STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175424	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/24/2026

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LAKEPOINT AUGUSTA, LLC	**901 LAKEPOINT DRIVE , AUGUSTA, Kansas, 67010**

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F0000	INITIAL COMMENTS The following citations represent the findings of a Health Recertification Survey and complaint survey regarding allegations in incident 3015354, and complaint 2808579. The census was 67. The sample included 18 residents.	F0000		
F0759 SS = E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a medication error rate below five percent. Twenty-six medications administrations were observed with 15 errors identified, resulting in a medication error rate of 57.69 %. Findings included: 1. Review of the Electronic Health Record (EHR) for Resident (R) 6 revealed the following orders: Finasteride (medication used to treat male pattern hair loss or enlarged prostate) five milligrams (mg), give one tablet via gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach) one time a day. Fludrocortisone acetate (a synthetic corticosteroid) 0.1 mg, give one tablet via G-tube one time a day. Furosemide (a loop diuretic) 40 mg, give two tablets via G-tube in the morning. Gabapentin (medication used to treat nerve pain and to control certain types of seizures) 600 mg, give	F0759		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0759 SS = E	Continued from page 1 one tablet via G-tube three times a day. Metoprolol (medication used to treat high blood pressure) 25 mg, give via one tablet via G-tube in the morning. Midodrine (medication used to treat low blood pressure when standing) 10 mg, give one tablet via G-tube three times a day. 24-hour (hr) Mirabegron (used to treat the symptoms of overactive bladder) 8 mg/milliliter (ml) extended-release suspension, give 3 ml via G-tube in the morning. Oxybutynin (medication used to treat urinary urgency, frequency, and incontinence) 5 mg, give one tablet via G-tube three times a day. Potassium Chloride (a medication to treat low blood potassium) 15ml/20 milliequivalent (MEQ), give 15 ml via G-tube two times a day. Simvastatin (a medication used to lower cholesterol) oral suspension 40 mg/5ml, give 5 ml via G-tube in the morning. ProSource oral liquid (nutritional supplement), give 30 ml via G-tube three times a day. Probiotic, give one tablet via G-tube one time a day. Clopidogrel (medication used to prevent blood clots) 75 mg, give one tablet via G-tube one time a day. Ferrous sulfate (oral iron supplement) 325 mg, give 1 tablet via G-tube one time a day. R6's EHR lacked orders for medications to be crushed and/or mixed and lacked an order for an oral tablet for simvastatin. Observed on 06/23/2026 at 11:00 AM, Licensed Nurse (LN) H crushed R6's oral tablet medications, which included an oral tablet for simvastatin and mixed them all in a cup with liquid medication. At 11:33 AM provided R6 his crushed and mixed medications via G-tube. LN H performed hand hygiene and wore gloves only. On 06/23/2026 at 11:22 AM, LN H said that all oral medication tablets were crushed and mixed with his ProSource, potassium chloride and mirabegron oral suspensions. She then confirmed there was no current order to crush R6's medications or to combine them and confirmed there should have	F0759		

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F0759 SS = E	Continued from page 2 been an order to crush and combine the medications. 2. On 06/22/2026 at 08:05 AM, Certified Medication Aide (CMA) R administered R34's aerosol 160-4.5 micrograms (mcg)/activated clotting time (ACT) (Budesonide-Formoterol Fumarate Dihydrate) one puff inhaled orally two times a day for chronic obstructive pulmonary disease. CMA R did not offer or encourage R34 to rinse her mouth after administration as ordered. On 06/23/2026 at 12:35 PM, Administrative Nurse D said that prior to crushing and/or mixing any medications an order should be obtained from the physician, and the pharmacist should be consulted to ensure medications could safely be mixed. The facility's policy "Administering Medications," date April 2019, documented that medications were to be administered in a safe and timely manner, and as prescribed. The policy washer documented that the individual administering the medication was to check the label and verify that it was the right resident, right medication, right dosage, right time, and right method (rout) of administration before giving the medication.	F0759		
F0550 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 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F0550		

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F0550 SS = D	Continued from page 3 §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 interviews, observation, and record review, the facility failed to ensure Resident (R) 22's was treated with respect and dignity while waiting to be assisted with meals. Findings included: - R22's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), need for assistance with personal care, senile degeneration of brain, and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). The "Annual Minimum Data Set (MDS)," dated 05/15/2026, documented a Brief Interview of Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented R22 was dependent on staff assistance with all activities of daily living. R22's "Cognitive Loss/Dementia Care Area Assessment (CAA)," dated 05/28/2026, documented she was at risk for a self-care deficit related to her dementia (a progressive mental disorder characterized by failing memory and confusion). R22's "Care Plan" documented the following interventions:	F0550		

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F0550 SS = D	Continued from page 4 02/20/2026 - She needed assistance with all decision making. She enjoyed talking with roommate and staff. She had little activity involvement related to her immobility. On 06/22/2026 at 08:18 AM, R22 sat reclined in her Broda chair (specialized wheelchair with the ability to tilt and recline) at the end of the dining room table. She faced away from her table mate. A cup of fluid sat on the table out of reach. On 06/23/2026 at 07:41 AM, R22 sat reclined in her Broda chair at the end of the dining room table. A glass of fluid sat on the table out of reach. She sat with her back to her table mate. At 08:17 AM, her table mate exited the dining room and R22 sat alone at the dining room table. At 08:23 AM, Certified Nurse Aide (CNA) P sat with R22 and assisted her with breakfast. On 06/23/2026 at 11:15 AM, R22 sat at the dining room table in her Broda chair with her back to her table mate. At 11:42 AM, an unidentified staff member placed a cup of fluid on the table out of R22's reach and the staff member sat down alone at another dining room table. At 12:04 PM, CNA P sat down with R22 and assisted her with lunch. On 06/24/2026 at 09:26 AM, CNA Q stated a resident should not have to sit in the dining room waiting for assistance with meals more than five to 10 minutes. On 06/24/2026 at 09:47 AM, Licensed Nurse (LN) G stated a resident should never sit in the dining room more than 20 to 30 minutes before staff assisted them with their meals. On 06/24/2026 at 12:35 PM, Administrative Nurse D stated R22 enjoyed sitting in the dining room. She stated R22 could ask to be moved if she wanted to sit in a different position. The facility's "Dignity" policy, last revised 02/2021, documented each resident would be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.	F0550		
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by	F0554		

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F0554 SS = D	Continued from page 5 §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews, the facility failed to ensure safe and appropriate self-administration of medication for Resident (R) 23, R37, and R45, which placed these residents at risk for unnecessary medication side effects and self-administration errors. Findings included: 1. R23's Electronic Medical Record (EMR) from the Admission Minimum Data Set (MDS)," dated 05/28/2026, documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. Review of R23's EMR physician orders under the "Orders" tab lacked an order for self-administration of medications. Review of R23's EMR under the "Assessment" tab lacked an assessment for safe self-medication administration. On 06/22/2026 at 08:11 AM, R23 laid on her bed with the bedside table next to the bed, a paper medication cup with pills sat on the bedside table. 2. R37's EMR from the "Quarterly MDS," dated 04/17/2026, documented a BIMS score of 12, which indicated moderately impaired cognition. Review of R37's EMR physician orders under the "Orders" tab lacked an order for self-administration of medications. Review of R37's EMR under the "Assessment" tab lacked an assessment for safe self-medication administration. On 06/22/2026 at 08:54 AM, R37 laid on his bed with the bedside table next to his bed, a paper medication cup with a pill sat on the bedside table. 3. R45's EMR from the "Significant Change MDS," dated 05/28/2026, documented a BIMS score of 15. Review of R45's EMR physician orders under the "Orders" tab lacked an order for self-administration of medications. Review of R45's EMR under the "Assessment" tab	F0554		

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F0554 SS = D	Continued from page 6 lacked an assessment for safe self-medication administration. On 06/22/2026 at 08:54 AM, R45 laid on his bed with the head of his elevated bedside table next to his bed. A paper medication cup with pills sat on the bedside table. On 06/24/2026 at 09:47 AM, Licensed Nurse (LN) G stated the residents can administer their own medications. LN G stated they are evaluated and determined to be safe by their BIMS score and then the physician would give an order for the residents to keep their medications in their room. On 06/24/2026 at 12:35 PM, Administrative Nurse D stated the residents are assessed for self-administration of their medications to determine if they are safe. She stated that assessment was documented in the resident's EMR under the "Assessment" tab. Administrative Nurse D stated then the resident's physician would give an order to self-administer their medication if they decide that was safe to do so. The facility's "Self-Administration of Medications" policy, last revised, 02/2021 documented residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so.	F0554		
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to ensure Resident (R)13's call light was within his reach to enable him to call for staff assistance. Findings included: - R13's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of pain, history of falls, overactive bladder, and need for assistance personal care.	F0558		

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F0558 SS = D	Continued from page 7 The “Quarterly Minimum Data Set (MDS),” dated 05/15/2025, documented a Brief Interview of Mental Status (BIMS) score of seven which indicated severely impaired cognition. The MDS documented R13 had limited range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension) bilaterally lower extremities. The MDS documented R13 was dependent on staff assistance for toileting, bathing, and transfers. R13's "Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA),” dated 12/01/2025, documented she required assistance with activities of daily living. R13’s “Care Plan” documented the following interventions: 09/23/2025 – Staff would ensure her call light was within reach and would encourage her to use it for assistance as needed. On 06/22/2026 at 09:51 AM, R13 sat in her high back wheelchair in her room as she watched TV. R13’s call light was pinned to the wall between her TV and dresser, out of her reach. On 06/09/2026 at 09:26 AM, Certified Nurse Aide (CNA)Q stated call lights should be placed on the person or clipped to the bed within reach. On 06/10/2026 at 09:47 AM, Licensed Nurse (LN) G stated call lights should always be within the resident’s reach when in the room. On 06/03/2026 at 12:35 PM, Administrative Nurse D stated call lights should be within the resident’s reach, if the resident was in their room. The facility’s “Accommodation of Needs” policy, last revised 03/2021, documented the facility’s environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity, and well-being.	F0558		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be	F0578		

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F0578 SS = D	Continued from page 8 construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to verify Resident (R) 7's advanced directive (a legal document in which a person specified what actions should be taken for their health, which may or may not include a do not resuscitate [DNR-decision whether, or not, to withhold medical intervention in the event the resident's heart stops] order) was properly documented on his charts and care plan. Findings included: - Review of the Electronic Health Record (EHR) for R7 included diagnoses of transient ischemic attack (TIA- temporary episode of inadequate blood supply to the brain), cerebral infarction (stroke - sudden	F0578		

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F0578 SS = D	Continued from page 9 death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), chronic pain due to trauma, quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), major depressive disorder, and anxiety disorder. R7's "Annual Minimum Data Set (MDS)," dated 05/21/2026, documented a Brief Interview of Mental Status (BIMS) of 15, which indicated intact cognition. R7's "Care Plan," dated 05/23/2025, documented that R7 was a full code. R7's EHR "home screen" documented his code status (full code or DNR) as DNR. R7's EHR documented a "Physician Order" for DNR, dated 05/22/2026. R7's EHR, under the admission section, had a signed DNR, dated 05/14/2026, with an uploaded date of 06/23/2026 by Administrative Nurse D. Review of R7's hard chart, kept behind the nurse's station, contained a blue sheet which read "full code." Observation on 06/23/2026 at 10:00 AM of R7's hard chart revealed a blue dot on the spine of the chart. On 06/23/2026 at 02:22 PM, Licensed Nurse (LN) I said the blue dot on the resident's hard chart notified staff that they were a full code and there was a DNR or blue sheet in the front of the chart, the code status was also in the EHR, and the resident care pan listed the code status. She verified R7's EHR listed him as DNR with an order and confirmed there was no DNR paperwork in the EHR. LN I said medical records performed the chart audits to make sure they were accurate and confirmed R7's "Care Plan" documented him as full code. On 06/23/2026 at 02:37 PM, R7 said that he wished to be a DNR. He reported that he had signed a DNR. On 06/24/2026 at 12:35 PM, Administrative Nurse D said that a resident's code status should be accurately uploaded in the EHR and the paper chart was to reflect the EHR. She also said it was a team effort to ensure the charts and EHR were accurate and should be corrected and updated regularly. The facility policy "Advance Directives," dated	F0578		

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F0578 SS = D	Continued from page 10 September 2022, documented that if the resident or resident's representative had executed one or more advance directives, or executed one upon admission, copies of those documents were to be obtained and maintained in the same section of the resident's medical record and be readily retrievable by any facility staff. The policy also documented that the plan of care for each resident was consistent with his or her documented treatment preferences and/or advance directive.	F0578		
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview,	F0583		

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F0583 SS = D	Continued from page 11 the facility failed to keep Resident (R) 23's protected health information (PHI) private on a medication cart parked in the main dining room. Findings included: - On 06/22/2026 at 07:45 AM, during initial tour a medication cart parked outside the dining room in the hallway with a laptop computer sitting on the top, the computer screen was unlocked and open, and R23's PHI was on the screen, visible to all who passed by the medication cart. The information visualized included R23's medications, date of birth, allergy information, and code status. On 06/22/2026 at 07:48 AM, Certified Medication Aide (CMA) R stated the computer screen should have been locked. On 06/24/2026 at 09:47 AM, Licensed Nurse (LN) G stated the medication should be locked, no personal information visible, and no medication left on the cart when staff walked away from the cart. On 06/24/2026 at 12:35 PM, Administrative Nurse D stated the medication cart should be clean, locked, and no personal health information left on the computer for others to see. The Facility's "Confidentiality of Information and Personal Privacy" policy, last revised 10/2017, documented the facility would protect and safeguard resident confidentiality and personal privacy.	F0583		
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 69 remained free from exploitation when facility staff reported that an employee coerced R69 into providing her $80.	F0602	"Past Noncompliance - no plan of correction required"	

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F0602 SS = D	Continued from page 12 Findings included: - R69's Electronic Medical Record (EMR) documented diagnoses of major depressive disorder, pain, and insomnia. R69's "Quarterly Minimum Data Set (MDS)," dated 04/01/2026, documented a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderate cognitive impairment. The assessment documented that R69 had little interest or pleasure in doing things and felt down and depressed. R69's "Care Plan," with a revision date of 01/03/2025, documented that she had impaired cognitive function/dementia or impaired thought processes related to dementia. Interventions, dated 01/03/2025, instructed staff to cue, reorient, and supervise R69 as needed. Staff were also instructed to discuss concerns about confusion, disease process, and nursing home placement with R69, her family and caregivers. R69's "Care Plan," with a revision of 04/16/2026, documented that she had depression. An intervention, with a date of 04/16/2026, instructed staff to monitor, document, and report as needed any signs or symptoms of depression, including hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing any negative statements, repetitive or health-related complaints, or tearfulness. Certified Medication Aide (CMA) S's "Notarized Witness Statement," dated 05/15/2026, documented she was giving R69's roommate medication and heard a housekeeper ask R69 if she could borrow $65.00 from her and R69 eventually said yes. She said that she heard R69 tell the housekeeper where her wallet was and after she removed that money from the wallet the housekeeper thanked R69 and promised to pay her back. The housekeeper then went around the privacy curtain and was startled to see CMA S in the room. CMA S documented that she immediately went and reported the incident to her supervisor. R69's "Notarized Witness Statement," dated 05/15/2026, documented that on the morning of 05/15/2026 Housekeeping U went to R69s room and asked her for $10.00 for a pair of earrings R69 had bought from her. R69 told her she only had $20 bills and asked Housekeeping U if she had change, and she said no. Housekeeping U then asked R69 for an additional $65.00 for food and groceries. R69 documented that she and R69 then asked Housekeeping U to get R69's wallet and R69 pulled	F0602		

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F0602 SS = D	Continued from page 13 out $80.00 and gave it to Housekeeping U. The “Facility Investigation,” dated 05/15/2026, documented that on 05/15/2026 staff reported concerns regarding possible financial exploitation of R69 by Housekeeping U. It was reported that Housekeeping U had previously sold R69 handmade jewelry for approximately $10 and had approached R69 asking for the money and R69 had told Housekeeping U that she only had a $20 bill and requested change. Another staff member overheard the conversation and heard Housekeeping U request additional money from R69, and R69 then provided Housekeeping U with approximately $80. Based on the investigative findings, the facility terminated Housekeeping U on 05/15/2026, a police report was filed on 05/15/2026, and the facility reimbursed R69 the $80.00 on 05/15/2026. Observed on 06/023/2026 at 10:15 AM, R69 ambulated in the hall with her walker. She greeted other residents and staff pleasantly and with a smile. On 06/22/2026 at 09:02 AM, R69 reported that the previous month a housekeeper told her that she needed to buy groceries and kept telling R69 she had no money. R69 said she felt bad for the housekeeper, so she ended up giving her a total of $80.00. She then said that the facility immediately reimbursed her the $80.00. On 06/23/2026 at 08:28 AM, R45 said staff had never asked her for money or anything, she thought that administration might have talked to her about abuse, neglect, exploitation (ANE). On 06/23/2026 at 08:35 AM, R56 and R66 both said that no staff had ever asked either of them for money or anything and that every so often administration would talk to them about ANE what to do if anything related to ANE occurred. Both said that the most recent education occurred May 2026. On 06/23/2026 at 08:45 AM, Certified Nurse Aide (CNA) M said that she had just hired last month, and the facility provided online education for ANE through an e-learning platform and there had also been a policy handout that was reviewed. On 06/23/2026 at 09:05 AM, Administrative Staff A said that ANE training occurred annually and anytime there was an instance or concern that arose. He said the last ANE education occurred a month ago and it was facility wide. Administrative Staff A said that last month a housekeeper exploited R69 for $80.00 and the facility immediately	F0602		

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F0602 SS = D	Continued from page 14 suspended the housekeeper and performed an investigation and reimbursed R69 the money on 05/15/2026. He said there were 34 residents interviewed by the social services designee (SSD) after the exploitation occurred, all residents had a BIMS of 12 or higher and the sample was throughout the building. He said that ANE education was facility wide and completed on 05/18/2026 and interviews were completed on 05/15/2026. Administrative Staff A also said that the employee was terminated, and a police report was filed. Review of the bank transaction from the facility to R69's account revealed that the facility reimbursed R69 the $80 on 05/15/2026, re-education was completed 05/18/2026, therefore PNC. The facility policy "Lakepoint Augusta Introduction to ANE" documented that exploitation was illegal or improper use of an individual's resources for another person's profit or advantage. The policy documented that employees must understand their legal obligation to report any suspected abuse, neglect, or exploitation.	F0602		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any	F0605		

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F0605 SS = D	Continued from page 15 physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--	F0605		

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F0605 SS = D	Continued from page 16 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interviews and observation, the facility failed to perform a gradual dose reduction (GDR) or provide a physician's rationale for not attempting the GDR for Resident (R) 44's psychotropic medications. Findings included: - R44's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and dementia (a progressive mental disorder characterized by failing memory and confusion).	F0605		

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F0605 SS = D	Continued from page 17 The “Significant Change Minimum Data Set" (MDS), dated 04/10/2026, documented a Brief Interview of Mental Status (BIMS) score of 00 which indicated severely impaired cognition. The MDS documented R44 received an antipsychotic and antianxiety medication during the observation period. R44’s “Care Plan,” dated 07/26/2024, documented R44 used psychotropic medications including Quetiapine (antipsychotic) and Haldol (antipsychotic) related to a mild neurocognitive disorder. Staff were to consult with the pharmacy and consider a dosage reduction when clinically appropriate at least quarterly. R44’s EMR revealed the following orders: Duloxetine (antidepressant) 60 milligrams (mg) once daily, dated 07/27/2024. Quetiapine fumarate 50 mg twice daily, dated 02/20/2026. R44’s EMR recorded a pharmacy consultant noted, dated 02/08/2026, which documented a recommendation was made and directed to see the medication review. The facility provided a “Note To Attending Physician/Prescriber” stamped as faxed on 02/10/2026 which documented R44 was receiving the following psychotropic medications that were due for review: haloperidol 1mg daily, quetiapine 37.5mg each morning and 25mg at bedtime and duloxetine 60 mg every morning. It listed a rationale that noted the Centers for Medicare and Medicaid (CMS) guidelines required psychotropic medications to be evaluated for dose reduction/discontinuation twice in the first year (at minimum), then at prescriber's discretion thereafter. The note listed several recommendations for GDR and asked for documented rationale. The physician did not mark any of the options listed but documented “no change” under the physician/provider response section. The response lacked a rationale why no GDR would be attempted. Observation on 06/22/2026 at 10:46 AM revealed that R44 laid in bed and appeared to be sleeping. Observation on 06/23/2026 at 08:39 AM revealed staff changed R44 and used a draw sheet to reposition him with no combative behavior or resistance from R44 observed.	F0605		

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F0605 SS = D	Continued from page 18 Observation on 06/23/2026 at 09:33 AM revealed R44 was in his bed and appeared to be sleeping. Observation on 06/23/2026 at 11:40 AM revealed the hospice nurse in the room assessing the resident who appeared to be sleeping. During an interview on 06/24/2026 at 09:21 AM, Administrative Nurse D stated that they had asked for a rationale for the consultant pharmacist recommendation related to the GDR but only had what was documented on the recommendation. The facility did not provide a policy related to psychotropic medications.	F0605		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident,	F0628		

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F0628 SS = D	Continued from page 19 the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge;	F0628		

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F0628 SS = D	Continued from page 20 (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return-	F0628		

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F0628 SS = D	Continued from page 21 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and interviews,	F0628		

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F0628 SS = D	Continued from page 22 the facility failed to ensure Resident (R)12, R76 and R37 and their representatives received a written notification of transfer that included a statement of the residents' rights, the transfer location, reason for the transfer and the state ombudsman information, as soon as practicable upon their transfer to the hospital. Additionally, the facility failed to notify the office of the Long-Term Care Ombudsman (LTCO) of the transfers. Findings included: 1. R12's Electronic Medical Record (EMR) recorded a "Discharge Minimum Data Set" (MDS)" dated 04/10/2026, which documented an unplanned discharge to an acute hospital with a return anticipated. R12's clinical record lacked evidence that a written notification of transfer was provided to R12 or their representative. Upon request, the facility was unable to provide evidence of the written notification. 2. R37's Electronic Medical Record (EMR) recorded a "Discharge Minimum Data Set" (MDS)" dated 04/27/2026, which documented an unplanned discharge to an acute hospital with a return anticipated. R37's clinical record lacked evidence that a written notification of transfer was provided to R37 or their representative. Upon request, the facility was unable to provide evidence of the written notification. 3. R76's EMR recorded R76 was transferred to the hospital via Emergency Medical Services (EMS) on 04/30/2026 at 02:15 PM for evaluation of symptoms. R76's EMR lacked evidence that the facility provided written notification of the transfer to R76 and/or her representative. Review of the facility's "Monthly Transfer Log to Hospital" which was submitted to the LTCO monthly for the timeframe of 02/01/2026 to 05/31/2026 lacked documentation of R12's, R37's and R76's transfer to the hospital. On 06/24/2026 at 08:54 AM, Administrative Staff A stated the facility had not provided R12, R37 and R76 (or their legal representatives) with written notice of their transfer to the hospital. and confirmed the LTCO was not notified. Administrative Staff A stated the social service department was responsible for the notification.	F0628		

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F0628 SS = D	Continued from page 23 The facility did not provide a discharge policy.	F0628		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the staff had properly secured storage of resident medications. Findings included: - Observed on 06/22/2026 at 10:38 AM, Licensed Nurse (LN) G unlocked the treatment/nurse cart in the 100/200/300 hall and then left it unattended as she went down the 200 hall and into a resident's room. The cart contained seven boxes that contained nebulized breathing treatments, three containers of Vick's vapor rub, tubes of icy hot muscle rub, several tubes of calmoseptine ointment, and dressing change supplies. Also contained in the treatment cart were two insulin injector pens for Resident (R) 3, one insulin injector pen for R54, two insulin injector pens for R46, two insulin injector	F0761		

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F0761 SS = D	Continued from page 24 pens for R24, two insulin injector pens for R52, two insulin injector pens for R40, two insulin injector pens for R63, two insulin injector pens for R69, and two insulin injector pens for R70. On 06/22/2026 at 10:45 AM, LN G said that a medication or treatment cart should never have been left unlocked and unattended. On 06/24/2026 at 12:35 PM, Administrative Nurse D said that any time a nurse or medication aide walked from the medication cart area or treatment cart the cart should have been cleaned and locked and no resident information readily available for viewing by unauthorized persons. The facility policy “Medication Labeling and Storage,” dated February 2023, documented that compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals would be locked when not in use, and trays or carts used to transport such items would not be left unattended when open or otherwise potentially available to others.	F0761		
F0804 SS = D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure staff served meals at safe and appetizing temperatures. Findings include: - On 06/23/2026 at 09:36 AM, Certified Nursing Aide (CNA) L delivered a breakfast meal to a room in the 100 hall. The temperature of the items was as follows: 116 degrees Fahrenheit (F) for the hashbrowns.	F0804		

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F0804 SS = D	Continued from page 25 114 degrees F for the cheese omelet. 115 degrees F for oatmeal. On 06/22/2026 at 08:15 AM, Resident (R) 70 stated the food arrives to his room cold. On 06/23/2026 at 09:40 AM CNA L said she was not sure how hot the food was supposed to register, but it likely should have been hotter. On 06/23/2026 at 10:55 AM, Dietary BB stated the standing warmer directly inside the door into the kitchen was used to hold the prepared meals for the residents that choose to eat in their rooms. Dietary BB stated the temperature of this warmer, referred to as “the hot box,” should be 145 degrees F. Dietary BB verified the temperature inside the warmer as 110 degrees F and stated the temperature could not be adjusted higher. The facility policy did not address palatable temperatures.	F0804		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but	F0880		

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F0880 SS = D	Continued from page 26 are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and observation, the facility staff failed to implement adequate infection control practices related to Enhanced Barrier Precautions	F0880		

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F0880 SS = D	Continued from page 27 (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care). Findings included: - During an observation on 06/23/2026 at 11:33 AM, observation revealed there was no signage or readily available personal protective equipment (PPE) to include gowns for Resident (R) 6 who had a gastronomy tube (G-tube: tube surgically placed through an artificial opening into the stomach). Further observation revealed that Licensed Nurse (LN) H donned gloves but no gown and provided R6 his medications via the G-tube. LN H verified that both a gown and gloves should have been worn for EBP. During an interview on 06/23/2026 at 08:45 AM, Certified Nurse Aide (CNA) M reported that EBP and PPE would be used by staff whenever a resident had an infection, CNA M said it was also used if the resident had a urinary catheter. During an interview on 06/24/2026 at 12:35 PM, Administrative Nurse D reported EBP and PPE are used for any indwelling device and any open wound being treated. The facility did not provide a policy for EBP or PPE practices.	F0880		
F0732 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:	F0732		

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F0732 SS = C	Continued from page 28 (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, staff, 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: The facility reported a census of 67 residents. Based on observation and interview, the facility failed to ensure the posted daily nurse staffing sheets included accurate information to include the daily census. Findings included: During an observation on 06/22/2026 at 10:13 AM, the daily staffing sheet that hung on the wall behind the front desk at the entrance station documented a	F0732		

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F0732 SS = C	Continued from page 29 census of 71. During an observation on 06/23/2026 at 11:05 AM, the same staff sheet dated 06/22/2026 was still posted on the wall. No sheet for 06/23/2026 was observed. On 06/22/2026 during the initial entrance into the facility, Administrative Staff A verified that the census was 67. During an interview on 06/23/2026 at 02:19 PM Administrative Staff A the customer service associate (CSA) updates the daily staffing sheets. He said there were three CSAs employed at the facility to ensure they would have one working every day of the week and if the CSAs were to call in, then the administrator would be responsible for updating the daily staffing sheet. He stated that if the daily staffing sheet had not been filled out correctly the CSA would need to be educated. The facility policy “Posted Direct Care Daily Staffing Numbers” documented that the facility would post daily for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents. The information recorded on the form should include the current date (the date for which the information is posted) and the resident census at the beginning of the shift for which the information is posted.	F0732		
F0851 SS = C	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	F0851		

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F0851 SS = C	Continued from page 30 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); (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 interview and record review, the facility failed to electronically submit accurate staffing information through the Payroll-Based Journaling (PBJ). Findings included:	F0851		

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F0851 SS = C	Continued from page 31 The PBJ Staffing Data Report provided by the Centers for Medicare and Medicaid Services (CMS) for the Fiscal Year (FY) 2026 Quarter 2 indicated the facility had excessive low weekend staffing. Review of the staffing sheets revealed the same number of direct care staff worked on weekends and weekdays. During an interview on 06/23/2026 at 02:19 PM Administrative Staff A verified the facility did not have low weekend staffing. He said the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Minimum Data Set Nurse (MDS) worked on the weekends as needed. The “Reporting Direct Care Staffing Information (Payroll Based Journal)“ policy, revised August 2022, documented direct care staffing information was reported electronically to CMS through the Payroll-Based Journal system. Complete and accurate direct care staffing information was reported electronically to CMS through the Payroll-Based Journal (PBJ) system in a uniform format specified by CMS.	F0851		