STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285267	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Louisville Care Center	410 West 5th Street Louisville, NE 68037

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45641 Licensure Reference Number 175 NAC 12.006.09(I) Based on observation, interview, and record review, the facility failed to ensure interventions were implemented to protect 1 (Resident 11) of 2 sampled residents from elopement (when a resident leaves a facility without authorization or supervision, and may be a threat to their health or safety). The facility census was 48. Findings are: A record review of the facility's Elopement (when a resident leaves a medical facility without being noticed or supervised) policy with a last revision date of 10/2024 revealed the facility would do risk assessment on admission, quarterly, and with a change of condition. Wander bracelets would be placed on resident's identified as exit seekers and interventions would be placed in the care plan. A record review of Resident 11's Clinical Census dated 01/11/2025 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 11's Medical Diagnosis dated 01/11/2025 revealed the resident had diagnoses of Diffuse Traumatic Brain Injury (TBI) (widespread brain damage caused by injury), fall on same level, and nicotine dependence. A record review of Resident 11's Minimum Data Set (MDS, a comprehensive assessment used to develop a resident's care plan) dated 10/15/2024 revealed the resident had a Brief Interview for Mental Status (BIMS, a score of a residents cognitive abilities) of 4 which indicated the resident was severely cognitively impaired. The resident required supervision or touching assistance with toileting, bathing, and upper body dressing. Partial moderate assistance with lower body dressing and footwear. The resident had 2 or more falls in the lookback period fallen in the last month. The resident was marked for inattention on the Acute Onset Mental Status area. The MDS revealed that the resident had a wander/elopement alarm. A record review of Resident 11's Progress Notes dated 01/11/2025 revealed that on 1/8/25 Resident 11 had attempted to leave the building. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 11's Progress Note dated 10/14/2024 revealed Behavior Note: Resident was observed abruptly wanting to leave. When ask about it, [gender] indicated that [gender] had been wanting something from the store to sharpen [gender] razor [gender] uses for shaving. Social Services has been working with resident and (family) on a plan for this. After further discussing with resident, [gender] indicated [gender] had known about today's outing (10/14/2024) to Dollar General. Resident was unable to go due to a limited number of wheelchair seats. A record review of the facility's Care Plan Meeting dated 10/03/2024 revealed Resident 11 was at risk for elopement and had attempted to go outside. The resident's behaviors were the resident was fixated on different things due to TBI. A record review of the facility's Team Meeting dated 10/29/2024 revealed Resident 11 continues to want to sit outside, has purpose, ie: people watching, watching birds, etc. No attempts or verbal comm of wanting to leave property. Prefers front entrance. Refuses supervision as [gender] feels [gender] is being treated like a child that way. After discussion, no wander guard at this time. Sister agrees with resident request. Will continue to observe for changes. A record review of Resident 11's Progress Note dated 11/01/2024 revealed Elopement Evaluation: -Evaluation: Elopement Score: 1.0 At Risk -History of elopement while at home: No. -History of attempting to leave the facility without informing staff: Yes. -Verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door: No. -Wanders: No. -Wandering behavior a pattern or goal-directed: No. -Wanders aimlessly or non-goal-directed: No. -Wandering behavior likely to affect the safety or well-being of self/others: No. -Wandering behavior likely to affect the privacy of others: No. -Recently admitted or readmitted (within the past 30 days) and has not accepted the situation: No. -Comments: Res. has forgotten to alert staff when (gender) is going out. However, resident is able to voice (gender's) plan stating I went out to sit with other residents already out there which in turn was verified. Resident needs reminders. A record review of the facility's Edit Intervention dated 11/10/2024 revealed the Assistant Director of Nursing (ADON) edited Resident 11's care plan to include elopement risk and added an intervention of: wears a wanderguard on wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 11's Care Plan with an admitted [DATE] revealed: -A focus area of the resident enjoys sitting out front at facility with other residents, notifies staff before going outside. Date initiated of 10/04/2024. No interventions. -A focus area of elopement risk. Date initiated of 11/10/2024. Interventions of elopement risk assessment shows resident was at risk for elopement with a date initiated of 11/10/2024, observe location in the community every shift with a date initiated 11/10/2024, and wears a Wanderguard on wheelchair with a date initiated of 11/10/2024. -A focus area of the resident is at risk of falls related to unaware of safety needs with a date initiated of 08/26/2024. -A focus area of the resident has had an actual fall with no injury, poor balance, unsteady gait (walking movement) with a date initiated of 10/31/2024. -A focus area of cognition with a date initiated of 11/10/24 and an intervention of requires reminders, has mild to moderate disorientation or difficulty recalling/retaining information, and displays deficits in judgement with a date initiated of 11/10/2024. -A focus area of mobility with a date initiated of 10/04/2024, and interventions of independent with moving self throughout unit in wheelchair and requires assistance for transfers and toileting. An observation on 01/07/2025 at 2:00 PM revealed Resident 11 exited the front door of the building and was halfway between the building and the parking lot before staff stopped the resident. The resident was only wearing a sweatshirt, sweatpants, socks and shoes. The resident did not have a coat, hat, or gloves. The temperature at the time was 22 degrees Fahrenheit. To the left side of the front of the building there is a steep driveway to a busy road and a large retaining wall between the facility and the Assisted Living facility below. An observation on 01/07/2025 at 2:20 PM did not reveal a wanderguard bracelet (an device placed on a resident that would cause an alarm to sound if a resident attempted to leave a monitored door) on Resident 11 or the resident's wheelchair. An observation on 01/07/2025 at 2:24 PM revealed Resident 11 attempted to leave the front door of the building and staff had to stop the resident. An observation on 01/08/2025 at 10:56 AM revealed Resident 11 went out the front door of the facility. The Office Manager (OM) seen the resident leave the building and went outside to get the resident. The resident was wearing a long sleeve sweatshirt, sweat pants, socks, and shoes. The resident was not wearing a coat, hat, or gloves. The temperature outside at the time was 16 degrees Fahrenheit. The OM seen the resident leave the facility, went outside and got the resident and brought back inside. The resident was very concerned about the bird feeders outside. When the resident was back inside, the resident went to the window to view the birdfeeder outside. The observation did not reveal a wanderguard bracelet on the resident or wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/07/2025 at 2:15 PM, Registered Nurse (RN)-C confirmed Resident 11 did not notify staff that the resident was going outside unattended, and the resident knew the resident needed to. RN-C reviewed a list of residents that were supposed to have a wander bracelet and reviewed the resident's orders and confirmed the resident was not on the list and did not have an order for a wanderguard. In an interview on 01/07/2025 at 2:20 PM, the facility's Office Manager (OM) confirmed Resident 11 did not tell the office staff that the resident was going outside when the resident left the building on 01/07/2025, but it was care planned that (gender) could go out. In an interview on 01/07/2025 at 2:20 PM. The facility's Administrative Assistant (AA) confirmed the AA seen the resident leave the building, tried to call the nursing staff but nobody answered, and the OM went outside to get the resident. In an interview on 01/07/2025 at 2:30 PM, the ADON confirmed Resident 11's care plan included an intervention for the resident to have a wanderguard as of 11/10/2024. The ADON confirmed there was not an order for the wanderguard. The ADON confirmed the resident did not have a wanderguard. The ADON confirmed the ADON reviewed the Edit Intervention dated 11/10/2024, confirmed the ADON added the intervention due to the resident was elopement risk and tried to leave the facility, but was unsure why the resident did not have a wanderguard. In an interview on 01/07/2025 at 3:15 PM, the ADON confirmed the facility did not consider the resident leaving the facility unattended was an elopement due to the staff seen the resident leave and the resident did not need a wanderguard. The ADON confirmed the Administration discussed it as a team over emails and decided not to put a wanderguard on the resident. In an interview on 01/08/2025 at 11:03 AM, the facility's OM confirmed the resident did not check in with the staff when the resident left the faciity on [DATE]. In an interview on 01/08/2025 at 11:09 AM, RN-C confirmed Resident 11 did not notify the nursing staff that he was leaving the building on 01/08/2025. In an interview on 01/08/2025 at 8:10 AM, RN-C confirmed the resident was not safe to go outside alone. RN-C confirmed the resident was impulsive (tendency to act without thinking) and the resident had poor safety awareness. In an interview on 01/08/2025 at 11:11 AM, Medication Aide (MA)-D confirmed that Resident 11 was not safe to be outside alone. The resident would be ok if supervised, but not alone. In an interview on 01/08/2025 at 8:57 AM, the facility's Infection Preventionist, who is also an RN and Quality Assurance Manager, confirmed the resident was not safe to go outside unattended and a wanderguard would be appropriate due to the resident attributes (quality or feature), BIMS, and safety concerns. In an interview on 01/08/2025 at 11:35 AM, the facility's Social Worker (SW) confirmed the SW was aware that Resident 11 had attempted to get out the back door, the side door, and today, the front door. SW confirmed that the resident was at risk for falls and was not safe to be out of the facility unattended. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/08/2025 at 11:23 AM, the Director of Nursing (DON) confirmed that with the resident exit seeking behaviors and safety awareness, something needed to be done to keep the resident safe. The DON will discuss with the staff. The DON confirmed a wanderguard was needed and was going to placed on Resident 11's wheelchair.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45484 Licensure Reference Number 175 NAC 12-006.09(J)(i)(1) Based on record reviews and interviews, the facility failed to obtain resident weights for 3 residents (Resident 32, Resident 3, and Resident 42) of 4 sampled for potential nutritional problems. The facility census was 48. Findings are: A record review of the facility's Resident Weights policy with effective date 11/10 revealed that residents with potential nutritional problems would be monitored by the dietitian on a weekly basis to determine if the resident had experienced a weight loss or gain that that equal or exceeds 5% in 1 month. 7.5% in 3 months, or 10% in 180 days. A. A record review of Resident 32's Admission Record printed 01/06/2025 revealed the resident was admitted on [DATE] and had diagnoses of adult failure to thrive (a state of decline that shows up as weight loss, decreased appetite, poor nutrition, and inactivity), a stage 4 (full thickness) pressure injury (an injury to the skin caused by prolonged pressure) to the sacrum (bony area at the base of the spine) and malnutrition. A review of Resident 32's Weight Summary printed 01/08/2025 revealed the resident was weighed three times in 2024. On 01/05/2024, the resident weighed 141 pounds (lbs). On 06/17/2024, the resident weighed 128.5 lbs, which is an 8.87 % loss. On 09/09/2024 the weight was 128.0 pounds. There were no further weights after 09/09/2024. An interview on 01/07/2025 at 11:00 AM with Registered Nurse (RN) C confirmed that residents got weighed at least once a week on bath days. RN C confirmed Resident 32 was not getting weighed because the resident refused to get out of bed and the facility did not have a lift with a scale, so did not have a method to weigh Resident 32. An interview on 01/08/2025 at 7:44 AM with the Infection Preventionist (IP) who was an RN confirmed the facility did not have a lift with a scale. An interview on 01/08/2025 at 11:49 AM with Nurse Aide (NA) F confirmed that residents got weighed on bath days, at least once a week. NA F confirmed Resident 32 had not been getting out of bed, so it had been a while since NA F had weighed the resident. NA F confirmed the Hoyer lift did not have a scale. An interview on 01/08/2025 at 2:10 PM with RN C confirmed that Resident 32 had not been weighed in the facility since September of 2024. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 01/08/2025 at 2:24 PM with the Assistant Director of Nursing (ADON) confirmed the facility expectation for resident weights was that every resident should be weighed weekly. The ADON further confirmed that Resident 32 was not being weighed because the facility did not have the equipment needed to weigh the resident. An interview on 01/08/2025 at 2:28 PM with the Registered Dietitian (RD) confirmed that the expectation for resident weights would be at least monthly. 45641 B. A record review of Resident 3's Clinical Census dated 01/08/2025 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 3's Medical Diagnosis dated 01/08/2025 revealed the resident had diagnoses of cerebral infarction due to unspecified occlusion or stenosis of unspecified artery (stroke caused by blockage of an unknown artery in the brain), memory deficit following other cerebrovascular disease (memory loss due to a stroke), COVID-19, gastro-esophageal reflux disease (GERD)(stomach acid flows back up into the throat),and depression. A record review of Resident 3's Minimum Data Set (MDS, a comprehensive assessment used to develop a resident's care plan) dated 11/12/2024 revealed the resident did not have a Brief Interview for Mental Status (BIMS, a score of a residents cognitive abilities) because the resident was rarely/never understood. of 4 which indicated the resident was severely cognitively impaired. The resident required partial/moderate assistance with bathing, supervision or touching assistance toileting, footwear, and personal hygiene (cleaning), setup assistance with dressing, and was independent with eating. The MDS revealed that the resident was on a mechanically altered diet (blended to a thinner thickness). A record review of Resident 3's Care Plan with an admitted [DATE] revealed a focus area of the resident had nutritional concerns due to diagnoses of COVID-19, GERD, memory deficit disorder, pneumonia, type 2 diabetes mellitus (uncontrolled blood sugar), underweight status and the resident was receiving a mechanically altered diet and an intervention to provide supplements as ordered. The resident was independent with eating and needed an escort to the dining room. A record review of the Resident 3's Mini Nutritional Evaluation dated revealed a score of 7 of 14 which indicated the resident was malnourished. A record review of the Resident 3's Nutrition Task dated 12/10/2024 - 01/07/2024 revealed on 01/06/2025 at 10:51 AM and 1:31 PM the resident ate 51% - 75% of meal and 01/07/2025 at 2:18 PM it was marked the resident ate 0 - 25%, on 01/07/2025 at 2:20 PM it was marked the resident ate 75 - 100%, and on 01/07/2025 at 6:15 PM it said the resident ate 25 - 50% of the meal. A record review of Resident 3's Weights And (&) Vitals dated 02/21/2023 - 01/06/2024 revealed the resident was weighed weekly until 11/1/2024 but did not reveal a documented weight since. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 3's Weights And (&) Vitals dated 01/08/2025 with the facility's Assistant Director of Nursing (ADON) revealed the resident was weighed weekly until 11/1/2024 but did not reveal a documented weight since. A record review of the Bath List - East sheets dated 11/07/2024 - 01/07/2025 with the ADON revealed the resident was weighed on 11/25/2024 but it was not recorded in Resident 3's Electronic Medical Record (EMR), and the scale was not working on 12/09/2024 and 12/12/2024. An observation on 01/06/2025 at 1:05 PM revealed Resident 3 was lying in bed sleeping with an untouched bowl of soup on the overbed table. An observation on 01/07/2025 at 9:06 AM -10:12 AM revealed Resident 3 was lying in bed sleeping with an untouched tray of food on the overbed table. An observation on 01/07/2025 at 10:13 AM revealed a Nursing Assistant (NA) removed the untouched meal tray from the Resident 3's room. An observation on 01/07/2025 at 1:16 PM revealed the Director of Nursing (DON) deliver a tray of food to Resident 3, attempted to wake resident and assisted with putting dentures in. Resident struggled to get plastic wrap of the soup and took a couple of bites before falling back asleep. An observation on 01/07/2025 at 1:31 PM revealed Resident 3 sleeping in bed with a lunch tray on the overbed table, the sandwich was untouched, the bowl of soup had a spoon in it but the bowl was full. There was a cookie on the tray that had 2 nibbles out of it. An observation on 01/07/2025 at 4:13 PM revealed Resident 3 was sleeping in bed with 2 Twinkies on the overbed table and 1 bite out of 1 of them. In an interview on 01/07/2025 at 10:16 AM, NA-G confirmed Resident 3 tried to take a couple of bites of the Cream of Wheat but that was it. NA-G confirmed the resident was not normally a breakfast eater but liked pasta. In an interview on 01/07/2025 at 4:15 PM, the DON confirmed the resident refuses the mechanically altered diet and Resident 3's family brings in snacks. The DON confirmed the resident refuses nutritional shakes. In an interview on 01/08/2025 at 8:13 AM, Registered Nurse (RN)-C confirmed that the weights in Resident 3's Electronic Medical Record (EMR) have not been entered since 10/31/2024 and review of the bath book did not reveal weights. RN-C confirmed the resident does drink the nutritional shakes twice a day per the order but does refuse baths once in a while. In an interview on 01/08/2025 at 2:28 PM the facility's RD confirmed it was the RD's expectation that weights would be done at least monthly. In an interview on 01/08/2025 at 2:24 PM, the ADON confirmed that weights should have been completed weekly on Resident 3 and was not. 48271 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. A record review of the Admission record reveals that Resident 42 was admitted to the facility on [DATE] with the diagnosis of Heart Failure (when the heart is unable to pump enough blood and oxygen to the body's organs), Chronic Kidney Disease (where your kidneys are not filtering waste effectively, potentially causing symptoms like fatigue, swelling in hands and feet), Hypertension (chronic condition where your blood pressure is consistently too high) , Chronic Pulmonary Edema (a long-term condition where fluid builds up in the lungs, making it hard to breathe), Shortness of Breath (the feeling of not being able to breathe deeply or normally), Transient Ischemic Attack (A brief stroke-like attack that, despite resolving within minutes to hours), Cerebral Infarction without Residual Deficits (recovers from a stroke without any long-term effects). A record review of the MDS Minimum Data Set, A comprehensive assessment of each resident's functional capabilities) dated Oct. 24/24 with a BIMS (Brief Interview for Mental Status, a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function) score of 15 meaning cognitively intact. A record review of the Client Coordination Note Report from hospice dated 12/9/24 that Resident 42 was admitted to St. Croix hospice on 12/9/24 with assistance with stand pivot, and ambulation with walker. A record review revealed on 10/31/2024 that Resident 42's weight was 123.4 lb. There was no other weights recorded for the months of November (2024), or December (2024). An observation of Resident 42 on 1/6/25 at 9:30 AM revealed Resident 42 sitting on edge of bed eating breakfast. Resident 42 reported that there was too much food on (genders) plate. Resident 42 stated (gender) enjoys hot chocolate with all meals. Resident 42 did receive hot chocolate with (genders) meals. An observation of Resident 42 on 1/6/25 at 12:30 PM sitting on the edge of bed eating lunch. An interview on 01/08/25 9:34 AM with Assistant Director of Nursing (ADON) and hospice nurse (RN-B) confirmed that Resident 42 is on hospice and RN-B confirms that hospice does not weigh Resident 42 and Resident 42 gets a bed baths and the facility has no way to weigh Resident 42 in bed. An interview on 1/8/25 at 2:28 PM with the facility's Dietician confirmed that weights are expected at least monthly, for residents who are on hospice or comfort care. The Dietician goes by meal intake and skin, and if the resident clothes are getting loose and if there is a significant weight loss, weights should be at least weekly. An interview on 1/8/25 at 3:00 PM with the ADON confirmed that every resident with weight loss is to be weighed weekly and that Residents 42 should have been weighed weekly because of weight loss.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45641 Licensure Reference Number 175 NAC 12.006.09(H)(vi)(3)(a) Based on observation, interview, and record review, the facility failed to provide cares for 1 (Resident 40) of 1 sampled resident's with a gastrostomy tube (G-tube, a tube inserted in the stomach to provide food, water, and medications). The facility census was 48. Findings are: A record review of the facility's Wound Care policy with a last revision date of 1/2024 revealed the facility was to cleanse the G-Tube area of insertion site by dabbing area with sterile water and gauze or per providers orders; noting area of breakdown, drainage, skin color, etc. Apply a clean, dry dressing such as gauze square around insertion site, may secure with paper tape. A record review of Resident 40's Clinical Census dated 01/08/2025 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 40's Medical Diagnosis dated 01/11/2025 revealed the resident had diagnoses of Gastrointestinal Hemorrhage (digestive tract bleeding) Gastrostomy status (tube in the stomach), Quadriplegia (paralyzed from the neck down), Traumatic Brain Injury, and depression. A record review of Resident 40's Minimum Data Set (MDS, a comprehensive assessment used to develop a resident's care plan) dated 12/17/2024 revealed the resident did not have a Brief Interview for Mental Status (BIMS, a score of a residents cognitive abilities) due to the resident was rarely/never understood. The resident was dependent on staff for all activities of daily living and mobility. The resident required tube feeding. A record review of Resident 40's Care Plan with an admitted [DATE] revealed a focus area of risk for impaired nutritional status and an intervention of feed resident via tube feeding. A record review of Resident 40's Clinical Physician Orders dated 01/08/2025 revealed the provider ordered to complete tube care site twice daily two times a day for Gastrostomy Status. An observation on 01/07/2025 at 12:35 PM with the Infection Preventionist (IP) revealed Licensed Practical Nurse (LPN)-H pulled Resident 40's gown above the G-tube, and the split sponge (a dressing with a split in it) was not between the resident's G-tube insertion site and the G-tube flange. The site appeared to have a blood-tinged drainage around it. LPN-H placed a clean split sponge dressing and placed between the G-tube insertion site and G-tube flange without cleaning the site and continued with cares. In an interview on 01/07/2024 at 4:00 PM, LPN-H confirmed there was not a split sponge between the residents G-tube insertion site and G-tube flange because the resident had a shower in the morning and bath staff did not notify LPN-H that the split sponge had been removed. LPN-H confirmed LPN-H did not clean the site before place a new split sponge on the G-tube and should have. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/08/2024 at 9:05 AM, the facility's IP confirmed the bath staff should have notified LPN-H the split sponge was removed so LPN-H could have replaced it. LPN-H should have cleaned the G-Tube insertion site prior to placing a new split sponge between the G-tube insertion site and the G-tube flange but didn't.

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	285267	A. Building B. Wing	01/13/2025

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45484 Licensure Reference Number 175 NAC 12-006.09(H) Based on record reviews and interviews, the facility failed to have a diagnosis in place to support the use of an antipsychotic (drugs that affect behavior, mood, thoughts, perception, and are used to manage psychotic disorders, which make it difficult to distinguish what is real from what is not) medication. This affected 2 residents (Resident 32 and Resident 7) of 5 residents sampled for unnecessary medication use. The facility census was 48. Findings are: A record review of the facility's Psychotropic [medications used to treat the symptoms of mental disorders] Medication Use policy with effective date 11/2023 revealed: Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and, The indications for use of any psychotropic drug shall be documented in the medical record. A. A record review of Resident 32's Admission Record printed 01/06/2025 revealed the resident was admitted on [DATE] and had diagnoses of dementia with behavioral disturbance (a term for several diseases that affect memory, thinking, and the ability to perform daily activities. Some people with dementia also exhibit behaviors such as agitation, restlessness, and wandering) and depression. There were no other mental disorders listed as diagnoses. A record review of Resident 32's Order Summary Report printed 01/06/2025 revealed the resident had an order for quetiapine (an antipsychotic medication) 25 milligrams (mg) take 1 tablet by mouth at bedtime with an indication for use of agitation. A record review of a Clinical Encounter Summary with an Encounter Date of 04/20/2023 revealed Resident 32 was on quetiapine at that time for restlessness and agitation. An interview with the Assistant Director of Nursing (ADON) on 01/13/2025 at 12:05 PM confirmed that Resident 32 did not have a documented diagnosis to support the use of an antipsychotic medication. 45641 B. A record review of Resident 7's Clinical Census dated 01/08/2025 revealed the resident was admitted to the facility on [DATE]. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 7's Medical Diagnosis dated 01/11/2025 revealed the resident had diagnoses of Insomnia (difficulty getting and staying asleep), Liver Disease, Morbid Obesity (severely overweight), Type 2 Diabetes Mellitus (uncontrolled blood sugars), and Depression. A record review of Resident 7's Minimum Data Set (MDS, a comprehensive assessment used to develop a resident's care plan) dated 11/05/2024 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a residents cognitive abilities) of 15 which indicated the resident was cognitively aware. The resident required partial moderate assistance with toileting, bathing, dressing, and footwear. The resident had Insomnia and was on an antipsychotic. A record review of Resident 7's Care Plan with an admitted [DATE] revealed a focus area of risk for insomnia dementia, a goal of the resident would achieve/maintain a constant sleep pattern, and an intervention of administer Quetiapine (a medication used to treat schizophrenia and bipolar disorder) as ordered by physician. A record review of Resident 7's Clinical Physician Orders dated 01/08/2025 revealed the provider ordered Quetiapine 25 milligram (mg) tablet, take 1 tablet by mouth at bedtime for Insomnia. A record review of Resident 7's New Prescription Summary dated 11/05/2024 revealed the provider ordered Quetiapine 25 mg tablet (Seroquel), Take 1 tablet by mouth daily every night. Diagnosis/Indication was F5101 - (ICD-10), which is Primary Insomnia. A note was on the order of: The resident was to start this medication after completed the Elavil taper. Effective date was 11/05/2024. The start date was 11/05/2024. A record review of Resident 7's Electronic Medical Record (EMR) did not reveal a sleep test, sleep diary, or sleep assessment had been completed. A record review of Resident 7's Behavior Monitoring and Interventions Report dated 09/06/2024 - 01/06/2025 did not reveal the resident had any behaviors or insomnia while on the Elavil or Quetiapine. A record review of Resident 7's Pharmacist's Recommendation to Prescriber dated 11/25/2025 revealed the pharmacy made a recommendation to the provider to discontinue the Quetiapine (that was started 11/13/2024 for insomnia) and start Trazadone (a medication used to treat depression that can be used off-label for Insomnia) 25 mg by mouth every night for sleep because Quetiapine can cause abnormal muscle movements and life-threatening neuroleptic malignant syndrome (a reaction that can cause muscle stiffness, high fever, altered mental status, irregular heart rhythms, and respiratory failure), increasing the overall risk. It did not reveal the provider responded to the recommendation. In an interview on 01/13/2025 at 9:40 AM, ADON confirmed Resident 7's Amitriptyline (Elavil) was discontinued, and Quetiapine was started 11/05/2025 for Insomnia. The ADON confirmed that a sleep test, sleep assessment, or sleep diary had not been completed for the Insomnia diagnosis. In an interview on 01/13/2025 at 12:47 PM, the ADON confirmed a psychotropic assessment had not been completed for Resident 7 and the last Abnormal Involuntary Movement Scale (AIMS) was 10/28/2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/13/2025 at 1:49 PM, the ADON confirmed the provider should not have changed the resident from Elavil to Quetiapine on 11/05/2024 without documentation of behaviors or doing the sleep diary. The ADON confirmed Resident 7 used the resident's own provider, not the facility's provider. If the resident used facility's provider, they would have done all the other needed steps. The ADON confirmed it takes months for that provider to address pharmacy recommendations, and the ADON had not attempted to contact the provider to address the pharmacy recommendation. In an interview on 01/13/2025 at 3:52 PM the facility's contracted pharmacist (PH)-A confirmed the provider ordered Seroquel and a pharmacy review was faxed to the ordering provider. The pharmacy did not get an addressed copy of the pharmacy review back from the provider. Quetiapine is not approved for the treatment of Insomnia and would not be a primary medication. PH-A confirmed Quetiapine could be used to treat Insomnia if the provider provided good enough rational. The consultant pharmacist recommended a sleep assessment be completed at a Quality Assurance and Performance Improvement (QAPI) meeting, and the last time they spoke to the facility, it had not been completed and should have been for that medication.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48271 Licensure Reference Number 175 NAC ,d+[DATE].11(E) Based on observations and interview, the facility failed to label and date opened packages of food and failed to dispose of expired food from the walk-in refrigerator and walk in freezer to prevent the potential for food borne illness. This had the potential to affect 47 residents that consumed food from the kitchen. Findings are: An initial observation on [DATE] at 8:15 AM of the walk in refrigerator in the kitchen revealed: - an undated zip lock bag of lettuce, - an undated zip lock bag of cut up celery. - a container of cooked vegetables dated [DATE], which indicated the food was expired, - an undated open package of turkey slices exposed to the air, - an undated zip lock bag of unknown meat, - 2 packages of undated white cheese packages, - an undated package of American cheese. An observation on [DATE] at 8:25 AM of the walk-in freezer in the kitchen revealed: - an undated open bag of French fries exposed to the air, -an undated zip lock bag of an unidentified white shredded substance, - an undated zip lock bag of an unidentified brown substance. An interview on [DATE] at 1:30 PM with the Dietary Manager (DM) confirmed that all food items listed above should have been labeled and dated. The DM confirmed that the cooked vegetables dated [DATE] were expired and should have been discarded.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. 48271 Licensure Reference Number 175 NAC 12-007.04(D) Based on observation and interview, the facility failed to ensure that the ventilation system was operational in 14 occupied rooms (Rooms 201,202,203,204,205,206,208,209,210,211,212,213,214, and 215). This affected 14 bathrooms used by 20 residents. This had the potential to affect odor control in the facility. The facility census was 48. Findings are: An observation on 1/6/25 at 9:30 AM revealed that bathrooms in rooms 203, 204 and 206 did not have functional ventilation as tested with 1 ply square of toilet paper held flat against the ventilation cover that did not hold the paper which indicated that there was no air draw, and the ventilation system did not work. An observation on 1/13/25 at 1:30 PM with the Maintenance Director (MD) revealed that bathrooms in rooms 201,202,203,204,205,206,208,209,210,211,212,213,214, and 215 did not have functional ventilation as tested with 1 ply square of toilet paper held flat against the ventilation cover in the resident bathroom that did not hold the paper which indicated that there was no air draw, and the ventilation system did not work. An interview on 1/13/25 at 2:00 PM with MD confirmed that the ventilation system was not functioning in the bathrooms on the 200 hallway and the ventilation system should be working.