STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255286	A. BUILDING _____ B. WING _____	12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE VIEW HEALTH AND REHABILITATION CENTER	1304 WALNUT ST WAYNESBORO, MS 39367

(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 (SA) conducted an annual recertification along with Complaint (CI) #19736 from 12/12/2022 to 12/16/2022. During the survey, the SA determined that the facility was not in compliance with the requirements of participation for Medicare and Medicaid and cited F-567, F585, F-640, F641, and F732. The SA did not cite any deficient practice related to CI#19736 related to a fall with injury. At the time of survey, the facility held a license for 90 beds and the facility census was 87.	F 000		
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on	F 567		1/24/23

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

Electronically Signed | 01/11/2023

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F 567	Continued From page 1 resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review the facility failed to ensure a resident had access to personal funds on the weekend for one (1) of 19 sampled residents with potential to affect 64 residents with resident trust fund accounts of 87 total residents in the facility. Resident #8. Resident#8 Review of the facility's policy, "Resident Trust Fund-Overview", with a revision date of 4/22/2019, revealed the care center will maintain all residents trust fund accounts in compliance with Federal and State regulations and with generally accepted accounting practices. An interview on 12/12/22 at 10:03 AM with Resident #8 revealed the resident had a trust fund account but was unable get money on the	F 567	F 567 Protection/Management of Personal Funds Resident #8 money replaced on December 29, 2022. Money was paid by the facility petty cash. All residents have the potential to be affected. Business Office Manager, Accounts Payable Clerk, Director of Clinical Services, and Executive Director was in serviced on January 10, 2023 regarding Trust Fund Banking Hours by Regional Revenue Cycle Manager. Signage posted on Business office door with Banking Hours for residents on December 14, 2022. Business office Manager placed a lock box, with money, in Medication Room	

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F 567	Continued From page 2 weekends because the office was closed on weekends. An interview on12/14/22 at 10:30 AM with the Social Service Director (SSD) revealed she previously issued the money in the business office, but Receptionist Central Supply (RCS) now keeps up with the money. The SSD stated when she was responsible for the money, residents had access to it on the weekends. An interview on 12/14/22 at 10:34 AM with RCS stated residents have access to their funds any time of the day and can get their funds anytime she is at work. She revealed that she works Monday through Friday 8AM to 5PM. RCS stated she is the only one that deals with the money and that if the residents need money on the weekend she tries to get them taken care of before the weekend. She confirmed that there is no other person here that gives out money on the weekends. On 12/14/22 at 03:40 PM in an interview with Administrator stated normally resident funds are available Monday thru Friday. She stated the residents are not able to get their money on Saturday and Sunday as the office staff is not present on Saturday and Sunday. She stated she was not aware of regulations concerning resident funds being available seven days a week. A review of Resident #8's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/22/22, revealed the resident had a Brief Interview of Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.	F 567	one (1), for after hours and weekend requests, on December 15, 2022. Monitoring of Trust Fund Banking began on December 14, 2022. Findings were brought to the Quality Assurance Performance Improvement Committee by Business Office Manager on December 16, 2022. Business Office Manager will monitor lock box money and replenish as needed three (3) times per week. Business Office Manager will monitor Trust Fund Banking weekly times three weeks. Findings will be brought to the Quality Assurance Performance Improvement Committee by the Business Office Manager monthly for 3 months beginning on January 23, 2023 to determine effectiveness and make necessary changes as indicated.	

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F 585	Continued From page 3	F 585		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business	F 585		1/24/23

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F 585	Continued From page 4	F 585		

address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement

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F 585	Continued From page 5 as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on Interview and Record Review, the facility failed to ensure resident grievances regarding food were resolved in a timely manner for nine (9) of 9 residents who regularly attended resident council meetings (Resident #8, Resident#12, Resident #13, Resident #14, Resident #15, Resident #19, Resident #20, Resident #53, and Resident #62) and a grievance regarding missing money for one (1) sampled resident. Resident #8. Findings Include: A record review of the facility's policy "Complaint/Grievance" with a revised date of 08/09/2018 revealed " ... Purpose: To support each resident's right to voice grievances; resulting in a follow-up and resolution while keeping the resident apprised of its progress toward resolution... The Grievance Office/designee shall act on the grievance an begin follow-up of the	F 585	F 585 Grievances Resident #8, 12, 13, 14, 15, 19, 20, 53, and 62 interviewed for likes and dislikes by Social Service Director on January 5, 2023. Likes and dislikes update on dietary meal card by Dietary Manager on January 9, 2023. Food Committee meeting held on December 21, 2022 by Registered Dietician and Director of Nursing. Resident #8 money replaced on December 29, 2022. Money was paid by the facility petty cash. All residents have the potential to be affected. Social Service Director in serviced on resolving grievances on January 6, 2023, by Executive Director. All residents interviewed for dietary likes and dislikes	

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F 585	Continued From page 6 concerns or submit it to the appropriate department director for follow-up... On 12/13/22 at 10:55 AM, the SSA conducted a resident council meeting with nine (9) residents in attendance including the Resident Council President. During the meeting, the residents complained about food not being palatable, either not seasoned or overly salty, and sometimes not thoroughly cooked. Residents stated complaints had been made at resident council meetings and the concerns were discussed but never addressed except for asking what the residents would like for meals. All residents attending the resident council meeting stated the facility never let them know of anything being done to address their grievances regarding food. On 12/15/22 at 2:00 PM during an interview with the Administrator, she confirmed the residents had been complaining about the food and grievances were supposed to be by Social Services. The administrator stated if the residents continue to complain about the food, the grievance is not resolved, and she had not reviewed the grievance logs. The Administrator stated staff needed additional training and in-services on dealing with grievances and resolving them. On 12/15/22 at 2:20 PM, during an interview with the Dietary Manager, she confirmed residents had complained about food, but she has not attended any resident council meeting. She confirmed that residents do still complain about food. An interview on 12/15/22 at 3:15 PM with the SSD revealed the SSD did attend some resident	F 585	beginning on January 5, 2023 and ending on January 9, 2023, by Dietary Manager and Social Service Director. Resident #8 provided lock box for personal items on December 21, 2022. Administrator, Director of Nursing, and Registered Dietician to sample meal tray weekly, beginning on January 6, 2023 for three (3) months. Grievances will be brought to Department Head morning meeting each morning and discussed, to include, status of either needing further investigation or to be resolved, beginning January 6, 2023. All unresolved Grievances will be brought to morning meeting and discussed until resolved. Findings were brought to the Quality Assurance Performance Improvement Committee by Social Service Director on December 16, 2022. Administrator began to interview cognitive residents with a Brief Interview Mental Status (BIMS) greater than 12 on January 6, 2023 to determine any grievances. Administrator will continue resident interviews weekly times three (3) weeks, then monthly times three months. Findings will be brought to the Quality Assurance Performance Improvement Committee by Administrator, monthly for three (3) months beginning January 23, 2023 to determine effectiveness and make necessary changes as indicated.	

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F 585	Continued From page 7	F 585		

council meetings and was the Grievance Contact person for the facility. The SSD stated grievances were discussed and she was responsible for ensuring grievances were addressed and ultimately resolved with some assistance at times from the Director of Nursing (DON). The SSD confirmed residents complain about food during resident council meetings. She agreed if the residents continued to complain about the food, the grievances were not resolved.

On 12/15/22 at 3:30 PM, during an interview with Activity Director, she confirmed the residents complained about food in resident council meetings. She stated she did not always write the complaints on the minutes of the council meeting regarding food because the residents continue to bring it up and there was no need to continue writing what had already been discussed. She agreed the complaints regarding food had not been resolved.

Resident #8

An interview on 12/12/22 at 09:42 AM with Resident #8 revealed she was admitted to the hospital in July 2022 and had a stay of over 2 weeks. Resident #8 stated when she came back from the hospital she noticed that items had been moved around in her room. Resident #8 stated prior to her hospitalization she had $160.00 in a small cardboard box that was sealed up with tape under her Sunday school book and her Bible was on top of the box. Upon return from the hospital her Bible had been moved and the money was missing. Resident #8 stated she informed the Social Service Director (SSD) that her money was missing.

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F 585	Continued From page 8	F 585		

A review of the facility's grievance log revealed Resident #8's missing money was listed on the grievance log on July 18, 2022.

A review of the grievance investigation report regarding Resident #8's missing money revealed the SSD looked for the money in the resident room and could not find it. There was no indication the money was replaced by the facility.

An interview on 12/14/22 at 3:53 PM with the SSD confirmed when Resident #8 returned from her hospital stay, the resident told the SSD her money was missing that had been under her Bible in an envelope. The SSD stated she looked for the money but could not find it. The SSD stated she spoke with the resident's niece (Niece #1) regarding the lost money and the resident's niece told her the resident probably misplaced it, and not to worry about replacing it.

In an interview on 12/14/22 at 4:34 PM with Niece #1 she denied anyone at the facility had contacted her regarding any missing money. Niece #1 stated she gives resident money when she visits with the resident and had given money to the resident in July. Niece #1 stated she knew it was over $100.00 but she wasn't sure exactly how much.

An interview on 12/14/22 at 4:42 PM with Resident #8's niece (Niece #2) revealed Resident #8 told her about money missing from her room after she returned from a hospitalization. Niece #2 confirmed Niece #1 gives the resident money when she visits. Niece #2 stated no one from the facility had spoken to her about the resident missing any money.

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F 585	Continued From page 9 Review of Resident #8's Admission Record revealed the resident was admitted by the facility on 9/27/20 with medical diagnoses including Essential Primary Hypertension and Recurrent Depressive Disorder. Review of Resident #8's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/22/22, revealed the resident had a Brief Interview of Mental Status (BIMS) score of 15 which indicated the resident was cognitively Intact.	F 585		
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, record review. and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) assessment for two (2) of 19 residents reviewed. Resident #9 and Resident #11. Findings include: A record review of the facility's policy "MDS" with a revision date 09/25/2107 revealed "The center conducts initial and periodic standardized, comprehensive and reproducible assessment no less than every three months for each resident including, but not limited to, the collection of date requiring functional status, strengths, weaknesses, and preferences using the federal and/or state required RAI (Resident Assessment Instrument). ... Each person completing a section	F 641	F 641 Accuracy of Assessments Modifications to Minimum Data Set (MDS) for resident # 9 and 11, were made on January 5, 2023 by the Director of Nursing. All residents have the potential to be affected. Executive Director, in serviced MDS nurse on accuracy of MDS, on January 5, 2023. Director of Nursing reviewed all MDS for residents receiving aspirin therapy and anticoagulants for accuracy, on December 30, 2022. No additional concerns identified. Monitoring began on December 15, 2022	1/24/23

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F 641	Continued From page 10 or portion of a section of the MDS signs the Attestation Statement indicating its accuracy ..." Resident #9 Record review of Resident #9's "Admission Record" revealed the facility admitted resident on 11/02/2006 with the diagnoses including Hemiplegia and Hemiparesis following other Cerebrovascular Disease affecting right dominant side. Record review of Resident #9's Quarterly MDS with an Assessment Reference Date (ARD) of 11/23/2022 revealed in section N-N0410 Medications received revealed resident received seven (7) days of anticoagulant medication in the seven (7) day look back period. Record review of Resident #9's Order "Summary Report" orders for active orders as of 10/25/2022 revealed the resident was prescribed Aspirin Tablet Chewable give 81 milligram (mg) via Peg-tube one time a day for circulation. There were no anticoagulant medications ordered. Record review of Resident #11's "Admission Record" revealed the facility admitted resident on 04/13/2016. The resident had current diagnoses including Angina Pectoris Unspecified and Pain in Left Arm. Record review of Resident #11's "Order Summary Report" active orders as of 11/28/22 revealed an order for Aspirin EC Tablet Delayed Release 81 mg give one tablet by mouth one time a day. There were no anticoagulant medications ordered.	F 641	by the MDS Nurse and Director of Nursing. Findings were brought to the Quality Assurance Performance Improvement Committee by Administrator on December 16, 2022. MDS nurse and Director of Nursing will monitor 2 MDS□ weekly for accuracy times three (3) weeks. Findings will be brought to the Quality Assurance Performance Improvement Committee by MDS nurse and Director of Nursing beginning on January 23, 2023, then monthly times three (3) months to determine effectiveness and make necessary changes as indicated.	

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F 641	Continued From page 11 Record review of Resident #11's Quarterly MDS with an ARD of 12/05/2022 section N N0410 Medications received revealed resident received seven (7) days of anticoagulant medication in the seven (7) day look back period. On 12/15/22 at 2:00 PM, during an interview with MDS nurse/Licensed Practical Nurse (LPN) #1, she confirmed the MDS for both Resident # 9 and Resident #11 were coded for anticoagulant given. LPN #1 stated she thought Aspirin was classified as an anticoagulant. She stated she continues to learn by going through the RAI manual to complete the MDS assessment and confirmed the MDS's were coded inaccurately for anticoagulant use. On 12/15/22 at 2:20 PM, during an interview with the Director of Nursing (DON), she confirmed Aspirin was not an anticoagulant. She expects the MDS nurse to code the assessment accurately. She confirmed both MDS for Resident #9 and Resident #11 were coded inaccurately.	F 641		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses.	F 732		1/24/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PINE VIEW HEALTH AND REHABILITATION CENTER	1304 WALNUT ST WAYNESBORO, MS 39367

(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 732	Continued From page 12 (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure staffing was posted and visible to staff, residents, and visitors for four (4) of four (4) days with potential to affect 87 of 87 residents in the facility. Findings include: A record review of the facility's policy "Daily Nursing Staff Form" with a revision date of 09/2017 revealed " ... Post beginning of each shift in a prominent place that is readily accessible to	F 732	F 732 Posted Nurse Staffing Information Nurse Staffing Information sheet posted by Director of Nursing on December 15, 2022. All residents have the potential to be affected. Director of Clinical Services, in serviced all staff on posting daily nurse staffing information, beginning on December 19,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 732	Continued From page 13 residents and visitors. Daily posting of this information is required for nursing homes participation in Medicate and Medicaid. Definition of Directly responsible for resident care includes but is not limited to activities such as assisting with ADL's (Activities of Daily Living), giving medications, supervising the care given STNA/CNA's (student nurse assistance/certified nurse assistant), performing nursing assessments, or notifying a physician about a change in condition ..." Facility observations on 12/12/22 and 12/13/22 revealed there was no posted facility staffing observed. An observation on 12/14/22 at 3:00 PM revealed a clear bin across from the Director of Nursing's (DON) office in front of the woman's bathroom with papers folded over. When papers were lifted, the bin had signage reading, "Daily Staff Posting and Survey Results". The State Agency (SA) observed a staffing sheet for 12/13/22 with only 6A-6P filled in. On 12/15/22 at 09:00 AM, SSA observed clear bin with papers still bent over and the signage not visible. There were no staffing sheets. On 12/15/22 at 11:10 AM, during an interview with Licensed Practical Nurse (LPN) #2, she stated she previously was responsible for posting the daily staffing, but since she was now working in assessments, she did not know who was responsible for posting staffing. An observation and interview on 12/15/22 at 11:30 AM with the DON and Administrator revealed staffing sheets were not visible due to	F 732	2022 and ending January 6, 2023. Facility purchased cabinet to maintain daily staff posting, on January 5, 2023. Director of Nursing began monitoring the posting of daily staffing hours on December 14, 2022. Findings were brought to the Quality Assurance Performance Improvement Committee by the Director of Nursing on December 16, 2022. Director of Nursing to monitor posting of daily staffing hours five (5) times per week for three (3) weeks. Findings to be brought to the Quality Assurance Performance Improvement Committee beginning on January 23, 2023, then monthly times three (3) months to determine effectiveness and make necessary changes as indicated.	

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F 732	Continued From page 14 papers being folded over and staffing was not posted where all staff, residents, or guests could view, and no staffing was posted today. The Administrator reported the survey results have always been there in the clear sheets but did confirm the results are not clearly visible to anyone to see or review. The DON reported sometimes LPN#2 posted the staffing and sometimes the DON.	F 732		