The window blinds were noted to be in disrepair with multiple bent and broken slats,	F 584	1. Resident rooms A12, C14, E3, B7, B9, and B15 were immediately addressed (1/6/25-1/9/25) to provide a clean, safe, and homelike environment. EVS staff worked in conjunction on 1/8/2025 to address all concerns for rooms A12, C14, E3, B7, and B15. Checklist items such as sweeping, mopping, dusting, trash being emptied, and bathrooms being cleaned were utilized per policy on same day (1/8/2025). Workorders for facility operations were put in immediately following survey rounds (1/8/2025) by the EVS manager to address dirty/dusty air units as well as rooms A12, B7W, B15□s light fixture (bugs) that was completed on 1/9/2025 by the facility technician. Room C14 bathroom floors were immediately addressed following survey rounds by EVS staff same day (1/7/2025). Room E3W□s broken electrical outlet cover was replaced by the facility operations technician same day (1/6/2025), and a work order has been placed for the room to be painted. 2. All residents have the potential to be affected by this practice. All resident rooms were audited on 1/9/2025, by Baldwyn Leadership to assess for possible cleanliness and environment concerns. Upon audit the facility will address as required. 3. The Environmental Services Manager will in-service all EVS staff starting 1/14/2025 and to be completed by 2/15/2025. These in-services address the	

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F 584	Continued From page 5 along with dust and debris that was noted in the corners of the room and on edges of the floor around the floor molding. On 1/8/25 at 9:30 AM, during an interview and observation of room A-12, the Environmental Service (EVS) Manager confirmed the areas of concern in this room which included missing paint, water stains on ceiling tiles, bugs in light fixture, blind slats bent and broken, floor with dust and debris, and broken wood molding with sharp point that could cause an injury. She stated their process for repairs was for staff to note these concerns and notify her and she would put in a work order for maintenance and this process was not followed for this room. She confirmed the facility failed to maintain the room in good repair and to ensure each resident had a safe, clean, comfortable, and homelike environment. During an interview on 1/8/25 at 11:20 AM, the Assistant Administrator confirmed the environmental and maintenance concerns for this room. He confirmed the facility failed to ensure each resident had a clean, safe, and homelike environment. ROOM #C-14 An observation in room C-14 bathroom on 01/06/25 at 9:55 AM and on 01/07/25 at 8:30 AM revealed a foul odor was noted. Further observations revealed there was an area measuring approximately one foot by one foot of yellow dried substance on the floor to the right of the commode in the resident's bathroom. An observation and interview with the Assistant Administrator on 01/07/25 at 3:35 PM in Room C-14, revealed that resident rooms and bathrooms were supposed to be cleaned every	F 584	significance of providing a safe, clean, and homelike environment for each resident. 4. Baldwyn Leadership will utilize Angel Rounds and screen (3) residents□ rooms weekly for one month (January) starting 1/20/2025, then every two weeks for one month (February), and once monthly (March) for possible significant changes. The results based from verbal exit from the State Survey Team will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee on 1/28/2025. These rounds/results along with the written statement of deficiencies report (CMS-2567) were up for review at our QAPI follow-up meeting on 1/28/2025. Recommendations from this committee will be reviewed on the (1/28/2025) QAPI Meeting and on-going for the next 2 scheduled quarterly QAPI meetings (April 2025 and August 2025) to ensure solutions are sustained.	

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F 584	Continued From page 6	F 584		

day. He agreed that the bathroom in room C-14 had an odor and confirmed that there was a dried yellow substance on the floor to the right of the commode. He revealed that he would get housekeeping in to mop it now.

An interview with EVS Manager on 01/08/25 at 9:08 AM revealed that all resident rooms and bathrooms were supposed to be cleaned and mopped every day. She revealed that she wasn't sure why the floor in Room C-14 bathroom was missed and stated, "That's an issue with me." The EVS Manager confirmed that not mopping the bathroom in Room C-14 was not acceptable and she agreed that the room was not a clean, homelike environment for the resident. She also revealed that she would address this issue with her staff.

ROOM #E-3
An observation in Room E-3 on 01/06/25 at 11:45 AM revealed an area approximately two feet by three feet on the wall behind the resident's bed with paint scraped off, sheet rock peeling and an electrical wall outlet cover broken off with the left half missing.

An interview with Maintenance on 01/08/25 at 9:00 AM revealed that if staff noticed anything needing his attention in the facility, they put in a work order, and he got to it as soon as he could. He revealed that when he received work orders, he prioritized their needs and addressed the issues as soon as he could. Maintenance revealed that with the age of the building, it was hard to keep up. Maintenance confirmed that the wall behind the bed in Room E-3 was in disrepair and confirmed that the electrical wall socket cover was broken. He revealed that he had not

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F 584	Continued From page 7	F 584		

received a work order on that room and would get it taken care of. He also agreed that room E-3 was not a homelike environment for the resident.

An observation in Room E-3 and interview with the EVS Manager on 01/08/25 at 9:15 AM, confirmed that the wall behind the head of the bed was in disrepair and in need of painting. She also confirmed that the electrical socket behind the bed was broken and needed to be replaced and revealed that she would put in a work order now. The EVS Manager revealed that any concerns with the building in need of repair were supposed to be reported to Maintenance and if he couldn't fix the problem, he contacted someone from the main unit. EVS Manager stated, "This should have been noticed and reported and we'll take care of it."

An interview with the Administrator on 01/08/25 at 10:45 AM, revealed that it was the responsibility of anyone who noticed a problem to put a work order in to maintenance. He revealed that this was an older building with challenges and stated, "We need to put work orders in and follow up."

ROOM B-7, B-9 AND B-15

An observation of room B-7 on 1/06/25 at 9:30 AM revealed a clear rectangular ceiling light covering with 12 dead brown insects inside.

An observation of room B-9 on 1/06/25 at 9:46 AM revealed the outer plastic airflow vent on the air/heat unit was covered in a black and white substance that was in a droplet pattern.

An observation of room B-15 on 1/06/25 at 11:51 AM revealed two clear rectangular ceiling light

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F 584	Continued From page 8 coverings with 15-20 dead brown insects inside. An observation and interview with EVS Manager on 1/8/25 at 9:30 AM revealed housekeeping was responsible for cleaning all the resident rooms every day. She explained that cleaning involved sweeping, mopping, dusting, emptying the garbage and whatever else that was needed. She revealed that the rooms were deep cleaned once weekly, which was a more in-depth cleaning such as wiping down the mattresses. The EVS Manager revealed the facility just started doing "angel rounds" a couple of weeks ago, which entailed an assigned staff member to every room to do a daily walkthrough and to look for any environmental concerns. She revealed if the residents had a complaint about their room or an issue was identified, a work order must be completed for maintenance to be fixed. She revealed after maintenance resolved the issue, he was required to sign off on the work order to show completion. During a walkthrough of rooms B-7 and B-15, the EVS Manager confirmed the dead insects in the ceiling light covers and stated, "That's some kind of bug." She revealed maintenance would be responsible for cleaning the light covers. She explained that any staff member who noticed a concern could have reported the issue. During a walkthrough of room B-9, the EVS Manager confirmed the air/heat unit vents were covered in a black and white substance. She explained it could be coming from a dirty filter. She revealed housekeeping was responsible for cleaning the vents daily with a Swiffer duster, and maintenance was responsible for changing and cleaning the filter. The EVS Manager confirmed her expectations were for the residents to have a clean, safe environment.	F 584		

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F 641 SS=D	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 staff interview and record review, the facility failed to accurately complete section A of the Minimum Data Set (MDS) for a resident with a serious mental illness for two (2) of 26 MDS reviewed. Resident #2 and #76 Findings Include: The facility provided a statement on letterhead dated 1/8/25 and signed by the Administrator that read, "We follow the CMS (Centers for Medicare and Medicaid) RAI (Resident Assessment Instrument) version 3.0 for policy information regarding MDS (Minimum Data Set) accuracy." Resident #2 Record review of Resident #2's "PASRR (Preadmission Screening and Resident Review) Summary Findings" dated 6/25/24 revealed under, "Mental Health:... The individual meets criteria for having a diagnosis of mental illness as defined by PASRR." Also revealed under, "Axis I primary: Schizophrenia" was listed. Record review of the Admission MDS with an Assessment Reference Date (ARD) of 8/5/24 revealed under section A 1500, "Is the resident considered by state level II PASRR process to have serious mental illness and /or intellectual disability or a related condition? No" was answered.	F 641	1. Resident numbers 76 and 2 had a Preadmission Screening and Resident Review (PASARR) Level II submitted but was not appropriately coded on the Minimum Data Set (MDS). Section A 1500 was corrected on 1/23/2025 to reflect accurate coding. 2. All residents have the potential to be affected by this practice. All residents' charts were audited on 1/9/2025, by Social Services to assess for possible significant changes within the last year and MDS staff have cross checked these for the proper coding for Section A Item 1500. 3. Social Services Director will follow policy for PASARR screenings and notify MDS to and provide a copy of each Level II results/recommendations. Results will be placed in resident medical record for staff accessibility. MDS staff will utilize results to code appropriately. The Quality Outcomes Coordinator will provide in-services with MDS staff starting 1/20/25 and ending same day (1/20/25) covering proper coding for Section A Item 1500. 4. All comprehensive assessments will be reviewed weekly by MDS staff starting 1/20/2025 for one month (January), bi-weekly for one month (February), and monthly for one month (March) to ensure accurate coding of Section A Item 1500.	2/15/25

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F 641	Continued From page 10 Resident #76 Record review of Resident #76's "PASRR Summary Findings" dated 2/27/24, revealed under, "Mental Health:... The individual meets criteria for having a diagnosis of mental illness as defined by PASRR." Also revealed under, "Axis I primary: Bipolar Disorder, Axis I secondary: Mood Disorder, Axis I tertiary: Post Traumatic Stress Disorder" was listed. Record review of Resident #76's Annual MDS with an ARD of 6/5/24 revealed, under section A 1500, "Is the resident considered by state level II PASRR process to have serious mental illness and /or intellectual disability or a related condition? No" was answered. An interview with the MDS Nurse on 1/8/25 at 2:50 PM revealed, she was informed by Social Services (SS) that they did not have any residents that was considered by the state PASRR process to have a serious mental illness and required a level II. She confirmed Resident #2 and #72's MDS was coded inaccurately and revealed the purpose of having correct information was to ensure the residents' plan of care was created and for billing purposes. An interview with SS on 1/8/25 at 3:10 PM revealed, she was aware Resident #2 and #76 received a level II PASRR and confirmed she did not relay the information to the MDS department. Record review of the "Patient Demographics" revealed the facility admitted Resident #2 on 7/29/24.	F 641	The results based from verbal exit from the State Survey Team will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee on 1/28/2025. These rounds/results along with the written statement of deficiencies report (CMS-2567) were up for review at our QAPI follow-up meeting on 1/28/2025. Recommendations from this committee will be reviewed on the (1/28/2025) QAPI Meeting and on-going for the next 2 scheduled quarterly QAPI meetings (April 2025 and August 2025) to ensure solutions are sustained.	

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(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 641	Continued From page 11 Record review of the "Patient Demographics" revealed the facility admitted Resident #76 on 6/20/23.	F 641		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) 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(p)(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(p)(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);	F 851		2/15/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255161	A. BUILDING _____ B. WING _____	01/09/2025

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F 851	Continued From page 12 (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(p)(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(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(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 and record review, the facility failed to submit accurate information into the Payroll Based Journal (PBJ) system for one (1) of four (4) quarters reviewed. Fourth Quarter 2024 Findings include: Record review of facility policy titled, "Staffing Guidelines", undated, revealed, "Guidelines for Payroll Based Journal submission: 1. The facility shall submit staffing data to the Centers for	F 851	1.No residents were affected. The facility is unable to correct the submitted PBJ data for the first quarter in 2024 due to the data entry period ending date. The direct care nursing reported hours appear lower than the actual staffed hours therefor are not in favor of the facility. The facility is unable to view data submissions for a closed quarter, specifically the first quarter of 2024, therefor an assumption of human error is identified as the cause for the inaccurate data reported.	

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F 851	Continued From page 13 Medicare and Medicaid Services (CMS) via CMS's Payroll Based Journal electronic data submission portal. 2. The facility shall submit staffing data in a uniform format according to specifications established by CMS." Record review of "PBJ Staffing Data Report" revealed the facility had "Excessively Low Weekend Staffing" for the fourth quarter of 2024. Upon entry into the facility on 1/6/25 at 9:10 AM, an interview with the Assistant Administrator revealed the facility had not been short staffed during the weekends or the week and he was uncertain why the PBJ report reflected that. He stated he would gather the necessary information for this concern. During an interview on 1/8/25 at 10:35 AM, the Managerial Assistant revealed she was the person responsible for entering the information into the PBJ system. She stated she began this job on 6/3/24, so during the fourth quarter she was new to the position. She revealed the clocking system automatically entered the hourly staff working into the system, but when a salary staff member works outside their normal hours, their time had to be entered manually. She stated the shifts were sufficiently covered during the fourth quarter and she confirmed that since she was new to the position it was likely that the data was not entered accurately. She stated she now had a better system of entering the salary employees' time, but at that time it was very likely it was entered inaccurately. An interview with the Assistant Administrator on 1/8/25 at 10:55 AM, revealed each shift was sufficiently staffed during the fourth quarter. He	F 851	2.The reporting of lower nursing hours than the actual worked nursing hours did not affect the residents of Baldwyn Nursing Facility. The error does affect the accuracy of worked nursing hours reported to CMS and potentially a lower quality measure rating as scored by CMS. 3.The Director of Nursing (DON) and/or Assistant Director of Nursing (ADON) will audit Payroll Based Journal (PBJ) data entries for accuracy prior to each quarter ending date as defined by Centers for Medicare and Medicaid Services (CMS). 4.Monthly, beginning 1/13/2025 and ongoing, the DON or ADON will review the Certification and Survey Provider Enhanced Reports (CASPER) 1705D PBJ STAFFING DATA REPORT to identify areas of concern which may include: Excessively Low Weekend Staffing, One Star Staffing Rating, No RN Hours, Failure to have Licensed and Nursing Coverage 24 Hours/Day. Monthly, 1/13/2025 and ongoing, the DON and/or ADON will review the CASPER report, Individual Daily Staffing Report, and compare to the facility□s time and attendance records. The results based from verbal exit from the State Survey Team will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee on 1/28/2025. These rounds/results along with the written statement of deficiencies report (CMS-2567) were up for review at our QAPI follow-up meeting on 1/28/2025. Recommendations from this committee will be reviewed on the (1/28/2025) QAPI	

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F 851	Continued From page 14 acknowledged the employee responsible for entering the information into the PBJ system was new to that position. He confirmed that since the facility was adequately staffed, the concern had to be due to the salary employees' time not entered into the system accurately. He confirmed the data entered should reflect the accurate staffing information in the facility.	F 851	Meeting and on-going for the next 2 scheduled quarterly QAPI meetings (April 2025 and August 2025) to ensure solutions are sustained.	