

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  295023	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/09/2024
NAME OF PROVIDER OR SUPPLIER  Carson Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2898 Highway 50 East Carson City, NV 89701	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557</b></p> <p>Based on interview, clinical record review, and document review the facility failed to ensure physician ordered medications were administered to a resident during the morning (AM) medication pass on 08/02/2024, and administered timely during the AM medication pass on 08/01/2024, for 1 of 5 sampled residents (Resident #5).</p> <p>Findings include:</p> <p>Resident #5</p> <p>Resident #5 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, chronic respiratory failure with hypoxia, and hypertensive heart disease with heart failure.</p> <p>On 08/08/2024 at 2:15 PM, Resident #5 verbalized the resident often received the resident's morning medications late.</p> <p>On 08/08/2024 at 2:49 PM, a Licensed Practical Nurse (LPN) verbalized the LPN often felt the LPN did not have adequate time to complete the LPN's assigned tasks each shift due to being shorthanded. The LPN explained the LPN often struggled to get residents' medications administered on time and confirmed medications were sometimes administered late.</p> <p>A Medication Administration (Admin) Audit Report lacked documented evidence Resident #5 received the resident's physician ordered medications during the AM medication pass on 08/02/2024.</p> <p>The Medication Admin Audit Report documented the following medications were physician ordered and scheduled to be administered at 7:00 AM:</p> <ul style="list-style-type: none"> <li>- GlycoLax Powder (Polyethylene Glycol 3350). On 08/01/2024, the medication was administered at 11:02 AM.</li> <li>- Cyanocobalamin tablet 1000 micrograms (mcg). On 08/01/2024, the medication was administered at 11:01 AM.</li> <li>- Coenzyme Q10 oral capsule 50 milligrams (mg). On 08/01/2024, the medication was administered at 11:01 AM.</li> </ul> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- Incruse Ellipta aerosol powder breath activated 62.5 mcg/inhalation (INH). On 08/01/2024, the medication was administered at 11:02 AM.</li> <li>- Ascorbic Acid tablet 500 mcg. On 08/01/2024, the medication was administered at 11:01 AM.</li> <li>- Xarelto tablet 20 mg (Rivoroxaban). On 08/01/2024, the medication was administered at 11:01 AM.</li> <li>- Senokot S oral tablet 8.6-50 mg (Sennosides-Docusate Sodium). On 08/01/2024, the medication was administered at 11:02 AM.</li> <li>- Folic Acid tablets one mg. On 08/01/2024, the medication was administered at 11:02 AM.</li> <li>- Ferrous Gluconate tablet 324 mg. On 08/01/2024, the medication was administered at 11:02 AM.</li> <li>- Lisinopril tablet five mg. On 08/01/2024, the medication was administered at 11:02 AM.</li> </ul> <p>The Medication Admin Audit Report documented the following medications were physician ordered and scheduled to be administered at 8:00 AM:</p> <ul style="list-style-type: none"> <li>- Metoprolol Tartrate tablet 50 mg. On 08/01/2024, the medication was administered at 11:01 AM.</li> <li>- Furosemide tablet 40 mg. On 08/01/2024, the medication was administered at 11:01 AM.</li> </ul> <p>Resident #5's Medication Administration Record (MAR) for August 2024 lacked documented evidence of the administration of the resident's physician ordered medications during the AM medication pass on 08/02/2024. The boxes on the MAR corresponding to the scheduled AM medications on 08/02/2024 were blank.</p> <p>On 08/09/2024 at 11:12 AM, the Director of Nursing (DON) explained a blank space on a resident's MAR indicated the medication was not administered to the resident. The DON verbalized if a medication was not administered, the DON's expectation of nursing staff was to put a progress note in the resident's medical record to explain why the medication was not administered.</p> <p>The DON explained medications were to be administered at the physician ordered time or within the facility's flex time. The DON explained the facility had a policy that allowed for a range of time in which medications could be administered. The DON reviewed Resident #5's MAR and clinical record and confirmed the physician ordered medications scheduled to be administered during the AM medication pass on 08/02/2024 were not administered to the resident. The DON verbalized the medications for the AM med pass were red, indicating the task was not completed. The DON verbalized Resident #5's clinical record lacked documentation related to the omission of the resident's physician ordered medications on 08/02/2024, and confirmed Resident #5 was present in the facility during the medication pass.</p> <p>The DON confirmed the medications ordered to be administered during the AM medication pass on 08/01/2024 were administered late.</p> <p>The facility policy titled General Dose Preparation and Medication Administration, revised 01/01/2013, documented prior to administration, facility staff should ensure the medication was the correct medication, at the correct dose, at the correct time, for the correct resident.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy titled Flex Time Medication Program, dated 2015, documented medications were to be administered as prescribed by the attending physician. Medications would be administered utilizing the Flex Time Schedule unless otherwise specified by the physician or excluded from the program. Examples of flex time schedule included a standard administration time of 6:30 AM-10:30 AM for medications ordered daily or in the morning and a standard administration time of 6:30 AM-10:30 AM and 4:30 PM-7:00 PM for medications ordered twice daily.</p>