STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295021	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Health & Rehabilitation Center of LV, LP	2945 Casa Vegas Street Las Vegas, NV 89169

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interview, record review, and document review, the facility failed to ensure the free water flushes (FWF) via Percutaneous Endoscopic Gastrostomy (PEG) tube (a feeding tube inserted through the abdominal wall into the stomach and used to provide nutritional support and feed patients who are unable to eat or drink) were provided as prescribed for 3 of 4 sampled residents (Residents 53, 48, and 45). The deficient practice could have led to an increased risk of inadequate hydration, delayed wound healing, electrolyte imbalance and adverse health outcomes. Findings include: Resident 53 (R53) R53 was admitted on [DATE], with diagnoses including severe protein-calorie malnutrition, dysphagia (difficulty swallowing) and gastrostomy. A physician's order dated 08/22/2024, documented a water flush via PEG tube at 125 milliliter (ml) every 4 hours. A Care Plan dated 09/09/2024, documented R53 was at risk for dehydration related to nothing by mouth status. The PEG tube provided all fluids and nutrition. On 09/10/2024 at 10:29 AM, R53 was in bed with eyes closed, incoherent, and non-verbal. R53 was receiving infusions through the PEG tube, and was receiving 100 ml of water every 4 hours. On 09/10/2024 at 12:01 PM, R53 was in bed, the tube feeding (TF) pump was off, and the FWF were not infusing. On 09/10/2024 at 2:23 PM, R53 was in bed, the TF pump was off, and the FWF were not infusing. On 09/10/2024 at 4:17 PM, R53 was in bed, and the FWF were infusing at 100 ml every 4 hours at 12:00 PM and off at 9:00 AM, running for 21 hours. The LPN confirmed both the TF and water flushes had been provided late. On 09/11/24 at 8:48 AM, R53 was in bed with eyes closed and FWF were infusing at 100 ml every 4 hours. (continued on next page)

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

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/11/2024 at 1:28 PM, the Director of Nursing (DON) reviewed R53's enteral pump history and confirmed 242 ml of FWF had been infused over 24 hours, 643 ml over 48 hours, and 1,268 ml over 72 hours. The DON indicated the staff were expected to adhere to the prescribed TF orders. On 09/13/2024 at 1:19 PM, the Charge Registered Nurse (CRN) confirmed R53's FWF order was 125 ml every 4 hours, nothing per orem (NPO/ or nothing by mouth) and dependent upon TF. The CRN confirmed R53 FWF had not been completely infused as prescribed. On 09/13/2024 at 1:48 PM, the Registered Dietitian (RD) indicated R53's FWF were ordered at 125 ml every 4 hours, which equated to 36 ml/hour, totaling 750 ml in 24 hours, 1500 ml in 48 hours, and 2250 ml in 72 hours. The RD confirmed based on the enteral pump history report, R53's FWF were not completely delivered as prescribed. On 09/13/2024 at 2:45 PM, upon verification at the bedside, R53's FWF were infusing at 100 ml every 4 hours. The RD confirmed R53's FWF were ordered at 125 ml every 4 hours and not 100 ml. The RD indicated there was a significant discrepancy in R53's FWF and indicated R53 was at risk for dehydration and delayed wound healing if the order was not fully delivered as prescribed. Resident 45 (R45) R45 was admitted on [DATE], with diagnoses including dysphagia and gastrostomy. A Physician Order dated 08/08/2024, documented FWF via PEG tube at 150 ml every 4 hours. On 09/10/2024 at 12:01 PM, R45 was in bed with eyes open, the TF pump was turned off, and the FWF were not infusing. On 09/10/2024 at 2:23 PM, R45 was in bed with eyes closed, the TF pump was off, and the FWF were not infusing. On 09/10/2024 at 4:20 PM, the FWF was infusing at 100 ml every 4 hours. The LPN indicated the TF and FWF should have been turned on at 12:00 PM and off at 9:00 AM, running for 21 hours. The LPN confirmed R45's TF and FWF were provided late. On 09/11/2024 at 1:36 PM, the DON verified the enteral pump history, which indicated R45's FWF infused was 447 ml over 24 hours, 1047 ml for 48 hours, and 1472 for 72 hours. The DON indicated the staff were expected to follow the FWF as prescribed. On 09/13/2024 at 4:05 PM, the Charge Registered Nurse (CRN) confirmed R45's FWF were infusing at 100 ml every 4 hours, but the order was 150 ml every 4 hours. The CRN confirmed R45's FWF were not completely infused via PEG as prescribed. On 09/13/2024 at 4:15 PM, R45's FWF were infusing at 100 ml every 4 hours. The RD indicated R1 should have received a water flush at 150 ml every 4 hours, totaling 900 ml per day (a shortage of 453 ml), 1800 ml over 2 days (a shortage of 753 ml), and 2700 ml over 3 days (a shortage of 1228 ml). The RD explained the shortage accumulation could potentially lead to dehydration. The RD also indicated the staff were expected to infuse the FWF via PEG tube as prescribed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 48 (R48) R48 was admitted on [DATE], with diagnoses including dysphagia and gastrostomy. A physician's order dated 08/09/2024 documented the FWF were to be administered at 75 ml every 4 hours via PEG tube. On 09/13/2024 at 4:05 PM, R48 was in bed and the FWF were infusing at 60 ml every 4 hours. The CRN confirmed R48's FWF should have been infusing at 75 ml every 4 hours. The CRN verified the actual total FWF infused was 150 ml over 24 hours, 300 ml over 48 hours, and 525 ml over 72 hours, confirming R48's FWF had been insufficiently infused. On 09/13/2024 at 4:15 PM, the Registered Dietitian (RD) confirmed R48 should have received 75 ml every 4 hours, not 60 ml. The RD confirmed R48's FWF were insufficiently infused resulting in a shortage of 825 ml over 72 hours. The RD indicated the nurses were responsible to verify the TF orders. A facility policy titled Tube Feeding, dated September 2021, documented to ensure the facility met nutritional guidelines and resident's nutritional requirements according to the physician's orders. The nursing staff were required to verify the order for tube feeding. A facility policy titled Assisted Nutrition and Hydration dated March 2023, documented to ensure that residents maintained acceptable parameters of nutritional status, were offered sufficient fluid intake to support proper hydration and health, and were provided a therapeutic diet when ordered. The policy also required that nutritional and hydration care and services be provided to each resident, consistent with their comprehensive assessment.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interview, record review, and document review, the facility failed to ensure the head of the bed was elevated to 30-45 degrees while the tube feeding (TF) was infusing and TF formula was delivered as prescribed for 4 of 4 sampled residents (Residents 53, 45, 48, and, 1) The deficient practice could have led to an increased risk of inadequate nutrition, weight loss, aspiration, and potential respiratory complications for the affected residents. Findings include: Resident 53 (R53) R53 was admitted on [DATE], with diagnoses including severe protein-calorie malnutrition, dysphagia (difficulty swallowing), and gastrostomy. The History and Physical dated 08/16/2024, documented R53 had severe dysphagia and the plan to continue Percutaneous Endoscopic Gastrostomy (PEG) tube (a feeding tube inserted through the abdominal wall into the stomach and used to provide nutritional support and feed patients who are unable to eat or drink) feeding for severe malnutrition and continue current feeding and other supplementation and recommendations per registered dietitian. The Nutritional assessment dated [DATE] documented a pending body mass index. R53 was NPO (nothing by mouth) with enteral nutrition of Glucerna 1.2 at 70 milliliters per hour (ml/hr.) providing 2016 kilocalorie's (kcal),101 gram (g) protein, and 1352 ml water. Nutritional interventions included maintaining NPO status and advancing to an oral diet as recommended. The tube feeding order was adjusted from 24 to 21 hours to allow time for therapy. A physician's order dated 09/10/2024, documented Glucerna 1.2 at 70 per hour x 21 hours (start at 12:00 PM and off at 9:00 PM) via PEG tube. To provide 1764 kcal and 88 g of protein. On 09/10/2024 at 10:29 AM, R53 was in bed in supine position with eyes closed, incoherent, and non-verbal. R53 received TF Jevity 1.2 via PEG tube and was infusing at 70 ml/hour. The TF bag was dated 9/10/2024. On 09/10/2024 at 12:01 PM, R53 was in bed, the TF pump was off, and nothing was infused. On 09/10/2024 at 2:23 PM, R53 was in bed, the TF pump was off, and nothing was infused. On 09/10/2024 at 4:17 PM, R53 was in bed, the TF Jevity 1.2 was infusing at 70 ml/hr. A Licensed Practical Nurse (LPN) indicated the TF should have been started at 12:00 PM and off at 9:00 AM, to run for 21 hours. The LPN confirmed the TF was infused late and the TF dose was not completely infused as prescribed. The LPN explained R53's head of bed should have been elevated at 45 degrees while the TF was infusing to prevent aspiration. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/11/2024 at 8:48 AM, the TF Glucerna 1.2 was infusing at 70 ml/hr. The TF bag was dated 09/11/2024. On 09/11/2024 at 1:28 PM, the Director of Nursing (DON) reviewed R53's enteral pump history and confirmed R53 received a total TF dose of 890 ml over 24 hours, 1924 ml over 48 hours, and 3076 ml over 72 hours. The DON indicated the staff should have followed the prescribed TF orders and ensured the resident's head of bed was elevated between 30-45 degrees. On 09/13/2024 at 1:48 PM, the Registered Dietitian (RD) confirmed the tube feeding (TF) of Glucerna 1.2 at 70 ml/hr. for 21 hours should have run from 12:00 PM to 9:00 AM daily. R53 should have received 1,470 ml over 24 hours, 2,940 ml over 48 hours, and 4,410 ml over 72 hours. The RD confirmed a TF dose discrepancy of 1,334 ml over 72 hours, while R53 only received 3,076 ml. On 09/13/2024 at 2:45 PM, the RD verified the TF dose delivery, confirming R53 was at risk for malnutrition, weight loss, and delayed wound healing if the prescribed order was not fully delivered over time. The RD indicated R53's body mass index remained stable at the time, with no significant weight changes. Resident 45 (R45) R45 was admitted on [DATE], with diagnoses including dysphagia and gastrostomy. A Physician Order dated 09/10/2024, documented Jevity 1.2 via enteral pump at 60 ml/hr. for 21 hours/day (start at 12:00 PM and stop at 9:00 AM) to provide 1512 kcal, 69 g protein. May use 1.5 if 1.2 not available. On 09/10/2024 at 2:45 PM, R45 was in bed in supine position and incoherent. The 1000 ml TF bag was hanging at bedside and not infusing at this time. Dated 09/10/2024, the TF formula bag contained approximately 718 ml. On 09/10/2024 at 4:26 PM, R45 was in bed with the head of the bed elevated at 10-15 degrees. The TF Jevity 1.2 was infusing at 60 cc/hr. and approximately 700 ml remaining in the bottle. The LPN confirmed R45's TF had been started late. The LPN explained R45's head of bed should have been elevated at 45 degrees while the TF was infusing to prevent aspiration. On 09/11/2024 at 8:05 AM, R45 was in bed, and the TF Jevity 1.2 was infusing at 60 ml/hr. On 09/11/2024 at 1:36 PM, the DON verified R45's enteral pump history and confirmed R45's total TF dose delivered was 920 ml over 24 hours, 2,052 ml over 48 hours, and 3,151 ml over 72 hours. The DON indicated the staff were expected to adhere to the prescribed TF orders. On 09/13/2024 at 2:01 PM, the RD indicated the TF order was Jevity 1.2 at 60 ml/hr. to run for 21 hours. The RD explained R45 should have received 1,260 ml in 24 hours, 2,520 ml in 48 hours, and 3,780 ml in 72 hours. The RD confirmed a discrepancy of 629 ml over 72 hours, resulting in a deficit in calories and protein due to the incomplete TF delivery. Resident 48 (R48) (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R48 was admitted on [DATE], with diagnoses including dysphagia and a gastrostomy. A physician order dated 09/13/2024, documented TF Jevity 1.2 should be provided at 60 ml/hr. via PEG tube for 21 hours daily, to start at 12:00 PM and stop at 9:00 AM, to provide 1512 kilocalories, 70 g of protein. On 09/13/2024 at 4:05 PM, the Charge Registered Nurse (CRN) confirmed R48's TF was infusing with Jevity 1.5 instead of Jevity 1.2. The CRN indicated the nursing staff were expected to administer the prescribed TF dose to prevent malnutrition or weight loss. The CRN confirmed the discrepancies in the enteral pump history revealed the following: 1102 ml over 24 hours, 2079 ml over 48 hours, and 3149 ml over 72 hours. On 09/13/2024 at 4:15 PM, the RD, confirmed R48 should have received TF dose of 3,780 ml over 72 hours with a discrepancy of 631 ml. The RD explained the cumulative shortages could lead to malnutrition and weight loss, and verbalized the importance of providing adequate protein and calories for nutrition. On 09/13/2024 at 4:20 PM, the Regional Consultant confirmed R48 had not documented any weight loss and had actually gained weight. Resident 1 (R1) R1 was admitted on [DATE] with diagnoses including dysphagia and a gastrostomy. A physician's order dated 04/19/2024, documented TF Jevity 1.2 via PEG tube at 60 ml/hr. running for 21 hours, to stop at 9:00 AM and start at 12:00 PM. On 09/13/2024 at 4:05 PM, the Charge Nurse (CRN) confirmed that R1's TF was infusing Jevity 1.2. The enteral pump history showed a total of 1,056 ml delivered over 24 hours, 2,075 ml over 48 hours, and 2,968 ml over 72 hours, all of which were below the prescribed TF volume. The CRN indicated the staff were expected to deliver the complete dose of the TF as ordered to prevent malnutrition or weight loss. On 09/13/2024 at 4:15 PM, the RD confirmed R1 should have received 1,260 ml over 24 hours (a shortage of 204 ml), 2,520 ml over 48 hours (a shortage of 445 ml), and 3,780 ml over 72 hours (a shortage of 812 ml). The RD indicated the staff were expected to administer the full TF dose to avoid potential malnutrition and weight loss due to the cumulative shortages. On 09/13/2024 at 4:20 PM, the Regional Consultant confirmed R1 was on Jevity 1.2 at 60 ml/hr. for 21 hours, from 12:00 PM to 9:00 AM. The consultant verbalized there was no documented weight loss, but rather, weight gain. A facility policy titled Tube Feeding, dated September 2021, required nursing staff to verify tube feeding orders to ensure the facility met the nutritional guidelines and the residents ' nutritional needs in accordance with the physician ' s orders. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility policy titled Enteral Feeding-Safety Precautions dated December 2018, was documented to ensure the safe administration of enteral feeding. To prevent aspiration, the policy mandated elevating the head of the bed at least 30-45 degrees during tube feeding and for a minimum of 1 hour after feeding. The staff recognized the risks associated with aspiration, including the supine position.

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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** 40131 Based on observation, interview, record review and document review, the facility failed to ensure the IV (intravenous) heplock was monitored, or discontinued when not in use for 1 of 16 sampled residents (Resident 171). This deficient practice could have resulted in potential risks, including infection, infiltration and phlebitis. Findings include: Resident 171 (R171) R171 was admitted on [DATE], with diagnoses including acute kidney failure, hypertension and dehydration. The Activities Progress Notes dated 09/05/2024, documented R171 was alert, oriented and able to verbalize needs. The Wound/weekly Monitoring assessment dated [DATE], documented R171 had an IV implanted port on left hand back and present on admission. On 09/10/2024, at 1:41 PM, R171 was in bed and verbally responsive. R171 had an IV heplock on left hand back, which was covered with a transparent and undated dressing. R171 verbalized a nurse had placed the IV access 5 or more days ago but was not on IV medications. R171 did not understand the purpose of keeping the IV heplock. A Licensed Practical Nurse (LPN), confirmed the heplock was in place and was old, with undated dressing, peeling tape, and blood residue on the IV tubing. The LPN indicated an order was required for any IV line access. On 09/10/2024 at 1:43 PM, the Charge Registered Nurse (CRN) who admitted R171 confirmed the IV heplock on R171's left hand was in place. The CRN acknowledged there was no order, admission assessment, or care plan had been completed for the use of the IV heplock. The CRN indicated R171 had been admitted on [DATE] and likely had the IV access from the hospital. The CRN explained any IV access should have been assessed upon admission, with orders obtained or the IV discontinued if it was not necessary. The CRN explained the heplock should have been flushed or discontinued if not in use, highlighting the risk of infection if it was improperly managed. On 09/11/2024 at 4:20 PM, the Director of Nursing (DON) confirmed the wound nurse identified the IV heplock during skin assessment, but the order was neither transcribed nor obtained to discontinue the heplock, as R171 was not on IV medications. The DON indicated it was the charge or admission nurse's responsibility to ensure the completion of the appropriate assessment and orders. The DON indicated failing to monitor and remove the IV heplock when it was not in use could potentially lead to infection. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/12/24 at 10:55 AM, the Nurse Practitioner (NP) indicated all IV line access should have been properly assessed, monitored, and removed if not in use. The NP explained if a resident was admitted with an IV line, communication with the infectious provider should have occurred regarding the possibility of IV antibiotics. If IV antibiotics were not required, the IV line should have been removed due to the risk of infection. A facility policy titled Maintaining Patency of Peripheral and Central Vascular Access Devices, dated August 2021, documented a prescriber's order was necessary for IV management.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 30667 Based on observation, interview and document review, the facility failed to ensure the kitchen vent hood, filters and dish machine were cleaned and maintained per policy. On 09/10/24 at 7:43AM, the initial kitchen observation revealed the following: -The kitchen vent exhaust hood filter with a copious amount of buildup. The Kitchen Manager indicated maintenance took care of the cleaning. -The dish machine had a copious amount of white and lime green build up on the exterior. The Dish Machine cleaning schedule was reviewed with the Kitchen Manager. The schedule documented the dish machine had been cleaned on 09/09/2024. The Kitchen Manager indicated the cleaning did not include the exterior. The Kitchen Manager verbalized; the dish machine appeared to be neglected. On 9/12/2024 at 11:14 AM, the Kitchen Manager showed that the oven, hood and dishwasher were cleaned. The Kitchen Manager explained the hood was cleaned quarterly by an outside company but then cleaned it themselves. On 9/13/2024 at 2:55 PM, the Maintenance Director indicated vent hood was cleaned every three months. The last cleaning was done on 05/29/2024 and the next cleaning due in September. The Maintenance Director indicated it was up to the dietary department to inform maintenance if the vent needed cleaning in between scheduled cleanings. The facility policy titled Hood and Filter - Operation and Cleaning, revised date 07/01/2016, documented the hood and filter system should be cleaned at least weekly, or more often as necessary. Due to potentially high fire hazard, it is important that hood filters are part of the cleaning schedule and are kept free of grease and dust. The facility policy titled Dish Machine Operation and Cleaning, revised 09/01/2021, documented on a weekly basis and as needed, clean the dish machine exterior with a deliming solution.

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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** 40131 Based on observation, interview, record review, and document review, the facility failed to ensure the transmission-based precautions (TBP) and enhanced barrier precautions (EBP) were followed upon entering the rooms, and a garbage bin was available for 2 of 16 sampled residents (Residents 33 and 69). The deficient practice could potentially lead to the spread of infectious diseases, an increased risk of cross-contamination, and compromised health and safety for both residents and staff. Findings include: Resident 33 (R33) R33 was admitted on [DATE], with diagnoses including pressure ulcer of sacral region, malignant neoplasm, breakdown of nephrostomy catheter, and osteomyelitis. A Physician order dated 09/10/2024, documented R33 was on contact isolation precaution. A care Plan dated 09/10/2024, documented R33 had signs and symptoms of gastroenteritis manifested by frequent diarrhea or loose stools, vomiting, and other symptoms. On 09/10/2024 at 11:25 AM, R33's room had signage for contact precautions, PPEs were readily available by R33's entrance door. R33 indicated had diarrhea and was not feeling good. Upon exiting R33's room, a Licensed Practical Nurse (LPN) removed the used PPE, but there was no garbage bin available inside the room or by the door. The LPN indicated there should have been a designated garbage bin available for the TBP room. On 09/10/2024 at 11:34 AM, the Activities Assistant looked at the contact precaution signage at room [ROOM NUMBER], and entered the room with no PPE. The signage advised staff and visitors to perform hand hygiene, don gloves upon entering the room, don a gown, and observe hand hygiene before leaving the resident-care environment. The Activities Assistant entered, delivered R33's mail and exited R33's room without performing hand hygiene. The Activities Assistant confirmed the PPE had not been worn and hand hygiene had not been performed upon entering and exiting a TBP room. The Activities Assistant explained the precautions should have been followed to prevent cross contamination. On 09/1220/24 at 3:10 PM, the IP indicated R33 was placed on contact precaution for norovirus (a highly contagious virus causing vomiting, diarrhea, and stomach pain, often spread through contaminated food, water, or surfaces). The IP indicated hand hygiene was required prior to entering, and upon exiting the room, to don PPE, and gloves were required. The IP indicated a training regarding infection control was provided to the staff recently. The IP explained a garbage bin with a biohazard lining or red bag should have been available inside the room. The IP indicated the number of affected residents for norovirus had been increasing daily, and following the precaution was important to prevent cross-contamination. The Activities Assistant was expected to perform hand hygiene prior to entering and exiting the room, and PPE should have been worn upon entering the TBP room, especially when delivering mail from room to room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295021	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Health & Rehabilitation Center of LV, LP	2945 Casa Vegas Street Las Vegas, NV 89169

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 69 (R69) R69 was admitted on [DATE], with diagnoses including syphilitic oculopathy and neurosyphilis. A Physician Order dated 09/09/2024, documented R69 was placed on EBP due to a peripherally inserted central catheter (PICC) line. A Care Plan dated 09/09/2024, documented R69 was on EBP related to the PICC line. The interventions included the staff performing hand hygiene and wearing personal protective equipment (PPE) during contact activities. On 09/10/2024 at 10:29 AM, R69's room had Enhanced Barrier Precautions (EBP) signage posted by the door for bed A and the bed B was scribbled out but still visible. A Certified Nursing Assistant (CNA) changed the linens for R69 (bed B) while the resident was in the shower room. The CNA did not wear a gown while removing the soiled linens and replacing with new ones. The CNA confirmed a gown had not been donned because R69 was not on precautions, assuming only the resident in bed A was. The CNA later realized R69 had intravenous or a PICC line and was receiving IV medication, and a gown should have been worn for self-protection. The CNA acknowledged there was a significant risk of contamination if precautions were not properly followed. On 09/12/24 3:10 PM, the Infection Preventionist (IP) indicated was required to don a gown when changing the resident's soiled linens to prevent cross-contamination. The IP indicated an EBP precaution was in place for the resident with tubes such as catheters, tube feedings, IVs, and wounds. A facility policy titled Resident Isolation - Categories of Transmission-Based Precautions (undated) indicated that TBP precautions were to be used when caring for residents with communicable diseases or transmissible infections. Hand hygiene and the required PPE should have been performed and worn prior to entry and discarded upon exiting the TBP room.