STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	C 10/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASS HEALTHCARE AND REHAB ROWAN, LLC	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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
E 000	Initial Comments An unannounced recertification and complaint investigation survey were conducted on 10/8/23 through 10/11/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # G7RU11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 10/8/23 through 10/11/23. Event ID # G7RU11. The following intakes were investigated NC00199544, NC00202374, NC00207207 and NC00207383. Six (6) of the 6 complaint allegations did not result in deficiency.	F 000		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to	F 640		11/3/23

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

Electronically Signed | 10/31/2023

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F 640	Continued From page 1 standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to finalize, and transmit Discharge Minimum Data Set (MDS) assessments within the required time frame for 3 of 3 residents reviewed for submission of MDS assessments (Resident #34, Resident #56, and Resident #66). Findings included: 1.Resident #34 was admitted to the facility	F 640	640 Compass Healthcare and Rehab-Rowan wishes to have this submitted plan of correction stand as its written as allegation of compliance. Our date of compliance is 11/3/23. The plan is prepared and/or executed to ensure compliance with regulatory requirements. 1. Resident #34 had a Discharge Return Not	

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F 640	Continued From page 2 04/19/23. Review of Resident #34's Discharge Return Not Anticipated (DCRNA) MDS assessment on 06/15/23 was not marked as completed and had not been accepted into the Centers for Medicare & Medicaid Services (CMS) Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) System within 14 days of completion. 2.Resident #56 was admitted to the facility on 05/19/22. Review of Resident #56's DCRNA MDS assessment on 06/06/23 was not marked as completed and had not been accepted into the CMS QIES or ASAP systems within 14 days of completion. 3.Resident #66 was admitted to the facility 04/28/23. Review of the Discharge Return Anticipated (DCRA) MDS assessment on for Resident #66 dated 06/05/23 was not marked as completed and had not been accepted into the CMS QIES or ASAP systems within 14 days of completion. On 10/11/23 an interview with the Administrator at 12:44 PM revealed the MDS Coordinator was not available for interview. The Administrator revealed all MDS assessments were required to be completed and submitted in the time frame required by CMS and the Resident Assessment Instrument (RAI) manual.	F 640	Anticipated (DCRNA) MDS assessment completed and transmitted on 10/17/23 by the MDS Coordinator. Residents #56 and #66 had a DCRNA MDS Assessment completed and transmitted on 10/26/23 by the MDS Coordinator. 2. The Administrator has conducted MDS audits on 10/27/23 for residents requiring a DCRNA MDS assessments to ensure MDS's are timely, completed and transmitted. The results of the audit did not identify any other DCRNA MDS's not completed or transmitted, in addition, there were no other MDS's noted to be late for completion or transmission. 3. The MDS coordinator has been re-educated by the administrator on 10/31/23 on completion of discharge assessments and verification of timely MDS transmission, utilizing Chapter 5 of RAI (Resident Assessment Instrument) 3.0 Manual. 4. The Director of Nurses and/or Administrator will be responsible to complete audits of discharge assessments and entry tracking assessments by evaluating the missing OBRA Assessment report weekly for 4 weeks, then monthly for 3 months and quarterly thereafter. Results will be reviewed through monthly QAPI (Quality Assurance Performance Improvement) committee and corrective	

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F 640	Continued From page 3	F 640	actions taken as necessary. The Administrator is responsible for overall compliance.	
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 interviews and record reviews, the facility failed to accurately complete a Minimum Data Set (MDS) assessment to reflect a resident's life expectancy for 1 of 3 residents reviewed (Resident #71) who were receiving Hospice services; failed to indicate a resident was admitted to Hospice for 2 of 3 residents reviewed (Resident #71 and Resident #46) who were receiving Hospice services; and failed to accurate report the discharge location for 1 of 3 residents selected for a closed record review (Resident #70). The findings included: 1. Resident #71 was admitted to the facility on 2/23/23 with a cumulative diagnosis which included a progressive neurological disorder and cancer. A review of Resident #71's physician orders and Nursing Notes revealed the resident began to receive Hospice services on 3/10/23. A significant change Minimum Data Set (MDS) assessment dated 3/15/23 was completed for Resident #71. A review of this MDS revealed the	F 641	641 Compass Healthcare and Rehab-Rowan wishes to have this submitted plan of correction stand as its written as allegation of compliance. Our date of compliance is 11/3/23. This plan is prepared and/or executed to ensure compliance with regulatory compliance. 1. Resident #71's quarterly MDS assessment dated 6/14/23 was corrected on 10/17/23 to indicate life expectancy of less than 6 months and special treatments, procedures and programs to indicate Hospice. Resident #46 significant change MDS assessment dated 5/7/23 was corrected on 10/27/23 to indicate that resident was receiving Hospice while a resident. In addition, Resident #46 quarterly MDS assessment dated 8/6/23 was corrected to indicate on MDS section Special Treatments, Procedures and Programs section, Resident #46 was receiving Hospice. Resident #70 Discharge MDS assessment dated 9/25/23 was corrected on 10/26/23 to	11/3/23

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F 641	Continued From page 4 section on "Health Conditions" indicated the resident had a life expectancy of less than 6 months. The MDS section on "Special Treatments, Procedures and Programs" indicated Resident #71 was receiving Hospice services. Review of Resident #71's quarterly MDS assessment dated 6/14/23 revealed the section on "Health Conditions" did not indicate the resident had a life expectancy of less than 6 months. Also, the MDS section on "Special Treatments, Procedures and Programs" did not indicate Resident #71 was receiving Hospice services. An interview conducted on 10/11/23 at 9:01 AM with the facility's Administrator revealed the MDS Coordinator was not available for interview. Upon request, the Administrator reviewed Resident #71's quarterly MDS assessment dated 6/14/23. At that time, she confirmed the MDS section on "Health Conditions" did not indicate the resident had a life expectancy of less than 6 months and the section on "Special Treatments, Procedures and Programs" did not indicate Resident #71 was receiving Hospice services. She stated the resident was receiving Hospice services, "the whole time." 2. Resident #46 was admitted to the facility on 7/12/22 with reentry on 5/1/23 from a hospital. Her cumulative diagnosis included heart failure and a history of cerebral vascular accident (stroke) and respiratory failure. A review of Resident #46's electronic medical record (EMR) indicated a Hospice Consult was ordered for this resident with a start date of 5/2/23. Further review of Resident #46's paper	F 641	indicate a discharge to an ALF (Community) 2. On 10/27/23 All MDS's of residents who receive end of life care/life expectancy and Hospice were audited by the Administrator for accuracy. All 6 residents identified were complete and accurate. There were no discharge MDS's identified to review. All other MDS assessments when completed daily, will be checked by the DON and/or Administrator to ensure MDS assessments are complete and accurate prior to submitting the assessment with focus on life expectancy, Hospice and Discharge location. All MDS's done daily will be audited for accuracy daily for 4 weeks then 50 % of MDS's weekly for 4 weeks then 50% of MDS's monthly for 3 months then 50% of MDS's quarterly thereafter. Audits will be completed by the Administrator and/or Director of Nursing. 3. An in-service was conducted by the Administrator on 10/31/23 for all disciplines who complete portions of the MDS on the accuracy of assessments to ensure resident status is correctly coded on each MDS assessment. Focused direction will be provided regarding coding for resident life expectancy, Hospice Services and Discharge location. 4. The DON and/or Administrator will audit All MDS assessments for accuracy when completed daily for 4 weeks then 50% of MDS's weekly for 4 weeks then 50% of the MDS's monthly for 3 months then 50%	

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F 641	Continued From page 5 chart revealed a Consent and Election for Hospice Care was signed by the resident's power of attorney and Hospice Agency Representative on 5/2/23. Resident #46's significant change Minimum Data Set (MDS) assessment dated 5/7/23 revealed the section on "Health Conditions" indicated the resident had a life expectancy of less than 6 months. However, the MDS section on "Special Treatments, Procedures and Programs" reported Resident #46 was only receiving Hospice services while not a resident. A review of Resident #46's quarterly MDS assessment dated 8/6/23 was also conducted. This MDS revealed the section on "Health Conditions" continued to indicate the resident had a life expectancy of less than 6 months. However, the MDS section on "Special Treatments, Procedures and Programs" did not indicate Resident #46 was receiving Hospice services. An interview conducted on 10/11/23 at 9:01 AM with the facility's Administrator revealed the MDS Coordinator was not available for interview. Upon request, the Administrator reviewed Resident #46's significant change MDS dated 5/7/23 and quarterly MDS assessment dated 8/6/23. At that time, the Administrator confirmed the section on "Treatments, Procedures and Programs" on each of the MDS assessments reviewed did not indicate Resident #46 was receiving Hospice services while she was a resident. 3. Resident #70 was admitted to the facility on 9/12/22.	F 641	of the MDS's quarterly thereafter. Results will be reviewed during the monthly QAPI committee meeting and corrective action taken as necessary. The Administrator will be responsible for overall compliance.	

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F 641	Continued From page 6 A review of the electronic and paper medical record for Resident #70 documented the resident was discharged on 9/25/23 to an assisted living facility (ALF) within the community. However, a review of Resident #70's discharge Minimum Data Set (MDS) assessment dated 9/25/23 documented Resident #70 was discharged to an acute care hospital. An interview conducted on 10/11/23 at 9:01 AM with the facility's Administrator revealed the MDS Coordinator was not available for interview. Upon request, the Administrator reviewed Resident #70's discharge MDS dated 9/25/23. At that time, the Administrator confirmed the MDS was coded to indicate the resident was discharged to a hospital. The Administrator reported Resident #70 was actually discharged to an ALF.	F 641		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the	F 727	727	11/3/23

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F 727	Continued From page 7 facility failed to use the services of a Registered Nurse (RN) for 8 consecutive hours per day, 7 days per week for 5 of 5 dates reviewed (10/2/2022, 10/30/2022, 11/13/2022, 11/26/2022, and 12/25/2022). The findings included: The Payroll Based Journal (PBJ) data report for fiscal year 2023, quarter 1 from October 2022 to December 2022 was reviewed. The report indicated the facility had 4 or more days within the quarter with no Registered Nurse (RN) hours. The dates provided by the report were 10/2/2022, 10/30/2022, 11/13/2022, 11/26/2022, and 12/25/2022. A. The nursing schedule for 10/2/2022 was reviewed. No RN was scheduled to work on that date. The time sheets for 10/2/2022 were reviewed and no RN had worked any shift on 10/2/2022. B. The nursing schedule for 10/30/2022 was reviewed. No RN was scheduled to work on that date. The time sheets for 10/30/2022 were reviewed and no RN had worked any shift on 10/30/2022. C. The nursing schedule for 11/13/2022 was reviewed. No RN was scheduled to work on that date. The time sheets for 11/13/2022 were reviewed and no RN had worked any shift on 11/13/2022. D. The nursing schedule for 11/26/2022 was reviewed. No RN was scheduled to work on that date. The time sheets for 11/26/2022 were reviewed and no RN had worked any shift on	F 727	Compass Healthcare and Rehab-Rowan wishes to have this submitted plan of correction stand as its written as allegation of compliance. Our date of compliance is 11/3/23. The plan is prepared and/or executed to ensure regulatory compliance. 1. The facility failed to have a Registered Nurse (RN) scheduled for 8 consecutive hours a day for 7 days per week for 5 of 5 days reviewed. After reviewing the deficient practice, no residents were found to have been affected. 2. An in-service was conducted by the Administrator on 10/31/23 with the Director of Nursing (DON), Scheduler and all RN's on staff on the requirement of RN coverage for 8 consecutive hours, 7 days per week, with mandatory rule of working 8 hours and the use of on-call RN for call outs and/or early departure. 3. A daily staff requirement meeting will be held by the Administrator, DON and Scheduler to review staffing needs and the required RN 8 consecutive hours per day. The review will be in advance and for the next scheduled day. On Fridays, the review will be for Saturday, Sunday and Monday. If there are no RN available, the RN on-call will be utilized to ensure the daily RN for 8 consecutive hours. 4. Daily audits were implemented on	

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F 727	Continued From page 8 11/26/2022. E. The nursing schedule for 12/25/2022 was reviewed. No RN was scheduled to work on that date. The time sheets for 12/25/2022 were reviewed and no RN had worked any shift on 12/25/2022. An interview was conducted with the Scheduler on 10/11/2023 at 10:42 AM. The Scheduler said she had been responsible for the nursing schedule for almost 6 years at the facility. The Scheduler reported she was not certain why the facility did not have a RN scheduled for the above dates. The Scheduler reported the facility had 4 available RNs (not counting the Director of Nursing [DON]) and one of those RNs may have been unavailable for those weekends listed as having no RN coverage. The Scheduler reported she had not contacted the DON to inform her there was no RN scheduled for 10/2/2022, 10/30/2022, 11/13/2022, 11/26/2022, or 12/25/2022. During an interview with the DON on 10/11/2023 at 11:39 AM, she reported she was not aware the facility did not have RN coverage on the above listed dates. The DON explained if the Scheduler had notified her, she would have come to the facility to provide the RN coverage for those dates. The DON reported she expected to be aware of when the facility did not have RN coverage for 8 consecutive hours, 7 days per week. The Administrator was interviewed on 10/11/2023 at 2:45 PM. The Administrator explained that the corporate office submitted the PBJ information directly from the time sheets/payroll information.	F 727	10/30/23 to ensure 8 consecutive hours of RN coverage 7 days per week. The audit is completed by the Scheduler and the DON and it is reviewed by the Administrator daily. Results of the daily RN requirement will be reviewed by the Quality Assurance Performance Improvement (QAPI) Committee monthly for three months then quarterly thereafter for continuous quality improvement.	

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F 727	Continued From page 9 The Administrator reported that the Scheduler should have notified the DON there were no RNs scheduled to work those listed dates and the DON would have provided the 8 hours of coverage.	F 727		
F 732 SS=B	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. (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.	F 732		11/3/23

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F 732	Continued From page 10 §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 record reviews, observations, and staff interviews, the facility failed to post daily accurate staffing information for 9 of 10 posted daily staffing forms reviewed and failed to maintain complete daily nursing staffing sheet daily for 3 of 6 days. The findings included: A. Daily posted nursing staffing sheets for the following dates were reviewed: 10/2/2022, 10/30/2022, 11/13/2022, 11/26/2022, 12/25/2022, 4/8/2023, 4/9/2023, 6/24/2023, 8/15/2023, and 8/16/2023. The following dates were incorrect: The daily posted staffing sheet dated 10/2/2022 indicated 5 Licensed Practical Nurses (LPNs) provide 24 hours of care on the afternoon shift. The schedule for afternoon shift (3:00 PM to 11:00 PM) and the schedule indicated 3.5 LPNs were scheduled to work that date. The daily posted staffing sheet indicated 3 Nursing assistants (NAs) provided 22.5 hours of care for the night shift (11:00 PM to 7:00 AM). The schedule for 10/2/2023 revealed 4 NAs were scheduled to work. The daily posted staffing sheet dated 10/30/2022 indicated 3 NAs provided 22.5 hours of care for the night shift and 5 Licensed Practical Nurses (LPNs) provided 24 hours of care on the	F 732	732 Compass Healthcare and Rehab-rowan wishes to have this submitted plan of correction stand as it□s written as allegation of compliance. Our date of compliance is 11/3/23. The plan is prepared and/or executed to ensure compliance with regulatory compliance. 1. The posted nurse staffing information is posted and updated daily by the 200-hall nurse for each shift. The Scheduler checks the posted nurse staffing form twice daily to ensure that it is complete and accurate. The Scheduler will check the nurse staffing form every morning and every afternoon Monday-Friday. The weekend charge nurse will monitor the nurse staffing form for accuracy each morning and afternoon on weekends (Saturday and Sunday) 2. A review of the nurse staffing form was completed by the Administrator of forms completed since 10/11/23. The staffing sheets were posted, and staffing numbers and hours were correct and reflected changes in the schedule. 3. The Administrator provided education on	

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	345288	A. BUILDING _____ B. WING _____	C 10/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASS HEALTHCARE AND REHAB ROWAN, LLC	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 11 afternoon). The schedule for 10/30/2022 revealed 4 NAs were scheduled to work the night shift and 3.5 LPNs were scheduled to work the afternoon shift. The daily posted staffing sheet dated 11/13/2022 indicated 5 NAs provided 26.5 hours of care for the afternoon shift. The nursing schedule dated 11/13/2022 revealed 3.5 NAs were scheduled to work. The daily posted staffing sheet dated 11/26/2022 indicated 4 LPNs provided 16 hours of care for the afternoon shift. The nursing schedule dated 11/26/2022 revealed 2 LPNs were scheduled to work. The daily posted staffing sheet dated 12/25/2022 indicated 7 NAs provided 50 hours of care for the day shift (7:00 AM to 3:00 PM) and 4 LPNs provided 20 hours of care for the afternoon shift. The nursing schedule dated 12/25/2022 revealed 6.5 NAs were scheduled to work the day shift and 3 LPNs were scheduled to work afternoon shift. The daily posted staffing sheet dated 4/8/2023 indicated 3 LPNs provided 24 hours of care on the afternoon shift and 7 NAs provided 34 hours of care on the afternoon shift. The schedule revealed 2.5 LPNs and 4.5 NAs were scheduled to work the afternoon shift. The daily posted staffing sheet dated 4/9/2023 indicated 0 RN was working and 2 LPN provided 16 hours of care for the night shift. The schedule revealed 1 RN and 1 LPN were scheduled to work. The daily posted staffing sheet for afternoon shift on that date indicated 4 NAs provided 20 hours of care. The schedule revealed 2.5 NAs were scheduled to work. The daily posted staffing sheet dated 6/24/2023 indicated 5 NAs provided 37.5 hours of care on day shift. The staffing sheet indicated 1 RN provided 4 hours of care on evening shift, 2 LPNs	F 732	10/31/23 for the Director of Nursing (DON), Scheduler and staff nurses on requirements for daily posting of nurse staffing numbers and hours. The education included information requirements such as; facility name, date, census, total number and actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care per shift. It is understood that posting is required on a daily basis, beginning each shift, in a clear and readable format, in a prominent place accessible to residents and visitors. Newly hired nurses will receive education during orientation. 4. The Administrator will conduct random quality reviews of staffing sheets to ensure accurate posted nursing staff hours 2 times per week for 4 weeks then monthly thereafter. Results will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly for continued quality improvement and monitoring updated as needed.	

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F 732	Continued From page 12	F 732		

provided 12 hours of care and 6 NAs provided 42 hours of care on the evening shift. The schedule indicated 4 NAs were scheduled to work the day shift, 0.5 RNs were scheduled to work the afternoon shift, 1.5 LPNs, and 4.5 NAs were scheduled to work the afternoon shift.
The daily posted staffing sheet dated 8/16/2023 indicated 3 LPNs provided 21 hours of care and 5 NA provided 44 hours of care during the afternoon shift. The schedule revealed 2.5 LPNs and 4 NAs were scheduled to work.
The Scheduler was interviewed on 10/11/2023 at 10:42 AM. The Scheduler reported she was counting both staff members for a split shift (7:00 AM to 7:00 PM) and was not aware she should count those staff members as one licensed person.
The Administrator was interviewed on 10/11/2023 at 2:45 PM. The Administrator reported the staffing sheets were to be updated by the charge nurse as staffing changes occurred. The Administrator reported she was not aware the Scheduler was miscalculating the number of staff working per shift.

B. The daily posted staffing sheets were observed on the following dates: 10/8/23, 10/9/2023, 10/10/2023, and 10/11/2023. During a tour of the facility on 10/8/2023 at 1:07 PM the posted staffing sheet was located on the nursing unit on a bulletin board beside the nursing station. Pinned to the bulletin board were three copies of the daily posted staffing sheet. The daily posted staffing sheet dated Friday, 10/6/2023 was completed for night shift (11:00 PM to 7:00 PM. There was no information posted for the day shift (7:00 AM to 3:00 PM) or the afternoon shift (3:00 PM to 11:00 PM).

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The daily posted staffing sheet dated Saturday, 10/7/2023 and the staffing sheet was completed only for night shift. There was no information posted for day or afternoon shift.

The daily posted staffing sheet dated Sunday, 10/8/2023 and the staffing sheet was completed only for night shift. There was no information posted for day or afternoon shift.
The Scheduler was interviewed on 10/11/2023 at 10:42 AM. The Scheduler reported the night shift nurses posted the new staffing sheet for the facility at midnight and each shift the charge nurse updated the staffing sheet with the census and the staffing. The Scheduler reported she did not know why the staffing sheets were not updated over the weekend. The Scheduler explained that she would complete the staffing sheets if the sheets were incomplete. The Scheduler reported she was not aware the staffing sheets were to be updated as changes occurred with staffing and the census.
The Administrator was interviewed on 10/11/2023 at 2:45 PM. The Administrator reported the night shift nurse was to post the new staffing sheet and each shift was responsible for updating the census and the staffing. The Administrator reported she expected the staffing sheet to be updated as changes occurred.