STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295001	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lefa Seran Snf	1st and A St Hawthorne, NV 89415

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34524 Based on observation, interview, clinical record review and document review, the facility failed to obtain informed consent prior to placing the resident in a scoop mattress for 1 of 12 sampled residents (Resident #14). Findings include: Resident #14 Resident #14 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, with anxiety, and pain. On 05/20/2024 at 11:20 AM, Resident #14 was in bed sleeping in a mattress that came up around the edges like a scoop. On 05/21/2024 at 8:04 AM, Resident #14 verbalized the resident had a weird mattress and did not know why. The resident explained the mattress was what the facility had and did not recall an explanation for use or signing documents regarding the mattress. Resident #14's clinical record lacked a care plan for the use of a scoop mattress. Resident #14's clinical record lacked documented evidence the risk and benefits were explained to the resident's Guardian and the resident had been assessed for the risk of entrapment and restraint. On 05/23/2024 at 7:26 AM, the Director of Nursing (DON) verbalized Resident #14 did not have a medical need for a scoop mattress. The DON explained the resident had a scoop mattress because there were no other mattresses available. The DON confirmed the resident did not have a care plan for the mattress, an assessment for entrapment was not completed, and an informed consent explaining the risks and benefits had not been signed for the resident.

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295001	A. Building B. Wing	05/23/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34524 Based on observation, interview and document review, the facility failed to provide a comfortable, homelike environment when the facility utilized an overhead paging system to communicate with the adjoining hospital staff and temperatures in the facility were below 71 degrees. The overhead paging system and the temperature had the potential to affect the entire facility census. Findings include: Overhead Paging System On 05/22/2024 at 11:12 AM, an overhead page was heard calling a Code Gray in room [ROOM NUMBER]. On 05/22/2024 at 11:12 AM, the Director of Nursing (DON) verbalized the code was called for room [ROOM NUMBER] of the adjoining hospital. The DON explained hospital pages were heard on the skilled nursing home side of the facility because the intercom system was for the entire building. The DON confirmed overhead pages from the hospital did not contribute to a homelike environment for residents residing in the skilled nursing facility. On 05/22/2024 at 11:20 AM, an overhead page was heard announcing a hospital staff meeting. On 05/22/2024 at 11:20 AM, a Licensed Practical Nurse (LPN) verbalized overhead hospital pages were heard all the time on the skilled nursing side of the facility. The LPN explained residents on the skilled nursing side of the facility had a homelike environment which included rooms designed to be like their homes and decorations and belongings personalized to the individual which extended to the common areas. The LPN confirmed the overhead hospital pages did not contribute to a homelike environment. On 05/23/2024 at 9:22 AM, a business office meeting for the hospital was announced on the overhead paging system. Temperature in the Facility Resident #7 Resident #7 was admitted to the facility on [DATE], with diagnoses including type two diabetes mellitus without complications, and hypo-osmolality and hyponatremia. Resident #8 Resident #8 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, with agitation, and pain. Resident #9 (continued on next page)

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	295001	A. Building B. Wing	05/23/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #9 was admitted to the facility on [DATE] with diagnoses including cerebral infarction and adult failure to thrive. Resident #10 Resident #10 was admitted to the facility on [DATE], with diagnoses including primary osteoarthritis, unspecified site, and type two diabetes mellitus with diabetic neuropathy, unspecified. Resident #11 Resident #11 was admitted to the facility on [DATE], with diagnoses including epilepsy, unspecified, not intractable, without status epilepticus and chronic obstructive pulmonary disease. Resident #15 Resident #15 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic kidney disease, stage three, unspecified, and acute bronchitis, unspecified. Resident #20 Resident #20 was admitted to the facility on [DATE], with diagnoses including congestive heart failure and chronic atrial fibrillation. On 05/20/2024 at 11:17 AM, residents were in the common areas of the facility in heavy sweaters and long sleeves. On 05/20/2024 at 11:18 AM, Resident #7 verbalized it was cold in the facility and the resident did not like it, but the staff were moving around so much, it was probably better for them. On 05/20/2024 at 12:14 PM, Resident #20 was wearing a long sleeve flannel shirt, pants, and shoes. On 05/20/2024 at 12:15 PM, Resident #20 verbalized the resident did not like to shower because it was cold. On 05/21/2024 at 9:28 AM, Resident #11 was in the common area during exercise time wearing a long sleeve, fluffy jacket. On 05/21/2024 at 9:31 AM, Resident #7 was in the common area using a stationary bike pedal machine with a long sleeve sweater on their lap. On 05/21/2024 at 9:32 AM, Resident #7 verbalized they were wearing the sweater, but warmed up a little with exercise and took it off. On 05/21/2024 at 9:45 AM, Resident #9 was sitting in the common area in a fluffy pink sweater. On 05/21/2024 at 9:46 AM, Resident #9 verbalized they were not cold because they were wearing a sweater. (continued on next page)

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	295001	A. Building B. Wing	05/23/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/21/2024 at 11:55 AM, a Certified Nursing Assistant (CNA) walked into the dining area and verbalized it was cold. On 05/21/2024 at 12:00 PM, Resident #20 verbalized they were not cold in the common areas because they were always prepared with a sweater. On 05/21/2024 at 12:01 PM, Resident #10 was seated at the dining room table waiting for lunch in a thick sweater. On 05/21/2024 at 12:02 PM, Resident #10 verbalized it was cold in the dining area. The resident explained it was too cold and the staff always kept it cold. Sometimes the staff would open the doors to the facility when it was raining or was windy and the residents would freeze. The resident verbalized They think when the temperature goes up outside, it needs to go down inside. On 05/21/2024 at 12:04 PM, Resident #11 verbalized they wore a sweater at the dining room table because they were cold and the staff kept it cold in the facility. The resident explained residents have told staff they were cold and staff informed maintenance. Maintenance would come look at the thermostat and would say it was comfortable but the resident exclaimed it was not comfortable for the residents. CNAs told the residents well, we're not cold, when the residents complained of the temperature. On 05/21/2024 at 12:10 PM, Resident #15 was eating lunch at the dining room table in a large, heavy jacket. On 05/21/2024 at 12:11 PM, Resident #15 verbalized it was cold and explained they always keep it cold in the hospital. The resident wore a heavy jacket because they were cold and preferred to be warm. On 05/21/2024, during the resident council interview, six out of ten residents verbalized it was too cold in the dining room and the room where exercise and karaoke took place. Six out of ten residents verbalized they have told staff it was too cold. One resident stated when they have complained of being cold, staff have responded by saying they were hot. Two residents verbalized they felt the staff's comfort was more important than the residents. Another resident verbalized one staff member informed them the staff member was going through menopause and took bipolar medication that made them hot. Temperatures at the nurse's station were as follows on: 05/21/2024 at 7:20 AM 69.1 degrees Fahrenheit (F) 05/21/2024 at 9:18 AM 69.4 F 05/21/2024 at 11:26 AM 69.4 F 05/21/2024 at 11:59 AM 69.6 F 05/21/2024 at 2:36 PM 70.0 F (continued on next page)

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	295001	A. Building B. Wing	05/23/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	05/22/2024 at 7:37 AM 69.6 F 05/22/2024 at 8:11 AM 70.0 F 05/22/2024 at 11:11 AM 69.6 F On 05/22/2024 at 8:11 AM, the Unit Clerk verbalized the temperature had been low in the facility due to inconsistent weather. The Unit Clerk explained the previous week, temperatures where high outside and the temperature in the facility was reaching 80 F. Maintenance adjusted the thermostat to a cooler temperature and then the weather changed outside and became cool. Maintenance had not adjusted the temperature in the facility to accommodate for the drop in temperature outside. The staff made sure the residents stayed warm by having the residents dressed in sweaters and giving them blankets. On 05/22/2024 at 8:12 AM, a CNA verbalized residents have stated they were cold and when they do, the staff provide blankets and sweaters to the residents. The CNA explained it was cold in the facility today and maintenance was slow to adjust the temperature in the facility. On 05/22/2024 at 8:17 AM, Resident #8 was in the TV room in a recliner. A CNA provided a blanket to Resident #8. The resident yelled out they were cold and wanted another blanket. The CNA put another blanket on the resident and remarked to the resident it was a bit cooler than usual in the facility. On 05/22/2024 at 9:30 AM, a CNA verbalized ooh, it's cold up in here! On 05/22/2024 at 9:31 AM, a Personal Care Technician (PCT) verbalized they personally felt it was cold in the facility the last few days. The PCT made sure residents were warm by ensuring they were dressed appropriately and provided blankets. On 05/22/2024 at 10:44 AM, the Activities Director verbalized the cooling system was new and facility staff were trying to regulate the temperature in the facility. Requests to change the temperature would be sent from the Skilled Nursing Facility (SNF) Manager and the DON to maintenance. Until the temperature was adjusted, the Activities Director explained the staff would offer blankets and sweaters to the residents if they were cold. On 05/22/2024 at 11:00 AM, the Activities Director confirmed the temperature at the nurses station, in the resident dining area, was 69.6 F. The Activities Director explained it was extremely hot last week and they believe there was an overcorrection to the thermostat. The Activities Director was unaware of the regulatory requirement of the temperature to be set at 71 F and confirmed each resident was different, but overall did not feel temperatures below 70 F were a comfortable homelike environment. Facility policy titled Safe Environment, undated, documented residents had a right to a safe, clean, comfortable and homelike environment. The facility must provide comfortable and safe temperatures.

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	295001	A. Building B. Wing	05/23/2024

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50210 Based on clinical record review and interview, the facility failed to ensure the accuracy of a Minimum Data Set 3.0 (MDS) assessment for 2 of 12 sampled residents (Resident #17 and #2). Findings include: Resident #17 Resident #17 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including pain unspecified, edema unspecified, and acute embolism and thrombosis of other specified deep vein of left lower extremity. Anticoagulant A physician's order dated 02/26/2024, with a start date of 03/04/2024, documented Eliquis oral tablet five milligrams (mg). Give five mg by mouth two times a day related to acute embolism and thrombosis of other specified deep vein of left lower extremity. Resident #17's care plan, with a focus initiated on 02/29/2024, documented the resident was prescribed Eliquis 5 mg twice a day. Resident #17's April 2024 Electronic Medication Administration Record (EMAR) documented Eliquis oral tablet 5 mg, was administered to the resident twice daily 04/14/2024-04/21/2024. Resident #17's last quarterly MDS assessment dated [DATE], section N0415 (Medications - High-Risk Drug Classes: Use and Indication) documented the resident was not taking an anticoagulant medication in the seven day look back period. Diuretic A physician's order dated 04/04/2024, with a start date of 04/05/2024, documented Bumex oral tablet 1 mg. Give one tablet by mouth one time a day related to edema unspecified. Resident #17's April 2024 EMAR documented Bumex oral tablet 1 mg was administered to the resident once daily 04/14/2024-04/21/2024. Resident #17's last quarterly MDS assessment dated [DATE], section N0415 (Medications - High-Risk Drug Classes: Use and Indication) documented the resident was not taking a diuretic in the seven day look back period. Opioid A physician's order dated 03/08/2024, documented Tramadol Hydrochloride (HCl) oral tablet 50 mg. Give one tablet by mouth every 12 hours as needed for pain. (continued on next page)

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	295001	A. Building B. Wing	05/23/2024

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #17's care plan with a focus initiated on 04/17/2024, documented the resident was prescribed Tramadol 50 mg as needed every 12 hours for pain relief. Resident #17's April 2024 EMAR documented Tramadol HCl 50 mg was administered on the following dates: -On 04/14/2024, at 9:10 PM -On 04/16/2024, at 9:04 AM and 11:33 PM -On 04/18/2024, at 9:55 AM and 10:03 PM -On 04/20/2024, at 8:52 PM -On 04/21/2024, at 9:21 PM Resident #17's last quarterly MDS assessment dated [DATE], section N0415 (Medications - High-Risk Drug Classes: Use and Indication) documented the resident was not taking an opioid in the seven day look back period. Hypoglycemic Resident #17's last quarterly MDS assessment dated [DATE], section N0415 (Medications - High-Risk Drug Classes: Use and Indication) documented the resident was taking a hypoglycemic medication. Resident #17's clinical record lacked any other documented evidence of a hypoglycemic being ordered or administered. On 05/23/2024 at 9:58 AM, the MDS Coordinator confirmed Resident #17's MDS assessment documented the resident was not taking an anticoagulant, opioid, or diuretic. The MDS Coordinator confirmed Eliquis was an anticoagulant, Tramadol HCl was an opioid, and Bumex was a diuretic. The three medications should have been accurately reflected on the MDS assessment. The MDS Coordinator confirmed Resident #17's MDS assessment documented the resident was on a hypoglycemic. The MDS Coordinator verbalized the resident was not on a hypoglycemic and confirmed the MDS assessment should not have indicated the resident was taking a hypoglycemic. 43311 Resident #2 Resident #2 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including multiple sclerosis and acute cholecystitis. The Facility Resident Matrix (802) received from the facility on 05/20/2024, documented Resident #2 had physical restraints. (continued on next page)

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	295001	A. Building B. Wing	05/23/2024

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2's last quarterly MDS assessment dated [DATE], Section P0100 (Restraints) documented the resident had bed rails and were used daily. On 05/20/2024 at 9:28 AM, Resident #2's bed did not have bedrails or a Halo Safety Ring affixed to the bed. On 05/23/2024 at 9:13 AM, Resident #2's bed did not have bedrails or a Halo Safety Ring affixed to the bed. On 05/23/2024 at 9:39 AM, the MDS Coordinator confirmed the 802 indicated Resident #2 had physical restraints. The MDS Coordinator explained Resident #2 used to have bedrails but did not have them any longer. The MDS Coordinator confirmed the resident's bed rails were removed in June 2023, and the MDS was not accurate for Resident #2.

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	295001	A. Building B. Wing	05/23/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34524 Based on observation, interview, clinical record review and document review the facility failed to update a fall care plan with new interventions for 2 of 12 sampled residents (Resident #1, and #5) and to include the use of a scoop mattress in a resident's care plan for 1 of 12 sampled residents (Resident #14). Findings include: Resident #1 Resident #1 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and epilepsy, unspecified, not intractable, without status epilepticus. On 05/21/2024 at 7:20 AM, Resident #1 was in bed asleep with a fall mat on the floor on the right side of the bed. A pressure alarm was on the floor mat. A Personal Care Technician (PCT) was seated next the resident's room. On 05/21/2024 at 7:21 AM, the PCT verbalized the PCT was stationed outside of Resident #1's room because Resident #1 was a fall risk. The PCT explained the resident had a position change alarm on the resident's bed and floor mat. If the resident got up from the bed or rolled onto the floor mat, the position change alarms would sound, alerting the staff. A Facility Reported Incident documented on 04/11/2024, Resident #1 was heard yelling out and was found sitting on the floor. The resident was determined to be ambulating in their room without assistance and fell . The facility would provide one to one supervision to prevent future occurrences. On 05/22/2024 at 11:15 AM, a Licensed Practical Nurse verbalized Resident #1 had falls and was very unstable. The LPN explained interventions to prevent falls for Resident #1 included one to one supervision, fall mats at the bedside, and a position change alarm on the floor mat and on the resident's bed. The LPN would expect to find those interventions on the resident's care plan. The LPN confirmed the care plan did not include one to one supervision until 05/20/2024. The LPN confirmed the care plan lacked floor mats and position change alarms. Resident #1's Comprehensive Care Plan documented Resident #1 had incidents of falling the past several months due to lack of safety awareness. Interventions were documented as follows: -resident to use a wheelchair for ambulating in the facility while their arm heals from a recent fall on 04/11/2024 -resident to be encouraged to sit out in day room and watch television to receive additional assistance when required (continued on next page)

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	295001	A. Building B. Wing	05/23/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An intervention initiated 05/20/2024, documented resident to have daily supervision and line of sight monitoring related to impulsivity and poor safety awareness. The care plan lacked an intervention for falls mats at the bedside and position change alarms on the resident's bed and bedside. On 05/22/2024 at 4:04 PM, the Director of Nursing (DON) verbalized Resident #1 had falls and overestimated their abilities. The DON explained Resident #1 fell and broke their wrist on 04/11/2024. The staff was made aware of the fall due to position change alarm on the floor mat. The intervention to prevent future falls was to implement one to one supervision of the resident. The DON confirmed fall mats and position change alarms were not on the resident's care plan and the care plan was updated on 05/20/2024 to include one to one supervision. The DON confirmed the interventions should have been updated on the care plan when they were implemented. Resident #5 Resident #5 was admitted to the facility on [DATE], with diagnoses including adult failure to thrive, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and fall on same level from slipping, tripping and stumbling without subsequent striking against object, initial encounter. On 05/20/2024 at 11:08 AM, Resident #5 was in bed with a fall mat at the bedside. On 05/20/2024 at 11:09 AM, Resident #5 verbalized they have had falls in the past. On 05/23/24 at 8:21 AM, a Certified Nursing Assistant (CNA) verbalized Resident #5 was a fall risk and could get out of bed by themselves with a standby assist. The CNA explained the resident overestimated their abilities and would try to get out of bed without calling for assistance. The resident had fall mats and a position change alarm. On 05/23/2024 at 8:32 AM, an LPN verbalized Resident #5 was a fall risk and had fall prevention interventions to include a floor mat and a position change alarm. A Fall Risk assessment dated [DATE], documented Resident #5 was a moderate fall risk. Resident #5's Comprehensive Care Plan documented Resident #5 was at risk for falls characterized by history of falls/injury, multiple risk factors related to impaired balance and pain. Interventions were documented as follows: -ensure environment was free of clutter -transfer and change positions slowly An intervention initiated 05/22/2024, documented resident would have a bed alarm in place to alert staff of resident movement due to poor safety awareness, unsteady gait and non-use of the call light for requesting assistance. The care plan lacked an intervention for falls mats at the bedside. (continued on next page)

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	295001	A. Building B. Wing	05/23/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/23/2024 at 10:32 AM, the DON verbalized Resident #5 had falls and a care plan for falls. The DON confirmed the intervention for position change alarms was not updated on the care plan until 05/22/2024, and the care plan lacked floor mats as an intervention. Resident #14 Resident #14 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, with anxiety, and pain. On 05/20/2024 at 11:20 AM, Resident #14 was in bed sleeping in a mattress that came up around the edges like a scoop. On 05/21/2024 at 8:04 AM, Resident #14 verbalized the resident had a weird mattress and did not know why. Resident #14's clinical record lacked a care plan addressing the scoop mattress. On 05/23/2024 at 7:26 AM, the DON verbalized Resident #14 did not have a medical need for a scoop mattress. The DON explained the resident had a scoop mattress because there were no other mattresses available. The DON confirmed the resident did not have a care plan for the mattress. The facility policy titled Fall Prevention, dated 04/01/2003, documented the resident's plan of care would be updated with the plan being used to prevent falls. The facility policy titled Care Plans, revised 03/22/2017, documented each resident would have a comprehensive person-centered care plan developed by the interdisciplinary team. The care plan must include the instructions needed for proved effective person-centered care of the resident to meet professional standards of quality of care. The comprehensive care plan would include a description of services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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	295001	A. Building B. Wing	05/23/2024

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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** 34524 Based on observation, clinical record review, interview and document review, the facility failed to remove floor mats from the bedside when residents were not in bed for 1 of 12 sampled residents (Resident #5), and assess a resident with a scoop mattress for risk of entrapment for 1 of 12 sampled residents (Resident #14). The deficient practices had the potential to increase falls and injury in the facility. Resident #5 Resident #5 was admitted to the facility on [DATE], with diagnoses including adult failure to thrive, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and fall on same level from slipping, tripping and stumbling without subsequent striking against object, initial encounter. On 05/20/2024 at 11:08 AM, Resident #5 was in bed with a fall mat at the bedside. The resident's walker was up against the resident's bed, with the back half on the floor mat and the front half on the tile floor. On 05/20/2024 at 11:09 AM, Resident #5 verbalized they have had falls in the past and had tripped on the mat while walking. On 05/22/2024 at 11:15 AM, a Licensed Practical Nurse (LPN) verbalized residents who were fall risks had floor mats at the bedside. The LPN explained the fall mats were always at the bedside, even when the resident was out of bed. The LPN confirmed floor mats at the bedside could pose a tripping hazard to ambulatory residents. On 05/22/2024 at 11:42 AM, a Housekeeping Lead verbalized floor mats were at the bedside of residents who had falls or were fall risks. The Housekeeping Lead explained floor mats were cleaned daily by Housekeeping. The floor mats were taken out of the resident rooms, preferably while the resident was out of the room, cleaned, dried, and placed back at the resident bedside. The Housekeeper confirmed the floor mats were always at the resident's bedside unless they were being cleaned. On 05/22/2024 at 1:58 PM, the Director of Nursing (DON) verbalized all floor mats had been picked up and would no longer be at the resident's bedside when the residents were out of bed. The DON confirmed floor mats at the bedside could be a tripping hazard for residents that were ambulatory. On 05/23/2024 at 8:21 AM, a Certified Nursing Assistant (CNA) verbalized Resident #5 was a fall risk and could get out of bed by themselves with a standby assist. The CNA explained the resident overestimated their abilities and would try to get out of bed without calling for assistance. The resident had fall mats and a position change alarm. The CNA explained the fall mats were always down in the resident's room. (continued on next page)

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	295001	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lefa Seran Snf	1st and A St Hawthorne, NV 89415

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/23/2024 at 8:32 AM, the LPN verbalized Resident #5 was a fall risk and had fall prevention interventions to include a floor mat and a position change alarm. The LPN explained the resident was able to ambulate from their bed to the bathroom and back with a walker. A Fall Risk assessment dated [DATE], documented Resident #5 was a moderate fall risk. Resident #5's Comprehensive Care Plan documented Resident #5 was at risk for falls characterized by history of falls/injury, multiple risk factors related to impaired balance and pain. Interventions were documented as follows: -ensure environment was free of clutter -transfer and change positions slowly The care plan lacked an intervention for fall mats at the bedside. On 05/23/2024 at 10:32 AM, the DON verbalized Resident #5 had falls and a care plan for falls. The DON confirmed the intervention for position change alarms was not updated on the care plan until 05/22/2024, and the care plan lacked floor mats as an intervention. Resident #14 Resident #14 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, with anxiety, and pain. On 05/20/2024 at 11:20 AM, Resident #14 was in bed sleeping in a mattress that came up around the edges like a scoop. On 05/21/2024 at 8:04 AM, Resident #14 verbalized the resident had a weird mattress and did not know why. The resident explained the mattress was what the facility had and did not recall an explanation for use or signing documents regarding the mattress. The resident verbalized they were able to get in and out of the bed and the scoop mattress did not restrict their movement. Resident #14's clinical record lacked a care plan addressing the scoop mattress. Resident #14's clinical record lacked documented evidence the risk and benefits were explained to the resident's Guardian and the resident had been assessed for the risk of entrapment. On 05/23/2024 at 7:26 AM, the DON verbalized Resident #14 did not have a medical need for a scoop mattress. The DON explained the resident was able to get in and out of bed and had a scoop mattress because there were no other mattresses available. The DON confirmed the resident did not have a care plan for the mattress and had not been assessed for risk of entrapment. The facility policy titled Safe Environment, undated, documented residents had a right to a safe, clean, comfortable and homelike environment.

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	295001	A. Building B. Wing	05/23/2024

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43311 Based on observation, interview, clinical record review, and document review, the facility failed to ensure cognitive assessments for the use of a grab bar device (Halo Safety Ring) were completed quarterly for 1 of 20 residents residing in the facility (Resident #12). Findings include: Resident #12 Resident #12 was admitted to the facility on [DATE], with diagnoses including heart failure, unspecified, hereditary and idiopathic neuropathy, unspecified, and peripheral vascular disease, unspecified. On 05/20/2024 at 4:08 PM, Resident #12's bed had a Halo Safety Ring on both upper sides of the bed. On 05/21/2024 at 12:47 PM, Resident #12's bed had a Halo Safety Ring on both upper sides of the bed. Resident #12's physician order dated 10/13/2023, documented: May have Halo Safety Ring for bed mobility and maintain functional capabilities during perineal care. Resident #12's care plan intervention dated 10/13/2023, documented the resident would receive a cognitive assessment completed quarterly to determine safe and responsible use of the Halo Safety Ring. Resident #12's clinical record lacked documented evidence of a Halo Safety Ring cognitive assessment since the installation of the Halo Ring Safety device to both upper sides of the resident's bed on 10/13/2023. On 05/23/2024 at 10:15 AM, the Skilled Nursing Facility (SNF) Manager confirmed the requirement of quarterly cognitive assessments for residents using Halo Safety Rings to ensure the resident understood how to use the device. The cognitive assessment would also be completed with any changes in condition and were done on paper and kept at the Nurse's station. The SNF Manager confirmed Resident #12's clinical record lacked a quarterly cognitive assessment and could not provide a paper copy of a quarterly assessment for January 2024 or April 2024. (continued on next page)

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	295001	A. Building B. Wing	05/23/2024

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Halo Safety Ring Device Policy, undated, documented the primary objective of the safety evaluation included safety risks associated with Halo Safety Rings and ensured the safe and appropriate use of the Halo Safety Rings. Before installing the device, a registered nurse would complete the comprehensive cognitive assessment to evaluate the resident's capacity to use the device safely. Quarterly cognitive assessments would be completed to evaluate the resident's ability to safely utilize the device. Physical Therapy would re-evaluate the resident for continued use following major changes in mobility.

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	295001	A. Building B. Wing	05/23/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43311 Based on observation, interview, clinical record review and document review the facility failed to ensure medication was administered with an error rate less than 5 percent (%). There were 35 opportunities and two medication errors. The medication error rate was 5.71%. Findings include: Resident #3 Resident #3 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including type two diabetes mellitus without complications and mixed hyperlipidemia. Resident #3's physician's order documented Niacin Extended Release tablet 500 milligrams (mg) give two tablets by mouth one time a day related to hyperlipidemia, unspecified. On 05/22/2024 at 7:41 AM, during medication pass observation, a Licensed Practical Nurse (LPN) administered one tablet of Niacin 500 mg to Resident #3. On 05/22/2024 at 12:44 PM, the LPN confirmed Resident #3 was prescribed two tablets of Niacin 500 mg and the LPN administered one tablet of the medication. Resident #15 Resident #15 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease, unspecified, cramp and spasm, and other fatigue. Resident #15's physician order documented Vitamin D3 25 micrograms (mcg) give two tablets by mouth one time a day for vitamin supplement. On 05/22/2024 at 8:07 AM, during medication pass observation, the LPN administered one tablet of Vitamin D3 25 mcg to Resident #15. On 05/22/2024 at 12:45 PM, the LPN confirmed Resident #15 was prescribed two tablets of Vitamin D3 25 mcg and the LPN administered one tablet of the medication. The LPN explained the resident could have a vitamin or supplement deficiency if the resident did not receive the ordered dose of the vitamin or supplement. On 05/22/2024 at 12:49 PM, the Director of Nursing (DON) explained a resident could encounter an adverse effect if the ordered supplement or vitamin was not administered according to the physician's order. On 05/23/2024 at 8:37 AM, the DON communicated the expectation of nursing staff to follow the physician's order 100 % of the time. (continued on next page)

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	295001	A. Building B. Wing	05/23/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Medication Administration Policy, dated 03/14/2024, documented medication administration procedures would include the Five Rights of medication administration: right patient, right medication, right dose, right route, and right time. Medications shall be administered strictly according to the prescriber's orders.

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	295001	A. Building B. Wing	05/23/2024

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 43311 Based on interview and document review, the Quality Assessment Performance Improvement (QAPI) Committee failed to identify the lack of COVID-19 (COVID) booster vaccinations offered to residents with the potential to affect the entire facility census. Findings include: On 05/22/2024 at 2:35 PM, the Skilled Nursing Facility (SNF) Manager confirmed COVID vaccinations and boosters were not provided to the residents for 2023 and 2024, as the facility had not put anything in place for the resident vaccinations. On 05/23/2024 at 9:51 AM, the Infection Preventionist confirmed the IP was responsible for all resident vaccinations and the Infection Control Program. The IP verbalized the IP was not involved with COVID vaccinations for the residents. The IP had depended on the Director of Nursing (DON) and the SNF Manager to order the COVID vaccine and the DON and SNF Manager would arrange consent, administration, and documentation. The IP confirmed the IP did not follow up on COVID vaccinations to ensure the vaccine was ordered or if each resident was screened for eligibility to receive the vaccine, education regarding the vaccine was provided to the residents/resident's representative, and if the vaccine was offered and either administered or declined for the years 2023 and 2024. On 05/23/24 at 10:03 AM, the SNF Manager confirmed COVID vaccinations were not ordered for the residents for the years of 2023 and 2024, because the SNF Manager and DON were focused on the resident influenza and pneumococcal vaccines. The SNF Manager confirmed the DON and the SNF Manager were responsible to order the resident COVID vaccines for 2023 and 2024, and did not order the vaccines. 50210 On 05/23/2024 at 10:51 AM, the Quality Assurance and Risk Manager verbalized the QAPI Committee had not initiated a Performance Improvement Project (PIP) related to the lack of residents being screened, offered, or provided education for COVID booster vaccinations. The QAPI Committee had not been aware the facility lacked the COVID booster vaccination for 2023-2024. The facility policy titled QAPI Plan, undated, documented the facility used QAPI to make decisions and guide their day-to-day operations. The QAPI Plan addresses care areas to include infection control, and focused on systems and processes, rather than individuals. The emphasis was on identifying opportunities for systemic improvement, and to educate individuals in facility processes and systems.

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	295001	A. Building B. Wing	05/23/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43311 Based on observation, clinical record review, interview, and document review the facility failed to ensure Enhanced Barrier Precautions (EBP) were implemented for 1 of 12 sampled residents (Resident #12). Findings include: Resident #12 Resident #12 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including peripheral vascular disease, unspecified, type II diabetes mellitus without complications, hereditary and idiopathic neuropathy, unspecified, and left lower extremity amputation. A physician's order for Resident #12 dated 04/22/2024, documented cleanse right second toe on right foot with wound cleanser. Apply medi (medical)-honey and cover with band aid every 48 hours for wound care. Resident #12's physician order dated 04/23/2024, documented apply pressure boot to resident's right foot every day and night shift for open sore on right second toe. A Nursing Progress Note dated 05/08/2024, documented Resident #12 had a small scabbed area on second toe which had been slow to resolve despite best efforts to treat. On 05/20/2024, in the morning, Resident #12's room lacked signage for EBP and did not have a Personal Protective Equipment (PPE) cart available at or near the room. On 05/21/2024 at 12:47 PM, Resident #12 was provided wound care by a Licensed Practical Nurse (LPN) who was also the Wound Care Nurse. Resident #12's room lacked signage for EBP or a PPE cart outside the room. On 05/22/2024 at 8:34 AM, the Wound Care Nurse confirmed Resident #12 received wound care every other day and the resident's room did not have EBP signage or PPE available outside the room. The Wound Care Nurse confirmed a resident receiving wound care would require EBP with a PPE hanging organizer affixed to the wall outside the resident's room. The Wound Care Nurse considered the wound unstageable. On 05/22/2024 at 12:57 PM, the Director of Nursing (DON) explained a resident with a wound should be on EBP and a PPE organizer was required to be placed outside the resident's room. The purpose of the PPE was to provide protection from potential materials that could pose an infection risk to the other residents. The DON confirmed Resident #12 had a chronic wound of the right second toe and should have been placed on EBP, however did not question this as the wound was scabbed over and not draining. (continued on next page)

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	295001	A. Building B. Wing	05/23/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/22/2024 at 1:18 PM, the Infection Preventionist (IP) confirmed the facility used CDC guidelines for the Infection Control Program. A resident on EBP would have a PPE cart or hanging organizer which included gowns, gloves, garbage bags, and masks and signage would be on the resident's door. The IP confirmed Resident #12 was not on EBP, did not have a PPE organizer at or near the resident's room, did not have signage, and received every other day wound care for a right second toe wound. The IP was not able to describe how individuals entering the room would be queued to don PPE prior to providing care. On 05/22/2024 at 1:50 PM, the IP explained any resident with a wound needed to be on EBP. A consequence to the resident not identified as requiring EBP was the wound/infection could be spread around to the staff and other residents. The other residents would be at risk for contamination or developing an infection. On 05/23/2024 at 10:10 AM, the Skilled Nursing Facility (SNF) Manager verbalized the expectation for a resident receiving wound care would be placed on EBP and have PPE available outside the room. Nursing and Certified Nursing Assistants (CNA) staff should use the PPE stored in the PPE organizer to impede bacteria transmission from resident to resident during direct care. The SNF Manager was not able to explain how staff would know to don PPE prior to entry without signage and a PPE organizer and would most likely rely on verbal communication. A Centers for Medicare and Medicaid Services (CMS) Memo QSO-24-08-NH, dated 03/20/2024, documented EBP as an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employed targeted gown and glove use during high contact resident care activities. EBP were indicated for residents with wounds and/or indwelling medical devices even if the resident was not known to be infected or colonized with a MDRO. Wounds included chronic wounds, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. Wound care was defined as any skin opening requiring a dressing. The facility policy titled Infection Prevention and Control Annual Plan, dated 2024, documented the purpose of the plan was to facilitate participation of each healthcare worker in infection prevention strategies at the user level and to limit unprotected exposure to pathogens.

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	295001	A. Building B. Wing	05/23/2024

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43311 Based on clinical record review, interview, and document review the facility failed to ensure residents were screened for eligibility to receive a COVID-19 (COVID) vaccine, education regarding the vaccine was provided to the resident or resident representative, and if the vaccine was offered and either administered or declined 19 of 20 residents sampled for immunizations (Resident #17, #2, #13, #19, #15, #9, #6, #8, #14, #3, #5, #18, #16, #12, #7, #11, #4, #1, and #10). Findings include: Resident #17 Resident #17 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including pain unspecified, edema unspecified, and acute embolism and thrombosis of other specified deep vein of left lower extremity. Resident #2 Resident #2 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including multiple sclerosis and acute cholecystitis. Resident #13 Resident #13 was admitted to the facility on [DATE], with diagnoses including adult failure to thrive, personal history of COVID-19, and hemiplegia, unspecified affecting unspecified side. Resident #19 Resident #19 was admitted to the facility on [DATE], with diagnoses including Parkinson's disease, chronic systolic heart failure, ventricular tachycardia, unspecified. Resident #15 Resident #15 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease, unspecified, cramp and spasm, and other fatigue. Resident #9 Resident #9 was admitted to the facility on [DATE], with diagnoses including cerebral infarction, unspecified and type two diabetes mellitus. Resident #6 (continued on next page)

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	295001	A. Building B. Wing	05/23/2024

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #6 was admitted to the facility on [DATE], and readmitted [DATE], with diagnoses including shortness of breath, personal history of COVID-19, chronic obstructive pulmonary disease, unspecified. Resident #8 Resident #8 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, with agitation, anemia, unspecified, and long term use of anticoagulants. Resident #14 Resident #14 was admitted to the facility on [DATE], with diagnoses including chronic atrial fibrillation, unspecified, pneumonia, unspecified organism, and shortness of breath. Resident #3 Resident #3 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including type two diabetes mellitus without complications and personal history of COVID-19. Resident #5 Resident #5 was admitted to the facility on [DATE], with diagnoses including type two diabetes mellitus without complications, adult failure to thrive, and personal history of COVID-19. Resident #18 Resident #18 was admitted to the facility on [DATE], with diagnoses including heart failure, unspecified, adult failure to thrive, and chronic kidney disease, unspecified. Resident #16 Resident #16 was admitted to the facility on [DATE], with diagnoses including chronic atrial fibrillation, lobar pneumonia, unspecified organism, and contact with and exposure to other viral communicable diseases. Resident #12 Resident #12 was admitted to the facility on [DATE], with diagnoses including type two diabetes mellitus without complications, personal history of COVID-19, and heart failure, unspecified. Resident #7 Resident #7 was admitted to the facility on [DATE], with diagnoses including type two diabetes mellitus without complications, hypothyroidism, unspecified, and deficiency of other specified B group vitamins. Resident #11 (continued on next page)

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	295001	A. Building B. Wing	05/23/2024

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #11 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including epilepsy, unspecified, chronic obstructive pulmonary disease, and unspecified asthma, uncomplicated. Resident #4 Resident #4 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebrovascular disease affecting unspecified side, personal history of COVID-19, and type two diabetes mellitus without complications. Resident #1 Resident #1 was admitted to the facility on [DATE], with diagnoses including epilepsy, unspecified, not intractable, without status epilepticus, personal history of COVID-19, and hyperkalemia. Resident #10 Resident #10 was admitted to the facility on [DATE], with diagnoses including acute cough, other myeloid leukemia not having achieved remission, and type two diabetes mellitus with diabetic neuropathy, unspecified. Resident #19's clinical record lacked documented evidence the resident was screened for eligibility to receive a COVID vaccine, education regarding the vaccine was provided to the resident or resident representative, and if the vaccine was offered and either administered or declined for 2024. Resident #17, #2, #13, #15, #9, #6, #8, #14, #3, #5, #18, #16, #12, #7, #11, #4, #1, and #10's clinical records lacked documented evidence the residents were screened for eligibility to receive the COVID vaccine, education regarding the vaccine was provided to the resident or resident representative, and if the vaccine was offered and either administered or declined for the years 2023 and 2024. On 05/22/2024 at 2:12 PM, the Infection Preventionist (IP) verbalized a consequence to a resident not receiving an up-to-date COVID vaccination could cause the resident to contract COVID and die. The IP communicated the resident's clinical documentation for immunizations were not monitored or updated and the facility was not sure how up-to-date the vaccinations were for each resident. On 05/22/2024 at 2:35 PM, the Skilled Nursing Facility (SNF) Manager confirmed COVID vaccinations and boosters were not provided to the residents for 2023 and 2024, as the facility had not put anything in place for the resident vaccinations. On 05/23/2024 at 9:51 AM, the IP confirmed the IP was responsible for all resident vaccinations and the Infection Control Program. The IP verbalized the IP was not involved with COVID vaccinations for the residents. The IP had depended on the Director of Nursing (DON) and the SNF Manager to order the COVID vaccine and the DON and SNF Manager would arrange consent, administration, and documentation. (continued on next page)

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	295001	A. Building B. Wing	05/23/2024

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The IP confirmed the IP did not follow up on COVID vaccinations to ensure the vaccine was ordered or if each resident was screened for eligibility to receive the vaccine, education regarding the vaccine was provided to the resident or resident representative, and if the vaccine was offered and either administered or declined for the years 2023 and 2024. On 05/23/2024 at 10:03 AM, the SNF Manager confirmed COVID vaccinations were not ordered for the residents for the years of 2023 and 2024 because the SNF Manager and DON were focused on the resident influenza and pneumococcal vaccines. The SNF Manager confirmed the DON and the SNF Manager were responsible to order the resident COVID vaccines for 2023 and 2024, and did not order the vaccines. On 05/23/2024 at 11:22 AM, the DON confirmed the facility's COVID policies lacked guidance regarding resident COVID vaccinations. The DON provided an immunization policy which did not include the administration of the COVID vaccine. A Centers for Disease Control and Prevention (CDC) document titled Stay Up to Date with COVID-19 Vaccines, updated 03/07/2024, documented people aged [AGE] years and older were considered up to date with COVID vaccinations when two updated 2023-2024 COVID vaccines were administered. People 65 and older who had received one dose of an updated 2023-2024 vaccine, should receive one additional dose of an updated COVID vaccine at least four months after the previous updated dose. The facility policy titled Immunizations, revised 04/06/2012, documented the immunization schedule would follow current CDC recommendations for immunizations. The resident medical record would include documented education to the resident/representative, the opportunity to refuse immunization, the consent/refusal form and date, and if administered, would document the vaccine manufacturer, lot number, and expiration date.