STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295008	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
El Jen Skilled Care	5538 W Duncan Dr Las Vegas, NV 89130

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41903 Based on observation, interview, record review, and document review, the facility failed to establish a process to identify residents with newly found changes or diagnosis to be referred for Preadmission Screening and Resident Review (PASRR) Level 2 evaluation for 1 of 27 sampled residents (Resident 98). The deficient practice had the potential to place residents at risk of not being evaluated for appropriate determination of necessary behavioral health services. Findings include: Resident 98 (R98) Resident 98 was admitted on [DATE] and readmitted on [DATE], with diagnosis including encounter for orthopedic aftercare following surgical amputation, type 2 diabetes, and peripheral vascular disease. On 08/20/2024 at 9:42 AM, R98 was observed sitting upright in bed while watched television. R98 was welcoming, calm and did not display concerning or withdrawn behaviors when interviewed. A Nevada PASRR Level I Identification Determination dated 09/22/2017, revealed R98 did not have dementia, mental illness (MI), mental retardation (MR) or any related condition (RC), and was deemed appropriate for nursing facility placement. R98's Admission Record Diagnosis Information documented a new diagnosis of bipolar disorder with an onset date of 08/13/2024. R98's medical record lacked documented evidence a referral was made for PASRR level 2 evaluation after the newly found diagnosis of bipolar disorder on 08/13/2024. On 08/21/2024 at 4:18 PM, the Assistant Director of Nursing (ADON) reported not knowing the facility process to request a PASRR level 2 evaluation after a resident had a new diagnosis of mental illness. (continued on next page)

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/22/2024 at 9:55 AM, the Minimum Data Set (MDS) Coordinator explained R98's medical record should have been reviewed after the new diagnosis and a referral for evaluation for PASRR level 2 should have been completed. The evaluation would have let the facility know if the resident was in the correct level of care. The MDS Coordinator reported there was no system in place after a new diagnosis to evaluate for PASRR level 2, due to new management and new staff. A facility policy titled PASRR Completion Policy (undated), documented the center was to make sure that all admissions had the appropriate Patient Assessment and Resident Review (PASRR) completed.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interview, record review, and document review, the facility failed to formulate a person-centered care plan addressing fluid restrictions and resident's non- and to develop and implement a care plan for hydration for a resident at risk of dehydration for 2 of 27 sampled residents (Resident 112 and 93). This deficient practice had the potential to lead to fluid overload, inadequate management of fluid restrictions, an increased risk of dehydration, and further complications Findings include: A facility policy titled Care Plans, Comprehensive Person-Centered revised March 2022, documented a comprehensive, person-centered care plan included the measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident. Resident 112 (R112) R112 was admitted on [DATE], with diagnoses including end stage renal disease, dependence on renal dialysis and history of sudden cardiac arrest. The History and Physical dated 07/11/2024, documented R112's work up revealed possible fluid collection and R112 underwent fluid aspiration. The Minimum Data Set, dated dated dated [DATE], documented R112 was on hemodialysis treatment. A Physician Order dated 08/14/2024, documented Fluid Restriction 1000 milliliter (ml) diet. On 08/21/2024 at 9:10 AM, R112 was in bed, verbally alert, and oriented. R112's stomach was severely distended. A yellow pitcher with ice water approximately 1000 ml was in place, along with an extra-large colored drink approximately 887 ml, which the cup was almost empty. There was also a covered disposable cup containing a yellow-colored drink (approximately 100 ml) and a carton of Nephro approximately 237 ml. R112 indicated the drink was ordered from a food chain. R112 indicated being thirsty most of the time and being able to go to the bathroom to urinate. R112 indicated fluids were restricted to a liter a day, the kitchen was strict and adhered to the order. R112 indicated the Certified Nursing Assistants (CNAs) were providing the ice water. R112 indicated had undergone paracentesis previously due to fluid overload. R112's medical records lacked documented evidence a person-centered care plan for fluid restriction and R112's non-compliance were formulated. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/21/2024 at 10:11 AM, a Licensed Practical Nurse (LPN) indicated R112 was receiving dialysis treatments and on fluid restrictions. The LPN confirmed the observation, a pitcher of ice water was at bedside, juices and a carton of supplement. The LPN indicated R112 was non-compliant with fluid restriction and indicated R112 ordered outside food and drinks. The LPN indicated with R112's non-compliance, the physician should have been notified and care planned. The LPN confirmed there was no documentation of R112's fluid restriction and non-compliance. On 08/21/2024 at 11:49 AM, a Registered Nurse (RN) Supervisor, indicated the fluid restriction required a physician order, which should have been transcribed and implemented. The RN Supervisor verbalized non-compliance with the fluid restriction could lead to edema and congestive heart failure. The RN Supervisor indicated there should have been a care plan for the fluid restriction and R112's non-compliance, but the care plans were not formulated. On 08/21/2024 at 4:27 PM, the Director of Minimum Data Set (MDS) indicated the staff who admitted R112 or the Licensed Nurses who received the new order was responsible for formulating the person-centered care plan for the fluid restriction or non-compliance. 29141 Resident 93 (R93) R93 was admitted on [DATE], with diagnoses including dementia. R93's medical record documented the following laboratory results: Sodium levels: 08/18/2024: 146 milliequivalents per liter (mEq/L). 08/07/2024: 146 mEq/L. 07/22/2024: 147 mEq/L. 07/07/2024: 146 mEq/L. The normal blood sodium level was between 135 and 145 mEq/L. Creatinine levels: 08/18/2024: 1.56 milligram over deciliter (mg/dL) (A normal range for creatinine levels in men was 0.7-1.3 mg/dL). On 08/21/2024 at 12:20 PM, R93 was eating in the dining room. The meal consisted in a hamburger and potato salad. The resident declined the beverage offered, as expressed a preference to not consume any beverage. The nursing staff supervising the meal experience did not encourage fluids. On 08/21/2024 at 1: 00 PM, a Certified Nursing Assistant (CNA) explained R93 disliked water or any other drinks, some cases drink juice but nurses gave water during medication administration. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician Order dated 08/11/2024, indicated to encourage more fluid intake every shift for hypernatremia. A Dietitian visit note dated 08/21/2024, documented R93 refused to consume any fluids provided and only consumed a few drops for medications. The note revealed despite having intravenous fluids, R93 was unable to maintain hydration. R93 had a no-added-salt (NAS) renal diet with a regular composition and thin liquids, and their oral intake was moderate to fair, but high-moisture foods were provided. The note indicated if the resident could not maintain hydration, a percutaneous endoscopic gastrostomy (PEG - a feeding tube inserted through the skin into the stomach to provide nutrition and hydration when inability to eat or drink is present) could be necessary to address their nutritional requirements. The medical record lacked documented evidence a care plan for hydration was initiated. On 08/21/2024 at 2:00 PM, a License Practical Nurse (LPN) assigned to provide care to R93, confirmed the record did not contain a care plan for hydration. The LPN acknowledged a care plan could provide different approaches to ensure R93 was hydrated. The facility policy titled Nutrition and Hydration to Maintain Skin Integrity with the last revision performed in October 2010, documented the purpose of the procedure was to provide guidelines for the assessment of resident nutritional needs, to aid in the development of an individualized care plan for nutritional interventions, and to help support the integrity of the skin through nutrition and hydration. The policy indicated dehydration risk factors included functional impairments, dementia, and/or fluid refusal, and a care plan should be documented in the medical record to address the risk factors.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29141 Based on observation, record review, interview, and document review, the failed to provide oral care for a patient with total dependent functional status for 1 of 27 sampled residents (Resident 26). The deficient practice had the potential to place residents at risk for infection, aspiration pneumonia, and affecting residents' quality of life. Findings include: Resident 26 (R26) R26 was admitted on [DATE], with diagnoses including Alzheimer's, hypothyroidism, hypertension, dysphagia, and schizoaffective disorder. R26 was receiving hospice care. The Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed R26 was dependent for oral care and helper would do all of the effort, requiring the assistance of 2 or more helpers. On 08/20/24 at 3:42 PM, R26 was observed with a dry mouth with white stringy material in the mouth. A Licensed Practical Nurse (LPN) confirmed the observation and indicated the Certified Nursing Assistant should have provided oral care. A Care plan dated 07/25/2024, documented R26 had potential for oral/dental health problems without teeth or dentures and should have daily mouth care. A review of the Oral Care Record from 07/24/2024 through 08/22/2024, revealed the oral care was provided inconsistently. On 08/22/2024 at 1:45 PM, the Director of Nursing (DON) explained oral care should have been provided by the staff regardless of the resident receiving hospice care. The DON indicated oral care should have been provided at least twice daily, once in the morning prior to breakfast, and before bedtime, or more often if it was needed. The facility undated policy titled Mouth Care documented the purpose of the oral care was to keep the resident's lips and oral tissue moist, to clean and fresh resident's mouth, and to prevent oral infections.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41903 Based on observation, interview, record review, and document review, the facility failed to complete post fall neurological checks after two falls for 1 of 27 sampled residents (Resident 106). The deficient practice had the potential to the delay of necessary medical intervention and care for residents. Findings include: Resident 106 (R106) R106 was admitted on [DATE] and readmitted on [DATE], with diagnosis including unspecified dementia, unspecified severity with other behavioral disturbance, adult failure to thrive and anxiety disorder. On 08/20/2024 at 10:49 AM, R106 was observed seated on a bedside chair with eyes closed, and without any signs or symptoms of pain or distress. A Care Plan dated 01/15/2024, documented R106 was at risk for further falls related to confusion, unaware of safety needs and psychotropic medication use. An incident note dated 06/9/2024, documented R106 was on the floor calling out Help me. Skin tears were noted in multiple areas on arms and legs and a small amount of bleeding was noted. A Post Fall Evaluation dated 06/09/2024, lacked documentation for fall details, vitals (other than resident weight), contributing factors, and interventions. A Progress Note dated 08/16/2024, documented R106 was seen on the floor sitting beside the bed and R106 reported I fell . A Post Fall Evaluation dated 08/16/2024, documented R106 sustained an unwitnessed fall. The medical record lacked documented evidence neurological checks were completed after the falls on 06/09/2024 and 08/16/2024. On 08/23/2024 at 12:36 PM, the Director of Staff Development (DSD), explained facility post fall protocol included neurological checks to be completed after falls. The DSD acknowledged neurological checks for falls on 06/09/2024 and 08/16/2024 were not found in the medical record. The DSD confirmed following the post fall protocol would have helped the staff identify changes in the resident, continued monitoring of the resident and provided the correct level of care. On 08/23/2024 at 3:50 PM, the Director of Nursing (DON) confirmed the medical record lacked documented evidence neurological checks were completed for the falls on 06/09/2024 and 08/16/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility document titled Fall Documentation Requirements (undated), listed items to be completed after a fall which included continued monitoring of residents for any change of condition, neurological checks, post fall evaluation, care plan completion, notification of family member/public guardian and medical director, and notification to Director of Nursing.

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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** 29141 Based on observation, record review, interview, and document review, the facility failed to ensure a resident with dementia did not have access to razors in their room for 1 of 27 sampled residents (Resident 8). Findings include: Resident 8 (R8) R8 was admitted on [DATE], with diagnoses including dementia with behavioral disturbance, psychotic disorder, psychotic disorder, depressive disorder, and anxiety. The Brief Interview for Mental Status (BIMS) note dated 08/22/2024, revealed R8 had moderately impaired cognition per BIMS score of 10/15. On 08/20/2024 at 10:00 AM, R8 was in the bathroom shaving himself, and a small cut in the left side of the face was noted. R8 had 5 additional razors on the sink. On 08/20/2024 at 10:10 AM, a Registered Nurse confirmed the observation and indicated R8 had cognitive impairment and it was unknown how R8 got the razors. The RN verbalized Certified Nursing Assistants (CNAs) provided assistance with the activities of the daily living including shaving. The RN indicated R8 should not have had razors since R8 was confused and represented a risk for accidents. The facility policy titled Safety and Supervision of Residents dated July 2017, documented the care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interview, record review and document review, the facility failed to ensure a fluid restriction was followed as ordered for a dialysis-dependent resident, the fluid intake was monitored, and a physician was notified of resident's non-compliance for 1 of 27 sampled residents (Resident 112), and to provide a one-on-one feeding assistant for a resident at risk for weight changes for 1 of 27 sampled residents (Resident 22). The deficient practice had the potential to result in adverse health outcomes, including fluid overload, increased blood pressure, complications related to the resident's dialysis treatment and to increase the risk for unfavorable nutritional for the resident susceptible to weight changes. Findings include: Resident 112 (R112) R112 was admitted on [DATE], with diagnoses including end stage renal disease, dependence on renal dialysis and history of sudden cardiac arrest. The History and Physical dated 07/11/2024, documented R112's work up revealed possible fluid collection and R112 underwent fluid aspiration. The Minimum Data Set, dated dated dated [DATE], documented R112 was on hemodialysis treatment. A Physician Order dated 08/14/2024, documented fluid restriction-1000 milliliter (ml) diet. On 08/20/2024 at 2:23 PM, R112 was unavailable for interview. R112 was on dialysis, a yellow pitcher of ice water approximately 1000 ml was at bedside. R112's Weight Summary documented the increasing weight: -8/6/2024 135.6 pounds (lbs) -7/30/2024 128.6 lbs -7/23/2024 126.8 lbs -7/16/2024 126.0 lbs -7/10/2024 119.8 lbs (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/21/2024 at 9:10 AM, R112 was in bed, verbally alert, and oriented. R112's stomach was severely distended. A yellow pitcher with ice water approximately 1000 ml was in place, along with an extra-large colored drink approximately 887 ml, which the cup was almost empty. There was a covered disposable cup containing a yellow-colored drink (approximately 100 ml) and a carton of Nephro approximately 237 ml. R112 indicated the drink was ordered from a food chain. R112 indicated being thirsty most of the time and being able to go to the bathroom to urinate. R112 indicated the fluid was restricted to a liter a day. The kitchen was strict and adhered to the order. R112 indicated the Certified Nursing Assistants were providing the ice water. R112 indicated had undergone paracentesis previously due to fluid overload. R112's medical records lacked documented evidence the fluid restriction was implemented; the fluid intake was monitored, and the physician was notified of R112's non-compliance. On 08/21/2024 10:11 AM, a Licensed Practical Nurse (LPN) indicated R112 was receiving dialysis treatments and on fluid restrictions. The LPN confirmed the observation, a pitcher of ice water was at bedside, juices and a carton of Nephro 237 ml. The LPN indicated R112 was non-compliant with fluid restriction and indicated R112 ordered outside food and drinks. The LPN indicated the physician should have been notified of the resident's non-compliance with the fluid restriction. The LPN confirmed there was no documentation of the resident's non-compliance with the fluid restriction or physician notification of the non-compliance. On 08/21/2024 at 11:28 AM, Certified Nursing Assistant 1 (CNA1) indicated the Licensed Nurse would inform the CNA of the resident's fluid restriction. The CNAs did not access or see physician orders only the nurses. On 08/21/2024 at 11:35 AM, Certified Nursing Assistant 2 (CNA2) indicated the ice water would be provided in the morning and before the end of shift. CNA2 indicated CNAs would be informed of a resident's fluid restriction by a notice posted in resident's rooms or per advice of the Licensed Nurse. The Medication Administration Record (MAR) lacked documented evidence the fluid restriction order was transcribed in the MAR until 08/21/2024. On 08/21/2024 at 11:49 AM, a Registered Nurse (RN) Supervisor indicated the fluid restriction required a physician order, which should have been transcribed and implemented. The RN Supervisor acknowledged there was an order for R112's fluid restriction but it was erroneously transcribed and not implemented. The RN Supervisor explained the order should have been clarified regarding the specific distribution of fluids and the actual fluid intake should have been monitored or documented. The RN Supervisor verbalized non-compliance with the fluid restriction could lead to edema and congestive heart failure. The RN Supervisor indicated there was no documented evidence the physician was notified. On 08/21/2024 at 2:20 PM, a Dietary Aide confirmed the yellow pitcher was a 1000 ml container, or 1 liter. The Dietary Aide was unaware which residents were on fluid restrictions, but the manager was unavailable and out of the facility. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/21/2024 at 2:24 PM, two Registered Dietitians indicated R112 was initially evaluated on 07/11/2024. Registered Dietitian 2 (RD2) indicated R112 was not assessed for the fluid restriction. RD1 confirmed R112 had an order for fluid restriction and the staff were expected to follow and monitor the fluid intake. Both RDs were not notified regarding R112's non-compliance with fluid restriction. RD1 acknowledged R112's weight had been increasing and verbalized fluid intake should have been monitored. On 08/21/2024 at 3:09 PM, the dialysis Registered Dietitian (RD) indicated as of 8/20/2024, the dialysis records based on the last 28 days R112 had excessive interdialytic weight gains and post weight above target weight. The dialysis RD confirmed R112's fluid allowance daily was based on target weight or dry weight, per 1000 ml/day plus 24-hour urine output. On 08/21/2024 at 4:30 PM, the Assistant Director of Nursing (ADON) indicated the fluid restriction order should have been communicated to the kitchen for appropriate fluid distribution for each meal and the Licensed nurse would inform the CNAs. The ADON indicated the fluid signage in the rooms was not practiced due to resident's privacy concerns. A facility policy titled Encouraging and Restricting Fluids October 2010, documented to verify there was a physician's order for this procedure. Follow specific instructions concerning fluid intake or restrictions. Be accurate when recording fluid intake. Record fluid intake of the intake side of the intake and output record. When a resident had been placed on restricted fluids, remove the water pitcher and cup from the room. If the resident refused, notify the supervisor and in turn, the physician. Be sure an intake and output record were maintained in the resident's room. 29141 Resident 22 (R22) R22 was admitted on [DATE], with diagnoses including chronic obstructive pulmonary disease, schizoaffective disorder, anemia, stage 4 pressure ulcer of sacral region. A review of the Intake Record from 07/23/2024 through 08/21/2024, revealed R22's intake varied ranging from 0-25 % 16 times, 26-50 %, 51-75 %, and 76-100 % 21 times respectively. There was a pattern in breakfast were R22 consumed 0-25 % (40 % of the time) and dinner when R22 consumed 76-100 % of the meals (43 % of the time). A Registered Dietitian (RD) note dated 07/17/2024, revealed the RD spoke with a Certified Nursing Assistant (CNA) who reported R22's intake varied when family brought outside food and the lack of regular family visits could be the reason for the poor intake and weight loss. The RD indicated R22 received a regular diet, regular texture, thin liquid consistency, mighty shake three times daily with meals, and Magic cup twice daily with lunch and dinner. A Nutritional Care Plan dated 07/12/2024, revealed R22 was at risk of altered nutritional status due to variable oral intake and appetite, pressure ulcer, and no upper teeth. The plan indicated R22 would maintain weight within 7.5% of 187.2 pounds, avoid malnutrition, and consume at least 50% of daily meals. Approaches included meal setup and monitoring. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician Order dated 02/28/2024, documented one on one (1:1) feeding assistant during all meals and snacks related to abnormal weight change. On 08/21/2024 at 4:53 PM, R22 was eating dinner in their room. There were no staff providing 1:1 supervision during the meal. According to a CNA, R22 ate independently. A review of the intake record revealed R22 ate 26-50 % of the dinner. On 08/22/2024 at 11:30 AM, the RD explained R22's weight fluctuated up and down as well the intake that was inconsistent. The goal for the measures recommended and implemented was to maintain optimal nutritional parameters. The order for 1:1 feeding assistant was to maintain consistency in the meal intake to prevent unplanned weight changes. The RD expected staff to follow the nutritional recommendations and orders. On 08/22/2024 at 11:50 AM, during meal observation in the dining room located in the memory unit, R22 was at a table with other residents. Three staff members were distributing meals and supervising the residents. R22 was eating without feeding assistance and ate 0- 25 % of the lunch. This observation was confirmed by a CNA. On 08/22/2024 at 12:45 PM, a Licensed Practical Nurse (LPN) confirmed R22 needed 1:1 assistance with meals. The LPN explained R22 was inconsistent with oral intake and would benefit with feeding assistance. On 08/22/2024 in the afternoon, the Director of Nursing verbalized it was the expectation for the staff to follow the physician order to assist R22 with meals.

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	295008	A. Building B. Wing	08/23/2024

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39418 Based on observation, interview, record review and document review, the facility failed to ensure Intravenous (IV) access was discontinued when not therapeutically needed for 1 of 27 sampled residents (Resident 124). The deficient practice had a potential for increasing the risk of an infection to a resident due to a prolonged portal of entry for microorganisms. Findings include: Resident 124 (R124) R124 was admitted on [DATE], with diagnoses including cerebral infarction and dysphagia. On 08/20/2024 at 10:32 AM, observed R124 had a left arm midline (a long, thin, flexible tube that is inserted into a large vein in the upper arm) IV line. The IV access had a transparent dressing dated 08/18/2024. R124's room had no IV pump in the vicinity. R124 was non-verbal but able to communicate with facial expressions and body movement. R124 shrugged when asked if the IV access was being used for any treatments. R124's physician order documented the following orders: - 08/06/2024, Midline insertion. No directions specified for order. - 8/6/2024, insert IV for bolus 1000 milliliters of Normal Saline (NS), no directions specified for order. Discontinued 8/6/2024. R124 physician order documented the IV was placed for a one-time order for IV hydration for hypotension (low blood pressure). R124 physician progress notes dated 08/07/2024, documented resident had an episode of hypotension. 1Liter of NS bolus given. Blood pressure was now stable. Labs reviewed, no overt abnormalities. Likely intravascular depletion. Oral intake had been low but peg tube was removed per family request. Will continue to encourage oral intake and hydration. Starting medication for appetite stimulant. Will also adjust antihypertensive medication. R124's physician and nursing progress notes lacked documented evidence for the need to maintain the midline. There was a lack of documented evidence the physician was made aware the midline was still in place with no therapeutic use. On 08/22/2024 at 1:15PM, a License Practical Nurse and the Infection Control IC nurse indicated unused IV lines should be addressed to the primary physician and if not needed should be discontinued. The nurses acknowledged the unused IV access should be addressed to the physician for removal at a minimum of 48 hours of not being used. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/22/2024 at 1:24 PM, R124's family member indicated the IV was placed to provide hydration to the resident earlier in the month. The family member indicated the resident had been drinking and eating well lately. On 08/22/2024 at 3:11 PM, the infection preventionist confirmed an IV access was a portal for infection and should have been discontinued when not needed. Nursing was expected to address the primary physician if an IV is not utilized and request for a discontinuation order. The facility policy titled Removal of an IV Catheter revised March 2022, documented remove the peripheral /midline IV catheter if: a. infusion therapy was discontinued. b. if not used within 24 hours. c. It is no longer in the plan of care.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interview, record review, and document review, the facility failed to ensure medications were acquired and available as prescribed for 2 of 27 sampled residents (Residents 29 and 7). The deficient practice had the potential to result in delayed treatment, exacerbation of medical conditions, decline in the residents' health and adverse health outcomes. Findings include: Resident 29 (R29) R29 was admitted on [DATE], with diagnoses including muscle wasting and atrophy, depression and anxiety disorder. A Physician Order dated 07/16/2024, documented Duloxetine Hydrochloride 30 milligrams (mg) to administer by mouth daily for depression manifested by sad affect. The Medication Administration Record (MAR) dated 08/22/2024, documented the Duloxetine was not administered due to unavailability. On 08/22/2024 at 8:24 AM, Licensed Practical Nurse 1 (LPN1) prepared R29's medications except Duloxetine. LPN1 explained the Duloxetine ran out of supply and unavailable. LPN1 explained the Licensed Nurses assigned on the previous days did not reorder the Duloxetine when the supply ran low. LPN1 indicated the process was to place the order electronically when a few dosages were left to ensure the medication was available as prescribed. On 08/22/2024 at 11:46 AM, during a telephone interview the Pharmacy Technician explained the facility should have reordered the medication when the supply ran low. The Pharmacy Technician indicated the last order was on 08/09/2024 and Duloxetine was delivered with 14 tablets. The Pharmacy Technician explained medication refills had to be reordered and were not automatically delivered. On 08/22/2024 at 12:05 PM, the Registered Nurse (RN) Supervisor indicated the Duloxetine should have been ordered when a few dosages were left. Resident 7 (R7) R7 was admitted on [DATE], with diagnoses including anxiety disorder and major depressive disorder. A Physician Order dated 04/01/2023, documented to give Sertraline Hydrochloride tablet 50 mg by mouth daily for major depressive disorder. On 08/22/2024 at 3:50 PM, Licensed practical Nurse (LPN2) indicated the Sertraline was not available for administration and would need to be reordered from the pharmacy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/22/2024, at 3:56 PM, during a telephone interview the Pharmacy Technician explained a refill request was not placed until today. The Pharmacy Technician explained to acquire a medication refill it needed to be requested and not automatically delivered. A facility policy titled Pharmacy Services Overview revised April 2019, documented the facility should accurately and safely provide or obtain the routine medications. The pharmaceutical services consists including the process of receiving, acquiring administering and monitoring of all medications. Ensuring the residents have sufficient supply of the prescribed medications and receive medications in a timely manner. The nursing staff were responsible for contacting the pharmacy if a resident's medication was not available for administration.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39418 Based on observation, interview and document review, the facility failed to ensure expired medications were discarded: 1) compounded intravenous (IV) antibiotics, 2) a bottle of tablet medications. The deficient practice had a potential for non-viable medications administered to residents. Findings include: 1) On 08/22/2024 at 12:40 PM, observed inside the medication refrigerator of 400 Hall medication room was (2) bags of compounded intravenous (IV) Vancomycin 1.2 gram. The IV bag label documented filled on 07/30/2024. Do not use 08/15/2024; and (4) bags of compounded IV Vancomycin 1.2 gram. The IV bag label documented filled on 08/01/2024. Do not use 08/15/2024. A license practical nurse (LPN) confirmed the findings and indicated the IV medications should have been discarded. The LPN indicated the resident listed on the medication bag was finished with the antibiotic regimen and the left-over bags should have been sent back to pharmacy. 41903 2) Expired bottle of Sodium Chloride tablets On 08/22/2024 at 11:40 AM, one bottle of Sodium Chloride tablets 1 gram was observed expired on 07/2024, in the [NAME] medication storage room. On 08/22/2024 at 11:50 AM, a Licensed Practical Nurse, confirmed the Sodium Chloride tablets 1 gram was expired and should have been discarded for resident safety. A facility policy titled Medication Labeling and Storage revised February 2023, documented if the facility had discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy should have been contacted for instructions regarding returning or destroying of those items.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 29141 Based on observation, interview and document review, the facility failed to follow guidelines for food storage and use. The deficient practice had the potential to expose residents to foodborne illnesses. Findings include: On 08/20/2024 in the morning during the inspection conducted in the kitchen, eight packets of hamburger buns dated 07/27/2024 were found in the dry storage. The cook indicated each packet of hamburger buns had a sticker with the date the buns were received. The cook indicated bread such as hamburger buns should be used within two weeks and discarded if not used. The cook acknowledged the buns been stored more than two weeks in the dry storage room. The facility policy titled Food Receiving and Storage and last revised in November 2022, documented food should be received and stored in a manner to comply with safe handling practices. The facility document titled Dry Storage Chart dated 05/12/2016, indicated the recommendations dictated by the chart outlined the proper storage time for opened and unopened dry items. The chart documented unopened packets of bred, including hamburger and hotdog buns, should be stored for four to five days when they are in the dry storage area.

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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** 29141 Based on observation, record review, interview, and document review, the facility failed to ensure wound care contractors followed enhanced barrier precautions during wound care treatment for 1 of 27 sampled residents (Resident 22). The deficient practice had the potential to cause health complications such as infections, delayed healing of the wound, and cross-contamination, compromising the quality of life and well-being of residents. Findings include: Resident 22 (R22) R22 was admitted on [DATE], with diagnoses including chronic obstructive pulmonary disease, schizoaffective disorder, and anemia. R22 was receiving wound care treatment for a stage 4 decubitus ulcer in the sacral area (a stage 4 decubitus ulcer is the most severe type of pressure ulcer and could spreads to the muscle, bone, or joints, and it can cause a serious bone infection). A sign posted at the entrance to the R22's room stipulated enhanced barrier precautions (EBP) should be implemented for all individuals engaging in high-contact activities, such as wound care, which necessitated the use of personal protective equipment (PPE) including gloves and gowns. On 08/20/2024 at 10:28 AM, three wound care staff were providing wound care to R22. The wound care staff were not wearing PPE during the procedure. The charge nurse confirmed the observation and acknowledged the wound care team should have followed the EBP guidance for PPE to prevent cross contamination. A Physician Order dated 07/11/2024, documented EBP every shift for pressure injury to sacrum. A care plan dated 08/22/2024, documented R22 needed EBP due to a pressure injury to the sacrum. The care plan indicated staff members shall wear the required personal protective equipment (PPE) during high-touch activities to reduce the transmission of multidrug resistant organism (MDRO) infection. On 08/22/2024 in the afternoon, the Director of Nursing (DON) explained EBP should have been followed during the wound care procedure provided to R22 to prevent spread of infections. The DON confirmed the contractor wound care team did not have training related to EBP. The facility policy titled Enhanced Barrier Precautions and last revised on dated March 2024, documented EBP that included the use of gloves and gowns in addition to standard precautions, were implemented when performing high-contact activities such as wound care treatment, to reduce the transmission of MDRO to residents. The policy indicated staff should be trained prior to caring for residents on EBP.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 29141 Based on observation, interview and document review, the facility failed to ensure it maintained an effective pest control program as evidenced by the presence of live cockroaches in the kitchen. The deficient practice had the potential to maintain the kitchen in a clean and sanitary manner. On 08/21/2024 in the morning during the kitchen inspection, two live baby cockroaches were identified in a corner behind the stove area near the triple compartment sink. Several dead baby cockroaches were seen in the same area. The floor surface behind the stove and under the sink were soiled with food debris and grease. The [NAME] and the Maintenance Director confirmed the observation. The [NAME] indicated pest control was conducted a couple weeks ago. On 08/22/2024 in the afternoon, the Maintenance Director provided proof of pest control performed on 08/07/2024. The Director acknowledged the report did not document if live insects were detected during the pest control visit. The facility policy titled Pest Control and last revised May 2024, documented the facility would maintain an ongoing pest control program to ensure the facility was kept free of insects.