STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295023	A. Building B. Wing	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carson Nursing and Rehabilitation Center	2898 Highway 50 East Carson City, NV 89701

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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 - Many	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on observation, interview, clinical record review, and document review the facility failed to obtain informed consent for a psychoactive medication prior to the administration of the medication for 1 of 14 sampled residents (Resident #12) and obtain informed consent prior to placing resident beds against the wall for 37 of 49 residents in the facility (Resident #3, #12, #13, #20, #27, #40, #45, #354, #355, #19, #39, #47, #303, #305, #306, #307, #308, #37, #25, #42, #18, #7, #34, #28, #21, #38, #22, #1, #31, #32, #26, #2, #29, #153, #36, #403, and #404). Psychoactive medications Resident #12 Resident #12 was admitted to the facility on [DATE], and readmitted on [DATE] and 08/11/23, with diagnoses including unspecified dementia, moderate, with mood disturbance, adjustment disorder with mixed anxiety and depressed mood, and major depressive disorder, single episode, unspecified. A physician's order dated 01/09/24, documented buspirone hydrochloride (HCl) 5 milligrams (mg), give two tablets by mouth two times a day for anxiety. A physician's order dated 02/13/24, documented mirtazapine tablet 7.5 mg, give one tablet by mouth at bedtime for depression. An informed consent dated 07/17/23 documented consent for buspirone, with a dose of 5 mg and a frequency of two times a day was obtained. Resident #12's clinical record lacked documented evidence of informed consent prior to administration of mirtazapine. On 02/15/24 at 9:35 AM, the Director of Nursing (DON) confirmed mirtazapine and buspirone HCl required an informed consent prior to administration. The DON confirmed Resident #12's current order for buspirone HCl was 5mg, give two tablets by mouth two times a day, totaling 10 mg per administration. The DON verbalized an informed consent for buspirone 5mg two times a day was the most recent informed consent completed by resident #12 and did not match the current order. The DON confirmed an informed consent for mirtazapine and the current dose of buspirone HCl was not obtained prior to administration of the medications. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy titled Psychotropic Medication Management, dated 12/2017, documented informed consent for psychoactive medications must be verified prior to use. Beds against the wall Resident #3 Resident # was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including fibromyalgia and other intervertebral disc degeneration, lumbar region. Resident #12 Resident #12 was admitted to the facility on [DATE], and readmitted on [DATE] and 08/11/23, with diagnoses including chronic obstructive pulmonary disease, unspecified and unspecified dementia, moderate, with mood disturbance. Resident #13 Resident #13 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease, unspecified and type two diabetes mellitus with diabetic polyneuropathy. Resident #20 Resident #20 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including alcoholic cirrhosis of the liver without ascites and muscle weakness, generalized. Resident #27 Resident #27 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side and muscle weakness, generalized. Resident #40 Resident #40 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including acute posthemorrhagic anemia and muscle weakness, generalized. Resident #45 Resident #45 was admitted to the facility on [DATE] with diagnoses including urinary tract infection, site not specified and muscle weakness, generalized. Resident #354 (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #354 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including displaced comminuted fracture of shaft of left fibula, subsequent encounter for closed fracture with routine healing, traumatic ischemia of muscle, subsequent encounter, and muscle weakness, generalized. Resident #355 Resident #355 was admitted to the facility on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and muscle weakness, generalized. Resident #3, #12, #13, #20, #27, #40, #45, and #355's clinical records lacked documented evidence the residents were notified of the risk of restraints and entrapment and did not include a signed consent prior to placing the residents' beds against a wall. 43310 Resident #19 Resident #19 was admitted to the facility on [DATE], with diagnoses including type II diabetes mellitus without complications, acute kidney failure, unspecified, and chronic obstructive pulmonary disease, unspecified. Resident #39 Resident #39 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including encounter for orthopedic aftercare following surgical amputation, type I diabetes mellitus with diabetic neuropathy, unspecified, chronic systolic (congestive) heart failure, functional quadriplegia, and personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits. Resident #47 Resident #47 was admitted to the facility on [DATE], with diagnoses including displaced intertrochanteric fracture of left femur, subsequent, other symptoms and signs involving cognitive functions and awareness, cardiomegaly, atherosclerotic heart disease of native coronary artery without angina pectoris, muscle weakness, and long term (current) use of anticoagulants. Resident #303 Resident #303 was admitted to the facility on [DATE], with diagnoses of pneumonia, unspecified organism, type II diabetes mellitus without complications, and spondylosis without myelopathy or radiculopathy, lumbar region. Resident #305 (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #305 was admitted to the facility on [DATE], with diagnoses including encephalopathy, unspecified, repeated falls, type II diabetes mellitus without complications, long term (current) use of anticoagulants, and adult failure to thrive. Resident # 306 Resident #306 was admitted to the facility on [DATE], with diagnoses including traumatic hemorrhage of cerebrum, unspecified, without loss of consciousness, subsequent encounter, and fall on same level, unspecified, subsequent encounter. Resident #307 Resident #307 was admitted to the facility on [DATE], with diagnoses including urinary tract infection, site not specified, type II diabetes mellitus without complications, adult failure to thrive, muscle weakness, generalized anxiety disorder, acquired absence of other left toe(s), and acquired absence of other right toe(s). Resident #308 Resident #308 was admitted to the facility on [DATE], with diagnoses including displaced fracture of medial malleolus of left tibia, subsequent encounter for closed fracture with routine healing, fall on same level, unspecified, subsequent encounter, morbid (severe) obesity with alveolar hypoventilation, lymphedema, not elsewhere classified, and chronic kidney disease, stage 3B. Resident #19, #39, #47, #303, #305, #306, #307, and #308's clinical records lacked documented evidence the residents were notified of the risk of restraints and entrapment and did not include a signed consent prior to placing the residents' beds against a wall. 30748 Resident #37 Resident #37 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including traumatic hemorrhage of cerebrum, unspecified, without loss of consciousness, subsequent encounter, enterococcus as the cause of diseases classified elsewhere, and muscle weakness (generalized). Resident #25 Resident #25 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including palmar fascial fibromatosis (Dupuytren), peripheral vascular disease, unspecified, mild cognitive impairment of uncertain or unknown etiology, and acquired absence of right leg above knee. Resident #42 Resident #42 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, cognitive social or emotional deficit following cerebral infarction, and muscle weakness (generalized). (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #18 Resident #18 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unspecified dementia, unspecified severity, with other behavioral disturbance, unspecified psychosis not due to a substance or known physiological condition, chronic obstructive pulmonary disease, unspecified. Resident #7 Resident #7 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including end stage renal disease, acquired absence of left leg below knee, heart failure, and muscle weakness (generalized). Resident #34 Resident #34 was admitted to the facility on [DATE], with diagnoses including hereditary motor and sensory neuropathy, hyperlipidemia, unspecified, and muscle weakness (generalized). Resident #28 Resident #28 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including spinal stenosis, lumbar region with neurogenic claudication, spinal stenosis, cervical region, spondylosis without myelopathy or radiculopathy, lumbosacral region, and Alzheimer's disease, unspecified. Resident #37, #25, #42, #18, #7, #34, #28's clinical records lacked documented evidence the residents were notified of the risk of restraints and entrapment and did not include a signed consent prior to placing the residents' beds against a wall. 31739 Resident #21 Resident #21 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, unspecified, bi-polar disorder, unspecified, major depressive disorder, recurrent, unspecified, chronic kidney disease, stage three unspecified, and type II diabetes mellitus with diabetic neuropathy, unspecified. Resident #38 Resident #38 was admitted to the facility on [DATE] with diagnoses including chronic systolic congestive heart failure, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, acute kidney failure, unspecified, muscle weakness, generalized, and dysphagia, oropharyngeal phase. Resident #22 (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #22 was admitted to the facility on [DATE], with diagnoses including unilateral primary osteoarthritis, right knee, other cerebral palsy, major depressive disorder, recurrent, unspecified, generalized anxiety disorder, muscle weakness, generalized. Resident #1 Resident #1 was admitted to the facility on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, chronic obstructive pulmonary disease, unspecified, acquired absence of left leg above knee, muscle weakness, generalized, and long term, current, use of anticoagulants. Resident #31 Resident #31 was admitted to the facility on [DATE], with diagnoses including chronic obstructive pulmonary disease, unspecified, type II diabetes mellitus with diabetic neuropathy, unspecified, chronic diastolic, congestive, heart failure, cognitive communication deficit, acquired absence of right leg below knee, acquired absence of left leg below knee, muscle weakness, generalized, depression, unspecified, and anxiety disorder, unspecified. Resident #32 Resident #32 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, without behavioral, psychotic or mood disturbance and anxiety, hemorrhage affecting left non-dominant side, essential primary hypertension, and muscle weakness, generalized. Resident #26 Resident #26 was admitted to the facility on [DATE], with diagnoses including extradural and subdural abscess, unspecified, depression, unspecified, altered mental status, unspecified, essential primary hypertension, and muscle weakness, generalized. Resident #2 Resident #2 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, without behavioral, psychotic or mood disturbance and anxiety, chronic diastolic congestive heart failure, unspecified atrial fibrillation, type II diabetes mellitus with hyperglycemia, hyperlipidemia, unspecified, pressure ulcer of right buttock, unstageable, and muscle weakness, generalized. Resident #29 Resident #29 was admitted to the facility on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, type II diabetes mellitus with diabetic chronic kidney disease, unspecified, chronic kidney disease, stage II, mild, bi-polar disorder, unspecified, generalized anxiety disorder, cognitive communication deficit, dysphagia, oropharyngeal phase, and muscle weakness, generalized. Resident #153 (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #153 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, without behavioral, psychotic or mood disturbance, generalized anxiety disorder, and major depressive disorder. Resident #36 Resident #36 was admitted to the facility on [DATE], with diagnoses including torsades de pointes, type II diabetes mellitus with hyperglycemia, heart failure, unspecified, unspecified atrial fibrillation, hyperlipidemia, unspecified, and hypothyroidism, unspecified. Resident #21, #38, #22, #1, #31, #32, #26, #2, #29, #153, and #36's clinical records lacked documented evidence the residents were notified of the risk of restraints and entrapment and did not include a signed consent prior to placing the residents' beds against a wall. 50210 Resident #403 Resident #403 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of encounter for orthopedic aftercare following surgical amputation. Resident #404 Resident #404 was admitted to the facility on [DATE], with diagnosis including hypertensive chronic kidney disease with Stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease, end stage renal disease, and dependence on renal dialysis. Resident #403 and #404's clinical records lacked documented evidence the residents were notified of the risk of restraints and entrapment and did not include a signed consent prior to placing the residents' beds against a wall. On 02/14/24 at 3:29 PM, the DON explained a restraint was anything impeding a resident's movement or normal access to the body. The DON explained an example of when a bed against a wall would be considered a restraint was if the resident had a stroke and had deficits/weakness on the open side of the bed. The DON confirmed an assessment for risk of entrapment, a physician's order, care plan and informed consent was required for the use of physical restraints. The DON confirmed, with a bed against a wall, the wall was adjacent to the resident's body while the resident was in bed, could not be easily moved by the resident and restricted the resident's freedom of movement. The DON verbalized the facility lacked a policy or process for determining if the bed against the wall restricted movement and acted as a restraint. The facility policy titled Proper Use of Bed Rails, dated 10/2022, defined a physical restraint as any manual method, physical or mechanical device, equipment, or material which met all of the following criteria: Was attached to or adjacent to the resident's body, could not be removed easily by the resident, and restricted the resident's freedom of movement or normal access to the resident's body. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy titled Resident Rights dated 10/22, documented the resident has the right to be informed by the physician or other practitioner of the risks and benefits of proposed care, of treatment and treatment alternatives. The facility policy titled Restraint Policy, revised 10/2017, documented residents would be free from physical restraints not required to treat the resident's medical symptoms. If the use of restraints was indicated, the facility would document ongoing re-evaluation of the need for restraints. The purpose of the policy was to avoid the unnecessary restriction to freedom of movement while facilitating the proper use of a device according to the resident's assessed needs and conditions. Procedure included obtaining informed consent. Documentation guidelines included informed consent. Cross reference with F656 and F689

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310 Based on observation, interview, and document review the facility failed to ensure a call light was within reach for 1 of 14 sampled residents (Resident #308). Findings include: Resident #308 Resident #308 was admitted to the facility on [DATE], with diagnoses including displaced fracture of medial malleolus of left tibia, subsequent encounter for closed fracture with routine healing, fall on same level, unspecified, subsequent encounter, morbid (severe) obesity with alveolar hypoventilation, lymphedema, not elsewhere classified, and chronic kidney disease, stage 3B. On 02/12/24 at 10:35AM, Resident #308 verbalized the resident was cold and needed to have padding placed under the residents left lower extremity to help ease discomfort. Resident #308 was sitting in a wheelchair in the resident's room. The resident's nightstand was approximately four feet behind the resident and the resident's call light button was draped across the nightstand with the call button resting behind the nightstand. Resident #308 was wheelchair bound and was not able to get up to reach the call light or reposition or propel the wheelchair in order to reach the call light. On 02/12/24 at 10:38 AM, the Executive Director confirmed Resident #308's call light was dangling behind the resident's nightstand and confirmed it was not possible for Resident #308 to reach the resident's call light. The Executive Director confirmed the expectation was a resident's call light would always be kept within reach of the resident.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on observation, interview, clinical record review, and document review the facility failed to honor a resident's request for a room change for 1 of 14 sampled residents (Resident #35). Findings include: Resident #35 Resident #35 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. On 02/12/24 at 9:38 AM, Resident #35 verbalized the resident would like a different room with more privacy. Resident #35 verbalized the room was cramped with too many people. The room had three residents residing in it. On 12/14/24 at 7:28 AM, Resident #35 reported the resident had last asked facility staff for a room change approximately one month prior. The resident verbalized feeling crowded and as if the roommates' personal items were encroaching on the resident's space. The resident explained the resident did not like staring at a roommate's underwear all day long. Incontience briefs belonging to Resident #35's roommate were observed on top of the dresser directly across from Resident #35's bed, in direct line of site. On 02/24/24 at 8:49 AM, during an interview with the Admissions Manager (AM) and the Assistant Social Worker (ASW) the AM verbalized the process if a resident requested a different room was to notify the AM or the ASW. The AM or the ASW would let the resident know what rooms were available. The ASW explained requests for room changes were kept on a list in the social services office and occasionally documented in progress notes. The ASW confirmed Resident #35 was not on the list of room change requests. On 02/20/24 at 8:57 AM, a Licensed Practical Nurse (LPN) explained if a resident requested a room change, staff would attempt to determine reason for request. The LPN verbalized the LPN would notify the Director of Nursing (DON) and contact admissions or social services for a room change form. The LPN denied receiving any room change requests from residents. On 02/20/24 at 9:06 AM, the DON explained the process if a resident requested a room change was to attempt to determine the reason for the request, make arrangements for more compatible room, talk to social services, and complete a room change form. The DON recalled a staff member received a room change request from Resident #35 the previous week. The DON explained the DON was aware of the room change request and should have communicated with social services to arrange the room change. The DON verbalized a bed opened up over the weekend and Resident #35 should have been moved. The DON confirmed Resident #35 had not been moved. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Change of Room or Roommate, reviewed 05/2023, documented it was the policy of the facility to conduct changes to room assignments when considered necessary and/or when requested by the resident. Requests for changes in room should have been communicated to the social service designee. The facility document titled Resident Rights, undated, documented a resident had the right to reside and receive services in the facility with reasonable accommodation of the resident's needs and preferences. A resident had the right to make choices about aspects of the resident's life in the facility that were significant to the resident. The resident had the right to personal privacy which included accommodations. The resident had a right to a safe, clean, comfortable and homelike environment.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310 Based on clinical record review, interview, and document review the facility failed to ensure written acknowledgement of the Advance Directive notice was provided to the resident or the resident's representative for 3 of 14 sampled residents (Resident #306, #12, and #305). Findings include: Resident # 306 Resident #306 was admitted to the facility on [DATE], with diagnoses including traumatic hemorrhage of cerebrum, unspecified, without loss of consciousness, subsequent encounter, and fall on same level, unspecified, subsequent encounter. on 02/12/24 at 3:22 PM, the Executive Director confirmed Resident #306's clinical record did not include a signed Advanced Directive Acknowledgement. Resident #12 Resident #12 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease, unspecified, chronic respiratory failure, unspecified whether with hypoxia or hypercapnia, age related physical debility, and adult failure to thrive. On 02/12/24 at 3:23 PM, the Executive Director confirmed Resident #12's clinical record did not include a signed Advanced Directive Acknowledgement. Resident #305 Resident #305 was admitted to the facility on [DATE], with diagnoses including encephalopathy, unspecified, repeated falls, type II diabetes mellitus without complications, long term (current) use of anticoagulants, and adult failure to thrive. On 02/12/24 at 3:30 PM, the Executive Director confirmed Resident #305's clinical record did not include a signed Advanced Directive Acknowledgement. The Executive Director verbalized the expectation was an Advanced Directive Acknowledgement form would be signed within 48 hours of admission to the facility. The facility policy titled Promoting the Right of Self-Determination for Healthcare Decisions and Advanced Healthcare Directives, dated 11/2016, documented an advance directive was a document in which a person stated choices for medical treatment and /or designated who would make health care decisions for the resident. Each resident and/or legal healthcare decision make was provided a mechanism for reaching decisions concerning referred intensity of care. Residents were informed upon admission, and periodically, of the resident's rights concerning self-determination of preferred intensity of care and the process for creating and implementing advanced health care directives.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on interview and clinical record review, and document review the facility failed to ensure a resident received a Notice of Medicare Non-Coverage (NOMNC) prior to dicharge for 1 of 3 unsampled residents (Resident #55). Findings include: Resident #55 Resident #55 was admitted to the facility on [DATE], with a diagnosis of acute respiratory failure with hypoxia. The clinical record for Resident #55 lacked documented evidence the resident or the resident's representative were provided a NOMNC prior to discharge from the facility. On 02/20/24 at approximately 11:15 AM, the Director of Nursing explained the social services department was responsible for and handled all beneficiary notices. On 02/20/24 at 11:48 AM, the Assistant Social Worker (ASW) verbalized a NOMNC was used to notify a resident when the resident no longer met criteria for skilled services and explain the resident's right to appeal the decision for discharge. The ASW explained the NOMNC was required to be provided no later than two days prior to the last day of covered services. The ASW confirmed Resident #55 should have received a NOMNC and there was no documented evidence a NOMNC was provided to Resident #55.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310 Based on observation, interview, clinical record review, and document review, the facility failed to ensure the privacy of residents' protected health information (PHI) was maintained for 1 of 14 sampled residents (Resident #27), and for 5 of 49 residents residing in the facility whose names were visible on an unstaffed and open computer screen (Resident #19, #26, #40, #355, and #103). Findings include: Resident #27 Resident #27 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, aphasia following cerebral infarction, and mental disorder, not otherwise specified. On 02/15/24 at 11:39 AM, a medication cart located in the facility's lobby had an open computer terminal screen displaying Resident #27's PHI including the resident's photograph, room number, age, date of birth, vital signs, and a list of the resident's medication. There were three residents in the lobby, a nurse could not be located at or near the cart. On 02/15/24 at 11:44 AM, a Licensed Practical Nurse (LPN) confirmed the computer terminal was left unattended and was open and displaying Resident #27's PHI. The LPN confirmed the LPN should have logged off from the computer prior to walking away. On 02/15/24 at 11:59 AM, the Administrator confirmed staff were expected to lock computer terminals prior to walking away and leaving the terminals unattended. 30748 Resident #19 Resident #19 was admitted to the facility on [DATE], with diagnoses including hypokalemia, acute kidney failure, unspecified, and type two diabetes mellitus without complications. Resident #26 Resident #26 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including extradural and subdural abscess, unspecified, polyneuropathy, unspecified and unspecified severe protein-calorie malnutrition. Resident #40 Resident #40 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including acute posthemorrhagic anemia, gastrointestinal hemorrhage, unspecified and moderate protein-calorie malnutrition. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #355 Resident #355 was admitted to the facility on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, other speech and language deficits following cerebral infarction, and dysphagia following cerebral infarction. Resident #103 Resident #103 was admitted to the facility on [DATE], with diagnoses including metabolic encephalopathy, alcohol abuse, uncomplicated, and moderate protein-calorie malnutrition. On 02/20/24 at 1:47 PM, a medication cart, located at the main entrance to the facility, was left unattended. The computer on the top of the cart was left open exposing Resident #19, #26, #40, #355 and #103's PHI. The Licensed Practical Nurse (LPN) approached the medication cart after approximately one minute. The LPN explained there was a locking mechanism on the computer, allowing the information to be hidden and the computer screen was supposed to be always locked when staff were not present at the cart. The LPN confirmed the resident information was exposed on the computer screen, leaving a potential for others to steal PHI not belonging to them. On 02/20/24 at 1:48 PM, the Director of Nursing (DON) verbalized the expectation for nurses manning medication carts was to lock the computers when not at the cart. Leaving resident information exposed was a Health Insurance Portability and Accountability Act (HIPAA) violation because resident information could be stolen. The facility policy titled HIPAA Introduction to Covenant Care's HIPAA Program, dated 09/01/13, documented per requirements of the law, the facility was responsible for protecting resident health information and would take accountability for any violation of an individual's privacy. The facility would establish appropriate safeguards to protect the privacy and confidentiality of health information. The facility policy titled Confidentiality of Personal and Medical Records, dated 10/2022, documented the facility honored the resident's right to secure and have records confidential, regardless of the form of storage or location of the records.

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Many	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. 49557 Based on observation, interview and document review, the facility failed to provide a homelike environment when the facility utilized an overhead paging system to communicate with staff. The overhead paging system had the potential to affect the entire facility census. Findings include: On 02/12/24 at 4:55 PM, in the A hallway, an overhead page was heard indicating a call on line one. On 02/13/24 at 8:40 AM, 11:31 AM, 1:28 PM, 3:15 PM, 3:22 PM, 3:23 PM, 3:24 PM, and 3:53 PM at various locations throughout the facility, overhead pages were heard indicating calls on line one. On 02/14/24 from 2:30 to 2:31 PM, in the hallway near the nurses' station in B hall, three overhead pages were heard indicating calls on lines one and two. On 02/14/24 at 3:04 PM, 3:10 PM, 4:06 PM, 4:14 PM, and 4:56 PM at various locations throughout the facility, overhead pages were heard. On 02/15/24 at 9:11 AM, in the A hallway, an overhead page was heard. On 02/20/24 at 8:23 AM, 10:42 AM, 2:04 PM, and 4:32 PM in A and Mid hallways and in the social services office, overhead pages were heard. On 02/20/24 at 4:25 PM, the Assistant Social Worker explained a homelike environment was created by residents having personal items such as blankets, stuffed animals, and pictures and being able to decorate the room to remind the resident of home. The Assistant Social Worker verbalized seeing med carts, the noise from call lights, limited privacy, and excessive noise detracted from a homelike environment. The Assistant Social Worker verbalized overhead paging could contribute to the facility not feeling homelike. The facility policy titled Safe, Clean, Comfortable, and Homelike Environment, dated 06/2023, documented the facility would maintain comfortable sound levels in the facility. Overhead paging would be limited to emergency situations and as needed for providing prompt care and treatment of residents. The facility document titled Resident Rights, undated, documented residents had the right to a safe, clean, comfortable, and homelike environment.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310 Based on record review, interview and policy review, the facility failed to ensure 1 of 14 sampled residents (Resident #30) and the Resident's Representative, received written notification of transfer or discharge. Findings include: Resident #30 Resident #30 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, cognitive social or emotional deficit following cerebral infarction, and type II diabetes mellitus with diabetic chronic kidney disease. On 02/12/24 at 1:13 PM, Resident #30 verbalized the resident was transferred to the hospital on 01/14/24 due to an infection. The resident was not sure what type of infection the resident was hospitalized for . Resident #30's Minimum Data Set 3.0 (MDS) assessment documented the resident was discharged from the facility on 01/14/24 and readmitted on [DATE]. A change of condition/transfer note date 01/14/24, documented Resident #30 was transferred to an acute care hospital in an ambulance due to abnormal vital signs (high/low blood pressure, high respiratory rate). Resident #30's clinical record lacked documented evidence the facility document titled [NAME] Notice of Transfer or Discharge - V3, undated, was completed when the resident was transferred and subsequently admitted to an acute care hospital. The form required the following items to be completed: -The name, phone number, and contact type (such as next of kin) for the person notified. -The effective transfer/discharge date . -The name, address, and phone number of the facility the resident was transferred or discharged to. -The reason the transfer or discharge was necessary and acknowledgement the resident's contact, such as next of kin, was notified of the reason. -Instructions for an appeal. -Name and contact information for the Ombudsman, State Medicaid supervisor of hearing and policy development, and the state Disability Advocacy and Law Center. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Bed hold information/instructions including who was notified, the decision to authorize or decline a bed hold for the resident, when telephone calls/written copies were provided and the method used to provide the information, such as sent with the transfer paperwork to the acute care hospital, hand delivered upon transfer, or sent via mail. -The signature and date signed by the person completing the form. On 02/15/24 at 10:13 AM, the Director of Nursing (DON) confirmed the facility used the [NAME] Notice of Transfer or Discharge V3 form to notify residents and/or their representatives of the circumstances and details regarding transfers and confirmed the form was not completed when Resident #30 was transferred and admitted to an acute care hospital on 01/14/24. The facility policy titled Transfer and Discharge (Including AMA), dated 09/10/19, documented transfer referred to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expected to return to the original facility. The facility's transfer/discharge notice was provided to the resident and the resident's representative, and the Long-Term Care Ombudsman as soon as practicable when an immediate transfer or discharge was required by the resident's urgent medical needs. The facility would maintain evidence the notice was sent to the Ombudsman.

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50210 Based on observation, interview, clinical record review, and document review, the facility failed to ensure a physician's order for wound care, wound vacuum, and dialysis was transcribed onto the admission orders for 3 of 14 sampled residents (Resident #2, #403 and #404). Findings include: Resident #403 Resident #403 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including encounter for orthopedic aftercare following surgical amputation, encounter for change or removal of surgical wound dressing, acquired absence of left leg below knee. On 02/12/24 at 11:46 AM, Resident #403 verbalized having the resident's leg amputated on 02/07/24 and having a wound vacuum for the surgical site. The resident explained the wound vacuum was blinking orange and thought the wound vacuum's batteries needed to be changed. On 02/12/24 at 3:38 PM, Resident #403 verbalized thinking the wound nurse (WCN) was unsure about what to do with the wound vacuum and believed the wound vacuum was no longer working. On 02/13/24 at 1:16 PM, Resident #403 verbalized the wound vacuum was removed on 02/12/24 at night when the surgical dressing was saturated, and the dressing was changed. On 02/13/24 at 3:26 PM, a Licensed Practical Nurse (LPN) verbalized the WCN was responsible for administering wound care and wound vacuum care. The LPN explained on 02/12/24 the LPN noticed the light on the wound vacuum was blinking orange. The LPN searched the Internet for information about it. The LPN consulted the WCN about the wound vacuum. The LPN recounted being informed the wound vacuum was single use and would be disposed of. The LPN confirmed there was no wound care physician's order in the resident's clinical record, nor was wound care listed in the medication administration record (MAR). The LPN confirmed there should be a physician's order for wound care. On 02/13/24 at 3:49 PM, the Director of Nursing (DON) verbalized the resident had a wound vacuum on 02/11/24 but was unaware the wound vacuum was removed because there was no physician's order for the wound vacuum. On 02/13/24 at 5:45, the Executive Director verbalized the DON should have obtained a physician's order for wound care after being made aware Resident #403 had no wound care order. A physician's order dated 02/13/24 at 6:27 PM, documented surgical incision site cleanse with wound cleanser, pat dry, apply abdominal gauze (ABD) pad, wrap with kerlix, then ace wrap every day shift every other day and as needed for dislodgement or soiling. On 02/15/24 at 9:26 AM, the DON explained insufficient wound care could lead to infection and incomplete healing of the wound. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/20/24 at 2:41 PM, the WCN verbalized the WCN admitted Resident #403 on 02/10/24 and noticed the resident had a wound vacuum. The WCN explained on admission of the resident, it was late, and the resident wanted to be done with the assessment by 10:30 PM to go to bed. The WCN explained when the WCN completed an assessment, the WCN would put in a physician's order and document the assessment. The WCN explained the WCN had two days to complete an admission assessment and confirmed the WCN would be responsible for documenting the monitoring and cleaning of a wound. The WCN confirmed there should have been a physician's order for the wound vacuum and a physician's order to monitor the wound vacuum. The WCN confirmed when the WCN saw the wound vacuum without a physician's order, the WCN should have immediately contacted the hospital for more information. Resident #404 Resident #404 was admitted to the facility on [DATE], with diagnoses including end stage renal disease, unspecified chronic kidney disease, and dependence on renal dialysis. On 02/12/24 at 02:34 PM, Resident #404 reported being out of the facility for dialysis treatment the morning of 02/12/24 and having a dialysis schedule for 7:00 AM to 12:00 PM on Mondays, Wednesdays, and Fridays. A physician's order dated 02/13/24 documented the following: -access line dressing changes and flushes to be done by dialysis site only. -dialysis treatments three times a week at 7:00 AM with dialysis site. -dialysis pre and post weights to be done by dialysis site. -dialysis access line for no lab draws, venipuncture or intravenous (IV) line use. -staff to inspect dialysis site right chest or internal jugular (IJ) tunneled catheter for infection daily every shift for localized pain, erythema, warmth, edema, or abnormal drainage. On 02/13/24 at 3:24 PM, a Licensed Practical Nurse (LPN) confirmed the physician's orders for dialysis were not documented until 02/13/24 and verbalized Resident #404's admitting nurse was responsible for documentation. The LPN explained on 02/12/24 Resident #404's representative informed the facility the resident needed to be released for dialysis. The LPN verbalized without documented physician's orders the facility would not have known the resident had an appointment for dialysis or to release the resident. The LPN also confirmed no follow up monitoring was documented. The facility policy titled, Wound Treatment Management, dated 10/19/19, documented wound treatments would be provided in accordance with physician orders, and in the absence of treatment orders, the licensed nurse would notify the physician to obtain orders. The facility policy titled Hemodialysis, dated 08/11/20, documented the facility will ensure the physician's orders for dialysis include the type of access and the location for dialysis, the dialysis schedule, the nephrologist's name and phone number, the dialysis facility name and phone number, transportation arrangements, medication administration or withholding of specific medication prior to dialysis treatment, and any fluid restriction if ordered by the physician. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	31739 Resident #2 Resident #2 was admitted to the facility on [DATE], with a diagnosis of pressure ulcer of right buttock, unstageable. Resident #2's Care Plan dated 09/15/23, documented the resident had a wound to the right buttock. A Skin and Wound Evaluation dated 10/04/23, documented the resident had an unstageable pressure injury to the right gluteus upon admission and the wound had no evidence of infection. The wound dressing was saturated, and the wound progression was deteriorating. An Advantage Wound Care Progress Note dated 10/05/23, documented an initial consult for Resident #2's right buttock. The progress note documented the wound as a pressure injury, with wound reopened, and obvious signs of wound infection due to odor and seropurulent drainage. Resident started on oral antibiotics on 10/05/23 by primary care physician. Due to presence of slough post debridement continues to classify as unstageable. Resident #2's physician's orders documented the first wound care order for the right buttock on 10/19/23: Wound site: Right buttock. Cleanse with normal sterile saline, pat dry, pack with Dakins moistened gauze, cover with foam dressing daily until resolved. Every day shift for wound care and as needed for dislodgement or soiling. Inform physician of any changes. On 02/15/24 at 2:56 PM, the Director of Nursing (DON) confirmed Resident #2 was initially assessed and wound care treatment had been performed by Advantage Wound Care on 10/05/23. The DON confirmed the first wound care order for Resident #2's right buttock pressure injury was obtained on 10/19/23, and should have been obtained upon admission to prevent the wound from deteriorating. The facility policy titled, Wound Treatment Management, dated 10/19/19, documented wound treatments would be provided in accordance with physician orders, and in the absence of treatment orders, the licensed nurse would notify the physician to obtain orders. Cross reference tag F684 and F692.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50210 Based on interview, clinical record review, and document review, the facility failed to ensure a baseline care plan was developed to address the use of a wound vacuum for 1 of 14 sampled residents (Resident #403), oxygen therapy and dialisys for 1 of 14 sampled residents (Resident #404). Findings include: Resident #403 Resident #403 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of encounter for orthopedic aftercare following surgical amputation. Wound care On 02/12/24 at 11:46 AM, Resident #403 verbalized having the resident's leg amputated on 02/07/24 and having a wound vacuum for the surgical site. The resident explained the wound vacuum was blinking orange and thought the wound vacuum's batteries needed to be changed. On 02/12/24 at 3:38 PM, Resident #403 verbalized thinking the wound nurse (WCN) was unsure about what to do with the wound vacuum and believed the wound vacuum was no longer working. On 02/13/24 at 1:16 PM, Resident #403 verbalized the wound vacuum was removed on 02/12/24 at night when the surgical dressing was saturated, and the dressing was changed. On 02/13/24 at 3:26 PM, a Licensed Practical Nurse (LPN) verbalized the WCN was responsible for administering wound care and wound vacuum care. The LPN explained on 02/12/24 the LPN noticed the light on the wound vacuum was blinking orange. The LPN searched the internet for information about it. The LPN consulted the WCN about the wound vacuum. The LPN recounted being informed the wound vacuum was single use and would be disposed of. The LPN confirmed there was no wound care physician's order in the resident's clinical record, nor was wound care listed in the medication administration record (MAR). The LPN confirmed there should be a physician's order for wound care. On 02/13/24 at 3:49 PM, Director of Nursing (DON) verbalized the DON had not met with Resident #403 but was able to confirm the WCN did an assessment. The DON explained the resident had a wound vacuum on 02/11/24 but was unaware the wound vacuum was removed. On 02/13/24 at 6:06 PM, the Executive Director verbalized the DON looked at Resident #403's surgical wound. A physician's order dated 02/13/24 at 6:27 PM, documented surgical incision site cleanse with wound cleanser, pat dry, apply abdominal gauze (ABD) pad, wrap with kerlix, then ace wrap every day shift every other day and as needed for dislodgement or soiling. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/15/24 at 9:26 AM, the DON explained insufficient wound care could lead to infection and incomplete healing of the wound. The DON verbalized if wound care was not documented in the medication administration record (MAR), it would not be documented anywhere else. The DON explained lack of wound care documentation could mean the resident did not receive wound care. On 02/20/24 at 2:41 PM, the WCN verbalized the WCN admitted Resident #403 on 02/10/24 and noticed the resident had a wound vacuum. The WCN explained on admission of the resident, it was late, and the resident wanted to be done with the assessment by 10:30 PM to go to bed. The WCN explained when the WCN did an assessment, the WCN would put in a physician's order and document the assessment. The WCN explained the WCN had two days to complete an admission assessment and confirmed the WCN would be responsible for documenting the monitoring and cleaning of a wound. The WCN verbalized being unsure about the wound vacuum, so the WCN spoke with the health information manager (HIFM) for wound care notes from the hospital. The WCN recounted changing the wound vacuum's batteries. The WCN explained when the resident used the slide board to transfer to and from the resident's bed, everything fell apart, so the WCN removed the wound vacuum and cleaned the wound, using an abdominal (ABD) pad, Kerlix wrap, and ACE bandage. The WCN confirmed the WCN did not document wound treatment for Resident #403 from 02/12/24. Resident #403's clinical record lacked baseline care plans for wound care and a wound vacuum. Resident #404 Resident #404 was admitted to the facility on [DATE], with diagnoses including end stage renal disease, unspecified chronic kidney disease, and dependence on renal dialysis. Oxygen A physician's order dated 02/09/24, documented to administer oxygen at 1 liter per minute (LPM) as needed for supplement. The clinical record for Resident #404 lacked a baseline care plan to address the resident's use of Oxygen therapy at 1 LPM. A care plan intervention was initiated on 02/12/24 to administer oxygen at 2 LPM continuous via nasal cannula (NC). On 02/12/24 at 12:39 PM, Resident #404 was observed without oxygen connected to the NC. On 02/12/24 at 3:03 PM, Resident #404 was approached by a Registered Nurse (RN1) and was asked whether the resident would prefer the oxygen flow to be set at two or three LPM. The resident requested three and the RN1 set the oxygen to three LPM. On 02/13/24 at 11:32 AM, Resident #404 was wearing NC connected to oxygen with a flow of 2 LPM. A physician's order dated 02/15/24, documented to administer oxygen at 2 LPM via NC as needed for supplement. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 02/15/24, documented to administer oxygen at 3 LPM via NC as needed for shortness of breath. The clinical record for Resident #404 lacked a baseline care plan to address the resident's use of Oxygen therapy at 3 LPM. On 02/15/24 at 3:41 PM, a Registered Nurse (RN2) verbalized the Oxygen flow of Resident #404 should be 2 LPM as needed according to the active physician's order but the admitting oxygen order for 1 LPM ordered on 02/09/24 was discontinued on 02/15/24. The RN2 confirmed oxygen needed to be on the baseline care plan and confirmed a care plan for 2 LPM continuous initiated on 02/12/24. The RN2 verbalized the care plan for oxygen was not accurate per the active order for 2 LPM via NC as needed for supplement. The RN2 also verbalized the care plan and physician's orders were not in agreement since Resident #404's admittance. Dialysis On 02/12/24 at 2:34 PM, Resident #404 reported being out of the facility for dialysis treatment the morning of 02/12/24 and having a dialysis schedule for 7:00 AM to 12:00 PM on Mondays, Wednesdays, and Fridays. A physician's order dated 02/13/24 documented the following: -access line dressing changes and flushes to be done by dialysis site only. -dialysis treatments three times a week at 7:00 AM with dialysis site. -dialysis pre and post weights to be done by dialysis site. -dialysis access line for no lab draws, venipuncture or intravenous (IV) line use. -staff to inspect dialysis site right chest or internal jugular (IJ) tunneled catheter for infection daily every shift for localized pain, erythema, warmth, edema, or abnormal drainage. On 02/20/24 at 9:53 PM, a Licensed Practical Nurse (LPN) confirmed the LPN would expect to see dialysis on the baseline care plan. The LPN verbalized the baseline care plan for Resident #404 was initiated on 02/12/24 and explained the date to be 72 hours after the admission of the resident on 02/09/24. The LPN verbalized according to policy, a baseline care plan must be initiated within 48 hours of admission and indicated Resident #404's care plan was not initiated timely. The facility policy titled Admission of a Resident, dated 07/2022, documented a baseline care plan will be developed within 48 hours of a resident's admission. The facility policy titled Baseline Care Plan, dated 10/2022, documented the facility would develop and implement a baseline care plan for each resident that includes the instruction needed to provide effectiv3 and person-centered care of the resident. The baseline care plan would be developed within 48 hours of a resident's admission and will include the minimum healthcare information necessary to properly care for a resident such as: initial goals based on admission orders and physician orders (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cross reference with tag F684 and F692.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 30748 Based on observation, interview, clinical record review and document review, the facility failed to develop care plans for 1) the placement of beds against the wall for 31 of 49 residents (Resident #37, #25, #42, #18, #7, #34, #28, #21, #38, #22, #1, #31, #32, #26, #2, #29, #153, #36, #3, #12, #13, #20, #27, #40, #45, #355, #19, #39, #47, #307, and #308), 2) the use of bed rails for 1 of 14 sampled residents (Resident #34), 3) the administration and monitoring of anticoagulant medications and diuretic medications for 1 of 14 sampled residents (Resident #39), and 4) the monitoring and care of a urinary catheter (catheter) and monitoring and treatment of lymphedema for 1 of 14 sampled residents (Resident #308). Findings include: Resident #37 Resident #37 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including traumatic hemorrhage of cerebrum, unspecified, without loss of consciousness, subsequent encounter, enterococcus as the cause of diseases classified elsewhere, and muscle weakness (generalized). Resident #25 Resident #25 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including palmar fascial fibromatosis (Dupuytren), peripheral vascular disease, unspecified, mild cognitive impairment of uncertain or unknown etiology, and acquired absence of right leg above knee. Resident #42 Resident #42 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, cognitive social or emotional deficit following cerebral infarction, and muscle weakness (generalized). Resident #18 Resident #18 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unspecified dementia, unspecified severity, with other behavioral disturbance, unspecified psychosis not due to a substance or known physiological condition, chronic obstructive pulmonary disease, unspecified. Resident #7 Resident #7 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including end stage renal disease, acquired absence of left leg below knee, heart failure, and muscle weakness (generalized). Resident #34 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #34 was admitted to the facility on [DATE], with diagnoses including hereditary motor and sensory neuropathy, hyperlipidemia, unspecified, and muscle weakness (generalized). On 02/12/24 at 10:13 AM, Resident #34's bed was up against the wall and had two quarter size bed rails, one on each side of the bed. Resident #34 lacked a care plan related to the use of bed rails. Resident #28 Resident #28 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including spinal stenosis, lumbar region with neurogenic claudication, spinal stenosis, cervical region, spondylosis without myelopathy or radiculopathy, lumbosacral region, and Alzheimer's disease, unspecified. On 02/12/24 at 7:15 AM, during a tour of the facility, Resident #37, #25, #42, #18, #7, #34, #28's beds were against the wall. Resident #37, #25, #42, #18, #7, #34, #28's clinical records lacked care plans for the beds against the wall. 31739 Resident #21 Resident #21 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, unspecified, bi-polar disorder, unspecified, major depressive disorder, recurrent, unspecified, chronic kidney disease, stage three unspecified, and type II diabetes mellitus with diabetic neuropathy, unspecified. Resident #38 Resident #38 was admitted to the facility on [DATE] with diagnoses including chronic systolic congestive heart failure, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, acute kidney failure, unspecified, muscle weakness, generalized, and dysphagia, oropharyngeal phase. Resident #22 Resident #22 was admitted to the facility on [DATE], with diagnoses including unilateral primary osteoarthritis, right knee, other cerebral palsy, major depressive disorder, recurrent, unspecified, generalized anxiety disorder, muscle weakness, generalized. Resident #1 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #1 was admitted to the facility on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, chronic obstructive pulmonary disease, unspecified, acquired absence of left leg above knee, muscle weakness, generalized, and long term, current, use of anticoagulants. Resident #31 Resident #31 was admitted to the facility on [DATE], with diagnoses including chronic obstructive pulmonary disease, unspecified, type II diabetes mellitus with diabetic neuropathy, unspecified, chronic diastolic, congestive, heart failure, cognitive communication deficit, acquired absence of right leg below knee, acquired absence of left leg below knee, muscle weakness, generalized, depression, unspecified, and anxiety disorder, unspecified. Resident #32 Resident #32 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, without behavioral, psychotic or mood disturbance and anxiety, hemorrhage affecting left non-dominant side, essential primary hypertension, and muscle weakness, generalized. Resident #26 Resident #26 was admitted to the facility on [DATE], with diagnoses including extradural and subdural abscess, unspecified, depression, unspecified, altered mental status, unspecified, essential primary hypertension, and muscle weakness, generalized. Resident #2 Resident #2 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, without behavioral, psychotic or mood disturbance and anxiety, chronic diastolic congestive heart failure, unspecified atrial fibrillation, type II diabetes mellitus with hyperglycemia, hyperlipidemia, unspecified, pressure ulcer of right buttock, unstageable, and muscle weakness, generalized. Resident #29 Resident #29 was admitted to the facility on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, type II diabetes mellitus with diabetic chronic kidney disease, unspecified, chronic kidney disease, stage II, mild, bi-polar disorder, unspecified, generalized anxiety disorder, cognitive communication deficit, dysphagia, oropharyngeal phase, and muscle weakness, generalized. Resident #153 Resident #153 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, without behavioral, psychotic or mood disturbance, generalized anxiety disorder, and major depressive disorder. Resident #36 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #36 was admitted to the facility on [DATE], with diagnoses including torsades de pointes, type II diabetes mellitus with hyperglycemia, heart failure, unspecified, unspecified atrial fibrillation, hyperlipidemia, unspecified, and hypothyroidism, unspecified. Resident #21, #38, #22, #1, #31, #32, #26, #2, #29, #153, and #36's clinical records lacked documented evidence the residents' care plans had been developed for beds against the wall. 49557 Resident #3 Resident # was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including fibromyalgia and other intervertebral disc degeneration, lumbar region. Resident #12 Resident #12 was admitted to the facility on [DATE], and readmitted on [DATE] and 08/11/23, with diagnoses including chronic obstructive pulmonary disease, unspecified and unspecified dementia, moderate, with mood disturbance. Resident #13 Resident #13 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease, unspecified and type two diabetes mellitus with diabetic polyneuropathy. Resident #20 Resident #20 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including alcoholic cirrhosis of the liver without ascites and muscle weakness, generalized. Resident #27 Resident #27 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side and muscle weakness, generalized. Resident #40 Resident #40 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including acute posthemorrhagic anemia and muscle weakness, generalized. Resident #45 Resident #45 was admitted to the facility on [DATE] with diagnoses including urinary tract infection, site not specified and muscle weakness, generalized. Resident #355 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #355 was admitted to the facility on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and muscle weakness, generalized. On 02/14/24 at 4:29 PM, Resident #3, #12, #13, #20, #27, #40, #45, and #355's beds were located up against the resident's bedroom wall. Resident #3, #12, #13, #20, #27, #40, #45, and #355's clinical records lacked documented evidence a care plan had been developed for beds against the wall. 43310 Resident #19 Resident #19 was admitted to the facility on [DATE], with diagnoses including type II diabetes mellitus without complications, acute kidney failure, unspecified, and chronic obstructive pulmonary disease, unspecified. Resident #39 Resident #39 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including encounter for orthopedic aftercare following surgical amputation, type I diabetes mellitus with diabetic neuropathy, unspecified, chronic systolic (congestive) heart failure, functional quadriplegia, and personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits. Resident #47 Resident #47 was admitted to the facility on [DATE], with diagnoses including displaced intertrochanteric fracture of left femur, subsequent, other symptoms and signs involving cognitive functions and awareness, cardiomegaly, atherosclerotic heart disease of native coronary artery without angina pectoris, muscle weakness, and long term (current) use of anticoagulants. Resident #307 Resident #307 was admitted to the facility on [DATE], with diagnoses including urinary tract infection, site not specified, type II diabetes mellitus without complications, adult failure to thrive, muscle weakness, generalized anxiety disorder, acquired absence of other left toe(s), and acquired absence of other right toe(s). Resident #308 Resident #308 was admitted to the facility on [DATE], with diagnoses including displaced fracture of medial malleolus of left tibia, subsequent encounter for closed fracture with routine healing, fall on same level, unspecified, subsequent encounter, morbid (severe) obesity with alveolar hypoventilation, lymphedema, not elsewhere classified, and chronic kidney disease, stage 3B. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/15/24 at 2:03 PM, Resident #19, #39, #47, #307, and #308's beds were located up against the residents' bedroom wall preventing the residents from exiting out of both sides of the residents' bed, creating a risk for entrapment and restraint. Resident #19, #39, #47, #307, and #308's clinical records did not include a care plan regarding the residents' risk for entrapment and potential for becoming restrained related to the residents' beds being placed against a wall. The lack of a care plan had the potential to increase the residents' risk for entrapment and restraint by failing to address the following: -monitoring the resident for concerns of entrapment and restraint. -monitoring and reporting changes in physical condition such as weight loss/gain, decreased range of motion, and decreased ability to perform activities of daily living, -monitoring and reporting changes in mentation, and -reassessing the resident for restraint and entrapment risk. On 02/14/24 at 3:29 PM, the Director of Nursing (DON) explained a restraint was anything impeding a resident's movement or normal access to the body. The DON explained an example of when a bed against a wall would be considered a restraint was if the resident had a stroke and had deficits/weakness on the open side of the bed. The DON confirmed an assessment for risk of entrapment, a physician's order, care plan and informed consent was required for the use of physical restraints. The DON confirmed, with a bed against a wall, the wall was adjacent to the resident's body while the resident was in bed, could not be easily moved by the resident and restricted the resident's freedom of movement. The DON verbalized the facility lacked a policy or process for determining if the bed against the wall restricted movement and acted as a restraint. The facility policy titled Proper Use of Bed Rails, dated 10/2022, defined a physical restraint as any manual method, physical or mechanical device, equipment, or material which met all of the following criteria: Was attached to or adjacent to the resident's body, could not be removed easily by the resident, and restricted the resident's freedom of movement or normal access to the resident's body. The facility policy titled Restraint Policy, revised 10/2017, documented if the use of restraints was indicated, the facility would document ongoing re-evaluation of the need for restraints. Procedure included developing a comprehensive care plan. The facility policy titled Care Plan, Comprehensive, dated 2008, documented care plans were individualized by identified resident problems, unique characteristics, strengths, and individual needs. The care plan was a comprehensive tool used by the Interdisciplinary Team (IDT) as a reference for resident specific problems and approaches to establish guidance on meeting the individual needs of the resident. Cross reference with F552 and F689 Anticoagulants and Diuretics Resident #39 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #39 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including encounter for orthopedic aftercare following surgical amputation, type I diabetes mellitus with diabetic neuropathy, unspecified, chronic systolic (congestive) heart failure, personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits, retention of urine, unspecified, and long term (current) use of aspirin. A physician's order dated 12/29/23, documented heparin sodium (porcine) injection solution 5000 units/milliliter (U/mL). Inject 1 ml subcutaneously every 8 hours for preventative until 02/16/24. A physician's order dated 12/29/23, documented aspirin chewable tablet, 81 milligrams (mg), give one tablet by mouth one time per day for prophylaxis. A physician's order dated 01/24/24, documented furosemide oral tablet 20 mg, give one tablet by mouth one time per day for edema/cardiac failure. Resident #39's clinical record did not include a care plan related to the use and monitoring of anticoagulant medications including heparin and aspirin and did not include a care plan related to the use and monitoring of a diuretic medication including furosemide. On 02/13/24 at 4:42 PM, the Executive Director verbalized the expectation was a care plan would be developed and implemented regarding the use and monitoring of anticoagulant medications and diuretic medications. The DON confirmed Resident #39's clinical record did not include a care plan for the use and monitoring of anticoagulant and diuretic medications. On 02/15/23 at 9:04 AM, the DON verbalized the DON had located care plans related to the use of anticoagulant medications and diuretic medications and confirmed the care plans were not entered into Resident #39's clinical record until 02/13/24. The DON confirmed the expectation was care plans related to the use of medications would be entered into a resident's clinical record within 24 hours of the order being written. Lymphedema and Catheter Resident #308 Resident #308 was admitted to the facility on [DATE], with diagnoses including displaced fracture of medial malleolus of left tibia, subsequent encounter for closed fracture with routine healing, fall on same level, unspecified, subsequent encounter, lymphedema, not elsewhere classified, urinary tract infection, site not specified, and overactive bladder. Resident #308's clinical record did not include a care plan related to monitoring or care of lymphedema, and did not include a care plan related to the care and monitoring of a catheter. On 02/1524 at 8:50 AM, the DON verbalized everything related to a residents care should be care planned, and confirmed a care plan related to the monitoring and care of Resident #308's catheter should have been developed and entered into the resident's Comprehensive Care Plan. On 02/15/24 at 8:55 AM, the DON confirmed Resident #308's clinical record did not include a care plan related to the care and monitoring of a catheter. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/15/24 at 8:57 AM, the DON confirmed Resident #308's clinical record did not include a care plan related to the care and monitoring of lymphedema and confirmed the care plan should have been entered. The DON verbalized care areas present at admit were included on a resident's baseline care plan and carried over to the resident's Comprehensive Care Plan. The DON verbalized Resident #308 had a catheter in place at the time of admission and was admitted to the facility with a diagnosis of lymphedema. The DON confirmed Resident #308's baseline care plan did not include a care plan related to lymphedema or the care and monitoring of a catheter. The facility policy titled Care Plan, Comprehensive, dated 2008, documented care plans were directed towards achieving and maintaining a resident's optimal status of health, functional ability, and quality of life. The care plan was individualized by identified resident problems, unique characteristics, strengths, and individual needs. The care plan was a comprehensive tool used by the Interdisciplinary Team (IDT) as a reference for resident specific problems and approaches in order to establish guidance to meet the individual needs of the resident. The care plan was accessible to all caregivers to ensure resident specific care information was exchanged and the consistent delivery of care services and approaches.

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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** 30748 Based on observation, interview, clinical record review, and document review, the facility failed to update a plan of care after a resident was discharged from hospice for 1 of 14 sampled residents (Resident #34). Findings include: Resident #34 Resident #34 was admitted to the facility on [DATE], with diagnoses including hereditary motor and sensory neuropathy, hyperlipidemia, unspecified, and muscle weakness (generalized). A physician's order dated 05/04/23, documented admit to facility on hospice services for aortic valve disorder. The order was discontinued on 07/20/23. Resident #34's care plans documented the following: -Self-Care Deficit as evidenced by needing assistance with Activities of Daily Living (ADL) related to cardiac disease. On hospice care related to end of life diagnosis. The care plan was last revised on 04/23/23. -The resident had hypertension related to a diagnosis of hypertension. On hospice related to end of life diagnosis. The care plan was last revised on 04/23/23. -The resident desires no life-prolonging measures in the event of cardiac or respiratory arrest as evidenced by advance directives. On hospice care related to end of life diagnosis. The care plan was last revised on 01/25/23. -The resident had impaired cognitive function/dementia or impaired short term memory loss. On hospice care related to end of life thought process. The care plan was last revised on 1/26/23. -Preferences: the resident would like to choose the clothing worn, taking care of the resident's own belongings, have a place to lock personal items to keep them safe, bathe the way the resident would like, and choose own sleeping routine and family or friends chosen to be involve din discussions about the residents care. On hospice care related to end of life diagnosis. The care plan was last revised on 10/20/23. -At risk for falls and injuries related to pain, cardiac disease and end of life hospice care. The care plan was last revised on 04/23/23. -The resident received hospice services related to a diagnosis of nonrheumatic aortic (valve) stenosis. On hospice care related to end of life. The care plan was last revised on 01/26/23. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had a mood problem related to hospice care related to end of life. The care plan was last revised on 01/24/23. -Altered nutrition and hydration related to hypertension. On hospice care related to end of life care. The care plan was last revised on 01/01/24. -Potential for pressure ulcer development related to impaired mobility. On hospice care related to end of life diagnosis. The care plan was initiated on 05/17/22. -The resident had acute/chronic pain . On hospice care related to end of life diagnosis. The care plan was last revised on 04/23/23. On 02/15/24 at 11:32 AM, the Director of Nursing (DON) explained Resident #34 was no longer on hospice and was discharged from hospice services on 07/20/23. The DON confirmed the resident's care plan was not revised to exclude hospice and should have been revised once discharged from hospice. The facility policy titled Care Plan, Comprehensive, undated, documented care plans were individualized by identified resident problems, unique characteristics, strengths and individual needs. Care Plans were comprehensive tools for the Interdisciplinary Team to utilize as a reference for resident specific problems and approaches to establish guidance on meeting the individual needs of the residents. Care plans were to be revised and updated as determined appropriate.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50210 Based on observation, interview, clinical record review and document review, the facility failed to ensure services provided met professional standards of quality of care by admitting a resident for orthopedic aftercare following surgical amputation without wound treatment or monitoring orders, physician orders were followed for the administration of pain medication, and the Director of Nursing provided assistance to a resident dependent on staff for activities of daily living (ADLs) when the resident attempted to disrobe the resident's pants for 1 of 14 sampled residents (Resident #403). Resident #403 Resident #403 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of encounter for orthopedic aftercare following surgical amputation. Wound Treatment and Monitoring Orders On 02/12/24 at 11:46 AM, Resident #403 verbalized having the resident's leg amputated on 02/07/24 and having a wound vacuum for the surgical site. The resident explained the wound vacuum was blinking orange and thought the wound vacuum's batteries needed to be changed. On 02/12/24 at 3:38 PM, Resident #403 verbalized thinking the wound nurse (WCN) was unsure about what to do with the wound vacuum and believed the wound vacuum was no longer working. On 02/13/24 at 1:16 PM, Resident #403 verbalized the wound vacuum was removed on 02/12/24 at night when the surgical dressing was saturated, and the dressing was changed. On 02/13/24 at 3:26 PM, a Licensed Practical Nurse (LPN) verbalized the WCN was responsible for administering wound care and wound vacuum care. The LPN explained on 02/12/24 the LPN noticed the light on the wound vacuum was blinking orange. The LPN searched the internet for information about it. The LPN consulted the WCN about the wound vacuum. The LPN recounted being informed the wound vacuum was single use and would be disposed of. The LPN confirmed there was no wound care physician's order in the resident's clinical record, nor was wound care listed in the medication administration record (MAR). The LPN confirmed there should be a physician's order for wound care. On 02/13/24 at 3:49 PM, the Director of Nursing (DON) verbalized the resident had a wound vacuum on 02/11/24 but was unaware the wound vacuum was removed because there was no physician's order for the wound vacuum. The DON confirmed there was no order to monitor the wound vacuum. The DON confirmed there were no physician's orders for wound care and confirmed if wound care was required, there should have been a physician's order for wound care On 02/13/24 at 5:45 PM, the Executive Director verbalized the DON should have obtained a physician's order for wound care after being made aware Resident #403 had no wound care order. A physician's order dated 02/13/24 at 6:27 PM, documented surgical incision site cleanse with wound cleanser, pat dry, apply abdominal gauze (ABD) pad, wrap with kerlix, then ace wrap every day shift every other day and as needed for dislodgement or soiling. (continued on next page)

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	295023	A. Building B. Wing	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carson Nursing and Rehabilitation Center	2898 Highway 50 East Carson City, NV 89701

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/15/24 at 9:26 AM, the DON explained insufficient wound care could lead to infection and incomplete healing of the wound. On 02/20/24 at 2:41 PM, the WCN verbalized the WCN admitted Resident #403 on 02/10/24 and noticed the resident had a wound vacuum. The WCN explained on admission of the resident, it was late, and the resident wanted to be done with the assessment by 10:30 PM to go to bed. The WCN explained when the WCN did an assessment, the WCN would put in a physician's order and document the assessment. The WCN explained the WCN had two days to complete an admission assessment and confirmed the WCN would be responsible for documenting the monitoring and cleaning of a wound. The WCN confirmed there should have been a physician's order for the wound vacuum and a physician's order to monitor the wound vacuum. The WCN confirmed when the WCN saw the wound vacuum without a physician's order, the WCN should have immediately contacted the hospital for more information. Hydrocodone Not Provided On 02/12/24 at 11:46 AM, Resident #403 verbalized the resident had not received hydrocodone since admittance on 02/10/24. On 02/12/24 at 3:36 PM, Resident #403 recounted being told the resident was unable to receive hydrocodone-acetaminophen (hydrocodone) because the facility was having trouble getting the medication from the pharmacy. A physician's order dated 02/10/24, with a discontinue date of 02/13/24, documented hydrocodone oral tablet 10-325 milligrams (mg), give one tablet by mouth every four hours as needed for severe pain seven through ten for three days. A physician's order dated 02/13/24, documented hydrocodone oral tablet 10-325 mg, give one tablet by mouth every four hours as needed for moderate to severe pain. Resident #403's Medication Administration Record (MAR) dated 02/13/24, lacked documentation for the administration of hydrocodone-acetaminophen 10-325 mg on 02/10/24, 02/11/24, 02/12/24, and 02/13/24. On 02/13/24 at 3:26 PM, the LPN verbalized the resident was admitted with an order for hydrocodone and the resident never received the medication. On 02/13/24 at 3:49 PM, the Director of Nursing (DON) confirmed there was no documented hydrocodone administration on the resident's MAR. On 02/13/24 at 4:45 PM, the DON confirmed Resident #403 had not been given hydrocodone since admittance on 02/10/24. The DON explained the DON asked the LPN to administer hydrocodone on 02/12/24. The DON recounted following up with the LPN on 02/13/24 and was told the LPN got busy and forgot to administer the hydrocodone. Acetaminophen for Significant Pain On 02/12/24 at 3:38 PM, Resident #403 reported pain to be at a level of nine. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/13/24 at 1:16 PM, Resident #403 verbalized being given acetaminophen the morning of 02/13/24 and described pain as high. On 02/13/24 at 1:22 PM, the resident pressed the call light and requested pain medication. On 02/13/24 at 3:06 PM, the resident confirmed receiving acetaminophen. On 12/13/24 at 4:41 PM, Resident #403 verbalized the resident received acetaminophen at 1:30 PM on 02/12/24 and 6:00 AM on 02/13/24. The resident explained the acetaminophen was somewhat effective. A physician's order dated 02/10/24, documented acetaminophen tablet 325 milligrams (mg), give two tablets by mouth every six hours as needed for mild pain one through three on the pain scale, not to exceed three grams of acetaminophen in 24 hours. The Medication Administration Record (MAR) dated 02/20/24, documented the acetaminophen was administered on the following occasions when pain levels were considered severe: -02/11/24 at 12:01 AM, pain was 8 -02/11/24 at 6:57 AM, pain was 8 -02/13/24 at 12:30 PM, pain was 7 On 02/13/24 at 3:49 PM, the Director of Nursing (DON) verbalized Resident #403's clinical record documented an average pain of six and eight and the resident had a physician's order documented for the administration of acetaminophen for a pain rating of one through three. The DON confirmed acetaminophen was not an acceptable pain medication to manage the pain level reported by the resident. On 02/13/24 at 4:45 PM, the DON explained the DON was informed the resident received acetaminophen on the morning of 02/13/24. The DON confirmed the acetaminophen administration was not documented after 5:32 AM on 02/12/24. The DON explained the lack of acetaminophen administration documentation within the MAR could lead to misadministration which may affect the liver and lead to overdose. ADL Dependent Resident Withheld Assistance A care plan focus initiated 02/12/24, documented a focus on self-care deficits as evidenced by needs assistance with ADLs related to left below knee amputation, weakness, diabetes mellitus and pain with an intervention of one-person physical assist required for dressing. A task documentation survey report dated 02/14/24, documented Resident #403's lower body dressing ability as follows: -02/11/24 at 3:24 PM, 04-meaning supervision or touching assistance -02/12/24 at 1:46 PM, 01-meaning dependent -02/12/24 at 9:59 PM, 02-meaning substantial/maximal assistance (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-02/13/24 at 1:59 PM, 02-meaning substantial/maximal assistance -02/13/24 at 9:13 PM, 02-meaning substantial/maximal assistance On 02/13/24 at 5:15 PM, the Director of Nursing (DON) was inquired about accompanying two inspectors to observe in resident's room whether Resident #403's surgical dressing was saturated. The DON requested Resident #403 to disrobe the lower body to allow visualization of surgical dressing. Resident #403 attempted to reposition in the chair to remove Resident #403's pants. The DON stood in the room and did not offer to assist the resident with undressing or positioning. The resident did not disrobe. On 02/13/24 at 5:45 PM, the Executive Director confirmed it would have been appropriate for the DON to assist the resident with disrobing to meet the needs of the resident. On 02/20/24 at 9:14 AM, a Certified Nursing Assistant verbalized Resident #403 required assistance maneuvering pants over the hip, rocking hips to pull up and push down pants between the hip and thighs, and getting pants past the knees and toes. The facility policy titled, Activities of Daily Living (ADLs), dated 06/18/19, documented the facility would ensure care and services would be provided for dressing. The facility policy titled Medication Administration, dated 10/15/19, documented medications were administered as ordered by the physician. The facility policy titled, Wound Treatment Management, dated 10/19/19, documented wound treatments would be provided in accordance with physician orders, and in the absence of treatment orders, the licensed nurse would notify the physician to obtain orders. Cross reference with tag F677, F684, F689, F697, and F757.

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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** 50210 Based on observation and document review, the facility failed to ensure the Director of Nursing provided assistance to a resident dependent on staff for activities of daily living (ADLs) when the resident attempted to disrobe the resident's pants for 1 of 14 sampled residents (Resident #403). Findings include: Resident #403 Resident #403 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of encounter for orthopedic aftercare following surgical amputation A care plan focus initiated 02/12/24, documented a focus on self-care deficits as evidenced by needs assistance with ADLs related to left below knee amputation, weakness, diabetes mellitus and pain with an intervention of one-person physical assist required for dressing. A task documentation survey report dated 02/14/24, documented Resident #403's lower body dressing ability as follows: -02/11/24 at 3:24 PM, 04-meaning supervision or touching assistance -02/12/24 at 1:46 PM, 01-meaning dependent -02/12/24 at 9:59 PM, 02-meaning substantial/maximal assistance -02/13/24 at 1:59 PM, 02-meaning substantial/maximal assistance -02/13/24 at 9:13 PM, 02-meaning substantial/maximal assistance On 02/13/24 at 5:15 PM, the Director of Nursing (DON) was inquired about accompanying two inspectors to observe in resident's room whether Resident #403's surgical dressing was saturated. The DON requested Resident #403 to disrobe the lower body to allow visualization of surgical dressing. Resident #403 attempted to reposition in the chair to remove Resident #403's pants. The DON stood in the room and did not offer to assist the resident with undressing or positioning. The resident did not disrobe. On 02/13/24 at 5:45 PM, the Executive Director confirmed it would have been appropriate for the DON to assist the resident with disrobing to meet the needs of the resident. On 02/20/24 at 9:14 AM, a Certified Nursing Assistant verbalized Resident #403 required assistance maneuvering pants over the hip, rocking hips to pull up and push down pants between the hip and thighs, and getting pants past the knees and toes. The facility policy titled, Activities of Daily Living (ADLs), dated 06/18/19, documented the facility would ensure care and services would be provided for dressing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cross reference tag F658 and F689.

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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 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** 50210 Based on observation, interview, clinical record review, and interview, the facility failed to ensure a resident admitted for orthopedic aftercare following surgical amputation was not provided wound treatment without physician's orders and physician's orders for wound treatment, monitoring and a wound vacuum were obtained upon admission for 1 of 14 sampled residents (Resident #403). Findings include: Resident #403 Resident #403 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of encounter for orthopedic aftercare following surgical amputation. On 02/12/24 at 11:46 AM, Resident #403 verbalized having the resident's leg amputated on 02/07/24 and having a wound vacuum for the surgical site. The resident explained the wound vacuum was blinking orange and thought the wound vacuum's batteries needed to be changed. On 02/12/24 at 3:38 PM, Resident #403 verbalized thinking the wound nurse (WCN) was unsure about what to do with the wound vacuum and believed the wound vacuum was no longer working. On 02/13/24 at 1:16 PM, Resident #403 verbalized the wound vacuum was removed on 02/12/24 at night when the surgical dressing was saturated, and the dressing was changed. On 02/13/24 at 3:26 PM, a Licensed Practical Nurse (LPN) verbalized the WCN was responsible for administering wound care and wound vacuum care. The LPN explained on 02/12/24 the LPN noticed the light on the wound vacuum was blinking orange. The LPN searched the Internet for information about it. The LPN consulted the WCN about the wound vacuum. The LPN recounted being informed the wound vacuum was single use and would be disposed of. The LPN confirmed there was no wound care physician's order in the resident's clinical record, nor was wound care listed in the medication administration record (MAR). The LPN confirmed there should be a physician's order for wound care. On 02/13/24 at 3:49 PM, the Director of Nursing (DON) verbalized the DON had not met with Resident #403 but was able to confirm the WCN did an assessment. The DON explained the resident had a wound vacuum on 02/11/24 but was unaware the wound vacuum was removed because there was no physician's order for the wound vacuum. The DON confirmed there was no order to monitor the wound vacuum. The DON confirmed there were no physician's orders for wound care and confirmed if wound care was required, there should have been a physician's order for wound care. On 02/13/24 at 5:45, the Executive Director verbalized the DON should have obtained a physician's order for wound care after being made aware Resident #403 had no wound care order. On 02/13/24 at 6:06 PM, the Executive Director verbalized the DON looked at Resident #403's surgical wound. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 02/13/24 at 6:27 PM, documented surgical incision site cleanse with wound cleanser, pat dry, apply abdominal gauze (ABD) pad, wrap with kerlix, then ace wrap every day shift every other day and as needed for dislodgement or soiling. On 02/15/24 at 9:26 AM, the DON explained insufficient wound care could lead to infection and incomplete healing of the wound. The DON verbalized if wound care was not documented in the medication administration record (MAR), it would not be documented anywhere else. The DON explained lack of wound care documentation could mean the resident did not receive wound care. The DON indicated the wound care nurse had scheduled working days, so facility staff know when the wound care nurse had not administered treatment and a task would show floor staff wound care needed to be administered. On 02/20/24 at 2:41 PM, the WCN verbalized the WCN admitted Resident #403 on 02/10/24 and noticed the resident had a wound vacuum. The WCN explained on admission of the resident, it was late, and the resident wanted to be done with the assessment by 10:30 PM to go to bed. The WCN explained when the WCN did an assessment, the WCN would put in a physician's order and document the assessment. The WCN explained the WCN had two days to complete an admission assessment and confirmed the WCN would be responsible for documenting the monitoring and cleaning of a wound. The WCN verbalized being unsure about the wound vacuum, so the WCN spoke with the health information manager (HIFM) for wound care notes from the hospital. The WCN recounted changing the wound vacuum's batteries. The WCN explained when the resident used the slide board to transfer to and from the resident's bed, everything fell apart, so the WCN removed the wound vacuum and cleaned the wound, used an abdominal (ABD) pad, Kerlix wrap, and ACE bandage. The WCN confirmed the WCN did not document wound treatment for Resident #403 from 02/12/24 and the WCN would not be able to provide treatment without a physician order but explained the WCN did clean the wound and remove the wound vacuum. The WCN confirmed there should have been a physician's order for the wound vacuum and a physician's order to monitor the wound vacuum. The WCN confirmed when the WCN saw the wound vacuum without a physician's order, the WCN should have immediately contacted the hospital for more information. The facility policy titled, Wound Treatment Management, dated 10/19/19, documented wound treatments would be provided in accordance with physician orders, and in the absence of treatment orders, the licensed nurse would notify the physician to obtain orders. Cross reference tag F635, F655 and F658.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31739 Based on clinical record review, document review, and interview, the facility failed to ensure a resident with a pressure injury received the necessary treatment to prevent the deterioration and infection of the pressure injury for 1 of 14 sampled residents (Resident #2) and wound care was provided per physician order for 1 of 14 residents (Resident #45). Finding include: Resident #2 Resident #2 was admitted to the facility on [DATE], with a diagnosis of pressure ulcer of right buttock, unstageable. Resident #2's Care Plan dated 09/15/23, documented the resident had a wound to the right buttock. A Skin and Wound Evaluation dated 10/04/23, documented the resident had an unstageable pressure injury to the right gluteus upon admission and the wound had no evidence of infection. The wound dressing was saturated, and the wound progression was deteriorating. An Advantage Wound Care Progress Note dated 10/05/23, documented an initial consult for Resident #2's right buttock. The progress note documented the wound as a pressure injury, with wound reopened, and obvious signs of wound infection due to odor and seropurulent drainage. Resident started on oral antibiotics on 10/05/23, by primary care physician. Due to presence of slough post debridement continues to classify as unstageable. A physician's order dated 10/05/23, documented clindamycin hydrochloride capsule, 300 milligrams (mg). Give one capsule by mouth every six hours for infection for seven days. Resident #2's physician's orders documented the first wound care order for the right buttock on 10/19/23: Wound site: Right buttock. Cleanse with normal sterile saline, pat dry, pack with Dakins moistened gauze, cover with foam dressing daily until resolved. Every day shift for wound care and as needed for dislodgement or soiling. Inform physician of any changes. On 02/15/24 at 2:56 PM, the Director of Nursing (DON) confirmed the resident was initially assessed and wound care treatment had been performed by Advantage Wound Care on 10/05/23. The DON confirmed the first wound care order for Resident #2's right buttock pressure injury was obtained on 10/19/23, and should have been obtained upon admission to prevent the wound from deteriorating. The DON confirmed Resident #2 had been ordered an oral antibiotic for seven days due to the right buttock wound infection. The facility policy titled, Wound Treatment Management, dated 10/19/19, documented wound treatments would be provided in accordance with physician orders, and in the absence of treatment orders, the licensed nurse would notify the physician to obtain orders. 49557 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #45 Resident #45 was admitted to the facility on [DATE], with diagnoses including pressure ulcer of right heel, unstageable and pressure ulcer of left heel, unstageable. On 02/12/24 at 1:31 PM, Resident #45 verbalized the resident had wounds on the left and right heels. [NAME] roll gauze (kerlix) was observed covering both the right and left heels. On 02/14/24 at 7:22 AM, Resident #45 recalled the dressings on the left and right heel wounds were not changed on 02/13/24. A physician's order dated 01/17/24, with a start date of 01/18/24, documented wound site: right and left heel. Cleanse with normal saline (NS), pat dry, apply Santyl, non-adherent cover, kerlix daily till resolved every day shift for wound care. Resident #45's care plan documented a focus of wound management. Interventions included: -Provide wound care per treatment order, date initiated 01/30/24 -Monitor ulcer for signs of infection, date initiated 01/30/24 Resident #45's care plan documented a focus of actual pressure ulcer, sites: right and left heel. Interventions included: -Treatment as per order, date initiated 12/28/23. -Monitor for signs and symptoms of infection daily - increased warmth of surrounding tissue, redness, swelling, pain, purulent drainage, foul odor. Notify physician if identified. Date initiated 12/28/23. Resident #45's Treatment Administration Record (TAR) lacked documentation of wound care having been provided on 02/13/24, 02/05/24, 01/29/24, and 01/22/24. On 02/15/24 at 9:26 AM, the Director of Nursing (DON) verbalized infection, incomplete healing, and worsening of a wound could result from wound care not being provided according to physician orders. The DON confirmed Resident #45's current physician order for wound care was cleanse with normal saline, pat dry, apply Santyl, non-adherent cover, kerlix. The DON confirmed the order was for the wound care to be performed daily. The DON reviewed Resident #45's clinical record and confirmed the clinical record documented wound care was not provided on 02/13/24, 02/05/24, 01/29/24, and 01/22/24. The facility policy titled Wound Treatment Management, dated 10/19/19, documented wound treatments would be provided in accordance with physician orders, including the frequency of dressing change. Treatments would be documented on the TAR or in the electronic health record.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 30748 Based on observation, clinical record review, interview and document review, the facility failed to have a policy or process for placing resident beds against the wall and assessing residents for entrapment and safety before placement for 37 of 49 residents (Resident #37, #25, #42, #18, #7, #34, #28, #21, #38, #22, #1, #31, #32, #26, #2, #29, #153, #36, #3, #12, #13, #20, #27, #40, #45, #354, #355, #403, #404, #19, #39, #47, #303, #305, #306, #307, and #308). The lack of assessments posed risks such as potential restraint, entrapment, and/or placement of residents with conditions predisposing them to accidents in beds against the wall. This widespread deficiency, affecting most of the residents, indicated a systemic issue characterized by a lack of established processes or policies, ultimately resulting in substandard quality of care. Additionally, the facility failed to ensure medications were not left unsecured in a resident's room by allowing a resident to self-administer a medication and creating a potential accident by leaving a medication unsecured for 1 of 14 sampled residents (Resident #17). Findings include: Resident #37 Resident #37 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including traumatic hemorrhage of cerebrum, unspecified, without loss of consciousness, subsequent encounter, enterococcus as the cause of diseases classified elsewhere, and muscle weakness (generalized). Resident #25 Resident #25 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including palmar fascial fibromatosis (Dupuytren), peripheral vascular disease, unspecified, mild cognitive impairment of uncertain or unknown etiology, and acquired absence of right leg above knee. Resident #42 Resident #42 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, cognitive social or emotional deficit following cerebral infarction, and muscle weakness (generalized). Resident #18 Resident #18 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unspecified dementia, unspecified severity, with other behavioral disturbance, unspecified psychosis not due to a substance or known physiological condition, chronic obstructive pulmonary disease, unspecified. Resident #7 (continued on next page)

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Carson Nursing and Rehabilitation Center	2898 Highway 50 East Carson City, NV 89701

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #7 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including end stage renal disease, acquired absence of left leg below knee, heart failure, and muscle weakness (generalized). Resident #34 Resident #34 was admitted to the facility on [DATE], with diagnoses including hereditary motor and sensory neuropathy, hyperlipidemia, unspecified, and muscle weakness (generalized). Resident #28 Resident #28 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including spinal stenosis, lumbar region with neurogenic claudication, spinal stenosis, cervical region, spondylosis without myelopathy or radiculopathy, lumbosacral region, and Alzheimer's disease, unspecified. On 02/12/24 at 7:15 AM, during a tour of the facility, Resident #37, #25, #42, #18, #7, #34, #28's beds were against the wall. Resident #37, #25, #42, #18, #7, #34, #28's clinical records lacked care plans for the beds against the wall. Resident #37, #25, #42, #18, #7, #34, #28's clinical records lacked documented evidence assessments for entrapment and restraint were completed for the beds against the wall. 31739 Resident #21 Resident #21 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, unspecified, bi-polar disorder, unspecified, major depressive disorder, recurrent, unspecified, chronic kidney disease, stage three unspecified, and type II diabetes mellitus with diabetic neuropathy, unspecified. Resident #38 Resident #38 was admitted to the facility on [DATE] with diagnoses including chronic systolic congestive heart failure, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, acute kidney failure, unspecified, muscle weakness, generalized, and dysphagia, oropharyngeal phase. Resident #22 Resident #22 was admitted to the facility on [DATE], with diagnoses including unilateral primary osteoarthritis, right knee, other cerebral palsy, major depressive disorder, recurrent, unspecified, generalized anxiety disorder, muscle weakness, generalized. Resident #1 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #1 was admitted to the facility on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, chronic obstructive pulmonary disease, unspecified, acquired absence of left leg above knee, muscle weakness, generalized, and long term, current, use of anticoagulants. Resident #31 Resident #31 was admitted to the facility on [DATE], with diagnoses including chronic obstructive pulmonary disease, unspecified, type II diabetes mellitus with diabetic neuropathy, unspecified, chronic diastolic, congestive, heart failure, cognitive communication deficit, acquired absence of right leg below knee, acquired absence of left leg below knee, muscle weakness, generalized, depression, unspecified, and anxiety disorder, unspecified. Resident #32 Resident #32 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, without behavioral, psychotic or mood disturbance and anxiety, hemorrhage affecting left non-dominant side, essential primary hypertension, and muscle weakness, generalized. Resident #26 Resident #26 was admitted to the facility on [DATE], with diagnoses including extradural and subdural abscess, unspecified, depression, unspecified, altered mental status, unspecified, essential primary hypertension, and muscle weakness, generalized. Resident #2 Resident #2 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, without behavioral, psychotic or mood disturbance and anxiety, chronic diastolic congestive heart failure, unspecified atrial fibrillation, type II diabetes mellitus with hyperglycemia, hyperlipidemia, unspecified, pressure ulcer of right buttock, unstageable, and muscle weakness, generalized. Resident #29 Resident #29 was admitted to the facility on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, type II diabetes mellitus with diabetic chronic kidney disease, unspecified, chronic kidney disease, stage II, mild, bi-polar disorder, unspecified, generalized anxiety disorder, cognitive communication deficit, dysphagia, oropharyngeal phase, and muscle weakness, generalized. Resident #153 Resident #153 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, without behavioral, psychotic or mood disturbance, generalized anxiety disorder, and major depressive disorder. Resident #36 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #36 was admitted to the facility on [DATE], with diagnoses including torsades de pointes, type II diabetes mellitus with hyperglycemia, heart failure, unspecified, unspecified atrial fibrillation, hyperlipidemia, unspecified, and hypothyroidism, unspecified. On 02/14/24 at 4:21 PM, during a tour of the facility, Resident #21, #38, #22, #1, #31, #32, #26, #2, #29, #153, and #36's beds were against the wall. Resident #21, #38, #22, #1, #31, #32, #26, #2, #29, #153, and #36's clinical records lacked documented evidence assessments for entrapment and restraint were completed for the beds against the wall. 49557 Resident #3 Resident # was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including fibromyalgia and other intervertebral disc degeneration, lumbar region. Resident #12 Resident #12 was admitted to the facility on [DATE], and readmitted on [DATE] and 08/11/23, with diagnoses including chronic obstructive pulmonary disease, unspecified and unspecified dementia, moderate, with mood disturbance. Resident #13 Resident #13 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease, unspecified and type two diabetes mellitus with diabetic polyneuropathy. Resident #20 Resident #20 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including alcoholic cirrhosis of the liver without ascites and muscle weakness, generalized. Resident #27 Resident #27 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side and muscle weakness, generalized. Resident #40 Resident #40 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including acute posthemorrhagic anemia and muscle weakness, generalized. Resident #45 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #45 was admitted to the facility on [DATE] with diagnoses including urinary tract infection, site not specified and muscle weakness, generalized. Resident #354 Resident #354 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including displaced comminuted fracture of shaft of left fibula, subsequent encounter for closed fracture with routine healing, traumatic ischemia of muscle, subsequent encounter, and muscle weakness, generalized. Resident #355 Resident #355 was admitted to the facility on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and muscle weakness, generalized. On 02/14/24 at 4:29 PM, Resident #3, #12, #13, #20, #27, #40, #45, #354, and #355's beds were located up against the residents' bedroom wall preventing the residents from exiting out of both sides of the residents' bed, creating a risk for entrapment and restraint. Resident #3, #12, #13, #20, #27, #40, #45, #354, and #355's clinical records lacked documented evidence the residents were assessed for risk of entrapment and restraint related to the placement of the residents' beds against the wall. 50210 Resident #403 Resident #403 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of encounter for orthopedic aftercare following surgical amputation. Resident #404 Resident #404 was admitted to the facility on [DATE], with diagnosis including hypertensive chronic kidney disease with Stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease, end stage renal disease, and dependence on renal dialysis. On 02/13/24 at 7:57 AM, Resident #403 and #404's beds were located up against the residents' bedroom wall preventing the residents from exiting out of both sides of the residents' bed, creating a risk for entrapment and restraint. Resident #403 and #404's clinical records lacked documented evidence the residents were assessed for risk of entrapment and being restrained, informed, or educated regarding the risk for entrapment and potential to be restrained, and did not include consent related to the risk for entrapment and the potential for the residents' becoming restrained by the placement of the bed. 43310 Resident #19 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #19 was admitted to the facility on [DATE], with diagnoses including type II diabetes mellitus without complications, acute kidney failure, unspecified, and chronic obstructive pulmonary disease, unspecified. Resident #39 Resident #39 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including encounter for orthopedic aftercare following surgical amputation, type I diabetes mellitus with diabetic neuropathy, unspecified, chronic systolic (congestive) heart failure, functional quadriplegia, and personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits. Resident #47 Resident #47 was admitted to the facility on [DATE], with diagnoses including displaced intertrochanteric fracture of left femur, subsequent, other symptoms and signs involving cognitive functions and awareness, cardiomegaly, atherosclerotic heart disease of native coronary artery without angina pectoris, muscle weakness, and long term (current) use of anticoagulants. Resident #303 Resident #303 was admitted to the facility on [DATE], with diagnoses of pneumonia, unspecified organism, type II diabetes mellitus without complications, and spondylosis without myelopathy or radiculopathy, lumbar region. Resident #305 Resident #305 was admitted to the facility on [DATE], with diagnoses including encephalopathy, unspecified, repeated falls, type II diabetes mellitus without complications, long term (current) use of anticoagulants, and adult failure to thrive. Resident # 306 Resident #306 was admitted to the facility on [DATE], with diagnoses including traumatic hemorrhage of cerebrum, unspecified, without loss of consciousness, subsequent encounter, and fall on same level, unspecified, subsequent encounter. Resident #307 Resident #307 was admitted to the facility on [DATE], with diagnoses including urinary tract infection, site not specified, type II diabetes mellitus without complications, adult failure to thrive, muscle weakness, generalized anxiety disorder, acquired absence of other left toe(s), and acquired absence of other right toe(s). Resident #308 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #308 was admitted to the facility on [DATE], with diagnoses including displaced fracture of medial malleolus of left tibia, subsequent encounter for closed fracture with routine healing, fall on same level, unspecified, subsequent encounter, morbid (severe) obesity with alveolar hypoventilation, lymphedema, not elsewhere classified, and chronic kidney disease, stage 3B. On 02/15/24 at 2:03 PM, Resident #19, #39, #47, #303, #305, #306, #307, and #308's beds were located up against the residents' bedroom wall preventing the residents from exiting out of both sides of the residents' bed, creating a risk for entrapment and restraint. Resident #19, #39, #47, #303, #305, #306, #307, and #308's clinical records lacked documented evidence the residents were assessed for risk of entrapment and becoming restrained, informed, or educated regarding the risk for entrapment and potential to be restrained, and did not include signed consents related to the risk for entrapment and the potential for the residents' becoming restrained by the placement of the beds. On 02/14/24 at 3:30 PM, the DON verbalized the definition of a physical restraint was anything impeding a resident's movement or normal access to the resident's body. The DON defined entrapment as becoming stuck in something, such as an arm becoming stuck in a chair. The DON confirmed an entrapment assessment was required when restraints were used and verbalized the facility did not use restraints. The DON explained an assessment was done when bars were used and added, even though they (grab bars) were not really restraints. The DON explained the facility discussed the use of handrails and bedrails with resident's. The DON verbalized the facility did not use any type of restraint and explained having a bed against a wall was not necessarily a restraint. The DON explained a bed against the wall would only be considered a restraint if a full bed rail was present on the other side of the bed, or if a resident had unilateral weakness and the resident's strong side was placed towards the wall. The DON confirmed placing a resident with the resident's strong side to the wall and weak side to the open side of the bed would be considered a restraint. On 02/14/24 at 3:34 PM, the DON verbalized the DON did not know if there was an actual physical assessment completed by the therapy department. The DON explained the DON did not know if the facility had an actual assessment and verbalized it was something discussed with the residents, however, it was not documented in the resident's electronic health records (EHR) . The DON verbalized an entrapment assessment would include ensuring things could not get caught in the side bar, concerns such as paralysis would be considered to determine if the resident was a good candidate. On 02/14/24 at 3:40 PM, the DON confirmed the facility did not have a policy or process in place regarding the placement of resident beds against a wall. The DON confirmed if a resident needed to get out of the bed on the side placed against the wall, it would be considered a restraint. On 02/14/24 at 3:41 PM, the DON verbalized the facility received admits as late as 8:00 PM, and confirmed no one was at the facility this late to complete a physical assessment. The DON confirmed new residents were admitted to beds positioned against a wall without having a physical assessment completed. On 02/14/24 at 3:42 PM, DON explained the process the facility had in place to ensure a resident was not restrained upon admission by being placed in a bed positioned against a wall was communication between staff members. The DON confirmed there was not a formal process in place. Regarding how the facility determined appropriateness of beds against the wall and bedrails for residents with cognitive disabilities the DON verbalized, I do not know, I will have to think about that one for a second. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/14/24 at 3:45 PM, the DON verbalized if the facility had a process for assessment in place, the assessment would include determining if a resident had control over the resident's body and was able to recognize where (spatially) the body was at, assessing if the mattress fit the bed frame, if there were any gaps present and if the bed was the correct size for the resident. On 02/14/24 at 3:47 PM, the DON confirmed a resident would not be able to move a bed away from the wall and confirmed this would restrict the residents movement from the bed. The DON acknowledged this was the definition of a physical restraint. The facility policy titled Proper Use of Bed Rails, dated 10/2022, defined a physical restraint as any manual method, physical or mechanical device, equipment, or material which met all of the following criteria: Was attached to or adjacent to the resident's body, could not be removed easily by the resident, and restricted the resident's freedom of movement or normal access to the resident's body. The facility policy titled Restraint Policy, revised 10/2017, documented residents would be free from physical restraints not required to treat the resident's medical symptoms. If the use of restraints was indicated, the facility would document ongoing re-evaluation of the need for restraints. The purpose of the policy was to avoid the unnecessary restriction to freedom of movement while facilitating the proper use of a device according to the resident's assessed needs and conditions. Assessment guidelines included but were not limited to safety needs and prior alternatives attempted. Procedure included but was not limited to assessing the resident's need for use of a restraint, identifying the least restrictive option, obtaining a physician's order, developing a comprehensive care plan, and obtaining informed consent. Documentation guidelines included restraint assessment, admission assessment and informed consent. Cross reference with tag F552, F656, F658 and F677 Medication Cup Resident #17 Resident #17 was admitted to the facility on [DATE], with diagnoses including gastro-esophageal reflux disease without esophagitis and sepsis due to Escherichia coli (E. coli). A physician order dated 01/15/24, documented antacid oral tablet, chewable 500 milligram (mg), give 2 tablet by mouth every six hours as needed for indigestion. On 02/12/24 at 10:59 AM, a medicine cup containing one antacid oral tablet was located in Resident #17's room on the bedside table. Resident #17's room door was open and accessible to other residents, including Resident #17's roommate. On 02/12/24 at 11:02 AM, an LPN confirmed the medicine cup on Resident #17's bedside table contained one antacid tablet. The LPN confirmed nurses were not allowed to leave medications unattended and/or for residents to take at a later time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy titled Medication Administration, dated 10/15/19, documented medications were administered in accordance with professional standards of practice. Staff administering medications were required to observe the residents' consumption of medications administered.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on observation, interview, clinical record review, and document review, the facility failed to ensure residents with oxygen therapy were administered oxygen per the physician's order for 3 of 14 sampled residents (Resident #12, #355 and #404). Findings include: Resident #12 Resident #12 was admitted to the facility on [DATE], and readmitted on [DATE] and 08/11/23, with diagnoses including chronic obstructive pulmonary disease (COPD), unspecified, chronic respiratory failure, unspecified whether with hypoxia or hypercapnia, and dependence on supplemental oxygen. A physician's order dated 05/04/23, documented oxygen at 3 liters per minute (LPM) via nasal cannula (NC) continuous every shift. Resident #12's care plan documented Resident #12 had shortness of breath (SOB) related to COPD and anxiety. Interventions included administering oxygen per provider orders. On 02/12/24 at 1:42 PM, Resident #12 was receiving oxygen via NC. The oxygen concentrator was set at 2 LPM. Resident #12 verbalized the resident frequently experienced SOB. On 12/12/24 at 2:25 PM, a Licensed Practical Nurse (LPN) confirmed Resident #12's order was for oxygen to be administered at 3 LPM via NC. The LPN confirmed Resident #12's oxygen concentrator was set to 2 LPM and adjusted the liter flow to 3 LPM. The LPN confirmed 2 LPM did not match the physician order. Resident #355 Resident #355 was admitted to the facility on [DATE], with diagnoses including acute respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), unspecified, and dependence on supplemental oxygen. A physician's order dated 01/26/24, with a start date 01/27/24, documented oxygen at 5 LPM via NC continuous every shift. Resident #355's care plan documented Resident #355 had COPD with respiratory failure with hypoxia. Interventions included administering oxygen as ordered: oxygen at 5 LPM via NC continuous. On 02/12/24 at approximately 10:20 AM, Resident #355 was receiving oxygen via NC. The oxygen concentrator was set between 2 and 2.5 LPM. On 02/12/24 at 1:15 PM, a Registered Nurse (RN)1 confirmed Resident #355's oxygen concentrator was set at 2 LPM. The RN1 confirmed a flow rate of 2 LPM did not match the current physician's order for 5 LPM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50210 Resident #404 Resident #404 was admitted to the facility on [DATE], with diagnoses including chronic atrial fibrillation, unspecified and hypertensive chronic kidney disease, unspecified. A physician's order dated 02/09/24, documented to administer oxygen at 1 LPM as needed for supplement. A care plan intervention was initiated on 02/12/24 to administer oxygen at 2 LPM continuous via nasal cannula (NC). On 02/12/24 at 12:39 PM, Resident #404 was observed without oxygen connected to the NC. On 02/12/24 at 3:03 PM, Resident #404 was approached by RN2 and was asked whether the resident would prefer the oxygen flow to be set at two or three LPM. The resident requested three and the RN2 set the oxygen to three LPM. On 02/13/24 at 11:32 AM, Resident #404 was wearing NC connected to oxygen with a flow of 2 LPM. A physician's order dated 02/15/24, documented to administer oxygen at 2 LPM via NC as needed for supplement and at 3 LPM via NC as needed for shortness of breath. On 02/15/24 at 3:41 PM, RN3 verbalized the Oxygen flow of Resident #404 should be 2 LPM as needed according to the active physician's order but the admitting oxygen order for 1 LPM ordered on 02/09/24 was discontinued on 02/15/24. The RN3 verbalized RN3 would need a physician's order with specific LPM to change the oxygen flow. If the RN3 assessed the resident to need a different oxygen flow, RN3 would need to report to the physician and recommend a change before changing the oxygen flow. On 02/15/24 at 3:49 PM, the RN2 verbalized the RN2 could ask a resident what the resident wanted the oxygen flow set at. The RN2 explained the RN2 could use discretion to change oxygen between two and six LPM, but the RN2 would then call the physician to ensure it does not become an issue. The RN2 confirmed the RN2 did change Resident #404's oxygen flow without an order and verbalized the RN2 spoke with the physician afterward. The RN2 was unable to find proof of the discussion with the physician. The RN2 confirmed oxygen was a medication. The RN confirmed the active physician's order on 02/12/24 to be 1 LPM and verbalized the oxygen flow administered of 3 LPM did not match the physician's order. The facility policy titled Oxygen Administration, dated 08/2014, documented to check the physician's order for liter flow. Use of nasal cannula included connecting tubing to the humidifier outlet and adjusting liter flow as ordered. Cross reference with tag F655.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50210 Based on observation, interview, clinical record review and document review, the facility failed to ensure a resident admitted for orthopedic aftercare following a surgical amputation had the severe pain managed according to the physician's order for 1 of 14 sampled residents (Resident #403) resulting in the resident experiencing actual severe pain. Findings include: Resident #403 Resident #403 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of encounter for orthopedic aftercare following surgical amputation. Resident #403's discharge summary from acute care, dated 02/10/24, documented the resident reported significant pain after the surgery but the pain was adequately controlled with pain medications. On 02/12/24 at 11:46 AM, Resident #403 explained the resident had the left foot amputated on 02/07/24 and was admitted on [DATE]. The resident verbalized the resident did not receive pain medication since admittance. The resident was grimacing in pain. On 02/12/24 at 3:38 PM, Resident #403 described pain from surgical site to knee as a nine (using a scale of one to ten) and a tolerable level at a four. The resident informed the nurse of the resident's pain and explained the resident needed hydrocodone to manage it. The resident explained the facility was unable to get the hydrocodone from the pharmacy. On 02/13/24 at 1:16 PM, Resident #403 verbalized the resident received acetaminophen in the morning. The resident described the pain as high. A physician's order dated 02/10/24, documented: - acetaminophen tablet 325 milligrams (mg), give two tablets by mouth every six hours as needed for mild pain one through three on the pain scale, not to exceed three grams of acetaminophen in 24 hours. -the highest level of pain to be recorded every shift. A physician's order dated 02/10/24, with a discontinuation date of 02/13/24, documented hydrocodone oral tablet 10-325 milligrams (mg), give one tablet by mouth every four hours as needed for severe pain seven through ten for three days. Resident #403's baseline care plan, dated 02/12/24, documented a focus on acute/chronic pain related to new left below knee amputation, surgical wound. The goal was the resident would voice a level of comfort of (SPECIFY residents states range of comfort) out of (SPECIFY) through review date. Interventions included the following: (continued on next page)

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	295023	A. Building B. Wing	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carson Nursing and Rehabilitation Center	2898 Highway 50 East Carson City, NV 89701

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Administer analgesia as per orders. -Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. -Monitor / record pain characteristics every (Q) shift and as needed (prn) for quality (such as sharp, burning); severity (1-10 scale); anatomical location; onset; duration (such as continuous, intermittent); aggravating factors; relieving factors. Physician notification and medication effectiveness. -Monitor/document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria; nausea; vomiting; dizziness and falls. Report occurrences to the physician. -Monitor/record/report to Nurse any signs and symptoms of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored, fast/slow); Vocalizations (grunting, moans, yelling out, silence); Mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); Eyes (wide open/narrow slits/shut, glazed, tearing, no focus); -Face (sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid, rocking, curled up, thrashing). The goals had not been completed and remained in a fill-in the blank, template format. A physician's order dated 02/13/24, documented hydrocodone oral tablet 10-325 mg, give one tablet by mouth every four hours as needed for moderate to severe pain. Pain Levels from Resident #403's clinical record were as follows: -02/11/2024 at 12:01 AM, pain was 8 -02/11/2024 at 3:26 AM, pain was 4 -02/11/2024 at 6:57 AM, pain was 8 -02/11/2024 at 6:31 PM, pain was 8 -02/11/2024 at 8:50 PM, pain was 6 -02/11/2024 at 8:51 PM, pain was 6 -02/12/2024 at 5:24 AM, pain was 2 -02/12/2024 at 5:32 AM, pain was 6 -02/12/2024 at 6:02 PM, pain was 0 -02/12/2024 at 9:38 PM, pain was 0 The Medication Administration Record dated 02/20/24, documented the acetaminophen was administered on the following occasions when pain levels were higher than ordered parameters: (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-02/11/24 at 12:01 AM, pain was 8 -02/11/24 at 6:57 AM, pain was 8 -02/11/24 at 8:50 PM, pain was 6 -02/12/24 at 5:32 AM, pain was 6 -02/13/24 at 12:30 PM, pain was 7 On 02/13/24 at 3:26 PM, a Licensed Practical Nurse (LPN) verbalized the resident had complained about pain since being admitted . The LPN explained the facility was unable to fill the order for hydrocodone. The LPN confirmed Resident #403 was admitted with a physician's order for hydrocodone and explained according to the MAR, the hydrocodone was not administered on 02/10/24, 02/11/24, 02/12/24, or 02/13/24 despite the physician's order. The LPN confirmed acetaminophen was administered in place of hydrocodone. The LPN verbalized the resident had rated pain with eights, nines, and tens. On 02/13/24 at 3:49 PM, the Director of Nursing (DON) confirmed an amputation was painful and pain medication should be available. The DON confirmed there was a physician's order for hydrocodone and confirmed no medication administration was documented on the MAR. The DON explained the facility had a medbank (emergency supply) and explained the DON needed to check if the medbank had Resident #403's hydrocodone. The DON verbalized the resident's clinical record portrayed an average reported pain level of six and eight. The DON verbalized a physician's order documented for the administration of acetaminophen for a pain rating of one through three. The DON confirmed acetaminophen was not an acceptable medication to manage the pain level reported by the resident. The DON confirmed the MAR lacked documentation for acetaminophen on 02/12/24. On 02/13/24 at 4:41 PM, the resident verbalized the resident was given acetaminophen at 1:30 PM on 02/12/24 and at 6:00 AM on 02/13/24. Resident #403 explained the acetaminophen was somewhat effective however, the resident had not experienced a pain level of zero since admittance and the resident never expressed a pain level of zero to facility staff. Resident #403 described the resident's lowest level of pain since admittance as a four due to acetaminophen. The resident explained the acetaminophen effect last up to two hours and the resident waited four hours between doses, leaving two hours of pain unaddressed. The resident explained when the resident elevated the resident's leg and wore a tight brace with pants on top to keep the brace in place, the pain was improved. On 02/13/24 at 4:45 PM, the DON confirmed the resident was not given hydrocodone since admittance on 02/10/24. The DON explained the DON told the LPN to administer hydrocodone from the medbank on 02/12/24 but the LPN got busy and forgot. The DON explained the DON was informed the resident received acetaminophen on 02/13/24 sometime in the morning. The DON confirmed the acetaminophen administration was not documented after 5:32 AM on 2/12/24. The DON explained the lack of acetaminophen administration documentation could result in overdose and liver problems. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 02/20/24 at 9:27 AM, the LPN verbalized all nurses input reported pain levels in the clinical record. Pain levels got transcribed into the MAR. The LPN explained a reported pain level of zero indicated no pain. If a resident was sleeping, the LPN assumed no pain but would add notes to indicate the resident was resting. The LPN verbalized when the LPN documented highest pain level reflected throughout a shift, the LPN would look through all levels of pain reported for the shift. The LPN confirmed the MAR documented zeros for both shifts on 02/14/24 for highest level of pain. The LPN verbalized the zeros were not accurate as the clinical record pain monitoring recorded for 02/14 was an eight at 6:00 AM, an eight at 2:43 PM, an eight at 7:01 PM and zero at 11:00 PM. On 02/20/24, the DON verbalized an admission assessment needed to be completed within 72 hours of the resident's admission. The DON was unsure why Resident #403's admission assessment was not completed and confirmed the DON was responsible for ensuring assessments were completed. A pain assessment completed by a nurse included pain indicated during the assessment, what the pain was and how often the resident experienced the pain. The DON explained when contacting the pharmacy, the pharmacy would usually deliver the prescription medication the same day. The DON confirmed the resident was admitted with a physician's order to administer hydrocodone every four hours. The DON verbalized every resident was assessed for pain every shift. The DON explained continued high pain could cause psychological harm to the resident. Regarding the monitoring of medication effectiveness, the DON noted that unknown may be documented for various reasons, although the DON was uncertain why it was documented for hydrocodone on 02/14/24 at 1:43 PM, 02/15/24 at 7:38 AM and 12:16 PM, and 02/18/24 at 4:56 PM. The DON verbalized acetaminophen would not be effective pain management for an amputation. The DON verbalized Resident #403 should have been assessed for amputation pain and because the assessment did not include amputation pain, the assessment was not correct. The DON verbalized a progress note mentioned phantom pain experienced by the resident and the resident went four days without hydrocodone to manage pain while an amputation without medication would likely have resulted in pain. The DON explained nurses were trained to assess pain by asking residents where the pain was, what the pain was, and how the resident would rate the pain between one and ten. The facility policy titled Pain Management, dated 11/12/19, documented the facility would ensure pain management was provided to residents who required such services, consistent with professional standards of practice. Cross reference with tag F658, F755 and F757.

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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** 30748 Based on observation, interview, clinical record review and document review the facility failed to ensure alternatives were attempted and entrapment risk was assessed prior to installation of bedrails for 2 of 14 sampled residents (Resident #34 and #355) and alternatives were attempted and documented as unsuccessful prior to the installation of a grab bar for 1 of 14 sampled residents (Resident #21). Findings include: Resident #34 Resident #34 was admitted to the facility on [DATE], with diagnoses including hereditary motor and sensory neuropathy, hyperlipidemia, unspecified, and muscle weakness (generalized). On 02/12/24 at 10:13 AM, the resident's bed had two quarter size bed rails, one on each side of the bed. A physician's order dated 01/30/24, documented grab bar to right side of bed to promote independence in transfers and bed mobility. No directions specified for order. The resident's clinical record lacked documented evidence a completed assessment, informed consent was obtained, and if alternatives were attempted prior to installation. 49557 Resident #355 Resident #355 was admitted to the facility on [DATE] with a diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. On 02/14/24, Resident #355's bed had grab bars in place on both sides of the bed. A consent dated 01/30/24, documented bilateral grab bars were recommended for bed mobility. The section of the consent titled Alternatives or other interventions attempted/used prior to considering the use of bed rails or restraints was left blank. The consent documented the prescribing physician should have reviewed reasonable alternatives and risks. A physician's order dated 02/12/24, documented bilateral grab bars when in bed to facilitate independent bed mobility. Resident #355's care plan documented self-care deficit. Interventions included bilateral grab bars per physician order for safety during care, provision to assist with bed mobility. Observe for injury or entrapment related to grab bar use. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/14/24 at 3:29 PM, the Director of Nursing (DON) confirmed an assessment of risk for entrapment should be completed prior to use of bed rails. The DON explained all bed rail assessments were completed by therapy and the documentation of the assessment would be in the therapy notes. On 02/15/24 at 8:46 AM, the Director of Rehabilitation (DOR) verbalized residents were assessed for safety prior to use of bed rails however it was no formal assessment or form completed. The DOR could not provide documented evidence of assessment of risk of entrapment for Resident #34 or Resident #355 prior to use of bed rails. On 02/15/24 at 10:13 AM, the DOR confirmed there was no documentation specific to assessment for safety or entrapment risk prior to use of bed rails. 31739 Resident #21 Resident #21 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, unspecified, bi-polar disorder, unspecified, major depressive disorder, recurrent, unspecified, chronic kidney disease, stage three unspecified, and type II diabetes mellitus with diabetic neuropathy, unspecified. On 02/12/24 at 1:18 PM, Resident #21 had a grab bar attached to the right side of the resident's bed. The grab bar was in the up position. A Physician's order dated 01/30/24, documented grab bar to right side of bed to promote independence in transfers and bed mobility. Resident #21's Care Plan dated 01/30/24, documented grab bar when in bed to promote independence with bed mobility and positioning. An Informed Consent for the Use of Bed Rails and Physical Restraints was signed and dated by the resident. Resident #21's clinical record lacked documented evidence alternatives were attempted prior to the installation of the grab bar. On 02/15/24 at 9:46 AM, the Health Information Officer confirmed Resident #21's clinical record lacked documented evidence alternatives were attempted prior to the installation of the grab bar. On 02/15/24 at 3:22 PM, the Director of Nursing (DON), confirmed alternatives had not been attempted prior to the installation of the grab bar to Resident #21's bed. The DON confirmed any attempted alternatives should have been documented in Resident #21's clinical record how they failed to meet the resident's needs prior to the installation of the grab bar. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled, Proper Use of Bed Rails, dated 10/2022, documented examples of bed rails included but were not limited to grab bars and assist bars. The medical record should have included an evaluation of alternatives attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the resident's assessed needs. Resident assessment should have assessed the resident's risk of entrapment between mattress and bed rail or in the bed rail itself. If no appropriate alternatives were identified, the medical record should have included evidence of assessment of the resident, the bed, the mattress, and rail for entrapment risk.

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 30748 Based on observation, interview, and document review, the facility failed to ensure a sufficient number of Licensed Nurses and Certified Nursing Assistants (CNAs) were scheduled to perform resident care according to the Facility Assessment for 2 of 2 shifts during the weekends in July, August and September of 2023. Findings include: The Centers for Medicare and Medicaid Services, Payroll-Based Journal (PBJ) Staffing Data Report, dated 07/01/23 through 09/30/23, documented the facility had excessively low weekend staffing. The Staffing Plan documented the facility staffing projections. The CNA schedule was maintained over two separate shifts; 6:00 AM-6:00 PM (first shift) projected 1:12 ratio of CNAs per residents and 6:00 PM-6:00 AM (second shift) projected a ratio of 1:16 ratio of CNAs per residents. On 02/15/24 at 8:21 AM, the Administrator explained the Staffing Plan was something that was created in January 2024 for staffing projections and there was not a Staffing Plan in place prior to January 2024. The Administrator verbalized not knowing an average census to base the number of staff needed to care for the resident population. A Staffing Plan, undated, documented the facility would require 3 licensed nurses for the day shift and a 1:12 ratio for CNA coverage during the day. Facility nursing schedules and timesheets documented the facility lacked adequate staffing coverage on the following dates during the day shift: -July 1, 2023, with a census of 51, the facility had two Certified Nursing Assistants (CNA) working the day shift. -July 2, 2023, with a census of 51, the facility had three CNAs working the day shift. -July 8, 2023, with a census of 52, the facility had three CNAs working the day shift. -July 9, 2023, with a census of 52, the facility had three CNAs working the day shift. -July 15, 2023, with a census of 50, the facility had 2 CNAs working the day shift. -August 5, 2023, with a census of 53, the facility had two Licensed Practical Nurses (LPN) working the day shift. -August 6, 2023, with a census of 52, the facility had two LPNs working the day shift. -August 12, 2023, with a census of 49, the facility had two LPNs working the day shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-August 13, 2023, with a census of 49, the facility had two LPNs working the day shift. -August 26, 2023, with a census of 58, the facility had four CNAs working the day shift. -August 27, 2023, with a census of 56, the facility had four CNAs working the day shift. -September 2, 2023, with a census of 53, the facility had two LPNs working the day shift. -September 3, 2023, with a census of 53, the facility had three CNAs working the day shift. -September 23, 2023, with a census of 50, the facility had two CNAs working the day shift. A Staffing Plan, undated documented the facility would require two licensed nurses for night shift and a 1:16 ratio for CNA coverage for the night shift. Facility nursing schedules and timesheets documented the facility lacked adequate staffing coverage on the following dates during the night shift: -July 30, 2023, with a census of 52, the facility had two CNAs working the night shift. On 02/15/24 at 2:01 PM, the Clinical Operations Analyst explained the Clinical Operations Analyst did not report an average census and staffing requirements and CMS was able to figure out the staffing requirements for the facility because census staffing needs were not required to be reported to CMS. The facility policy titled Facility Assessment, implemented on 10/25/20, documented the facility assessment would include, at a minimum, the facility's resident populations, staffing needs, physical resources and risk assessments. The facility policy titled Payroll Based Journal (PBJ)-Direct Care Hours Reporting, implemented 10/2022, documented the facility was required to electronically submit timely information to CMS. The reporting must include complete and accurate direct care staffing information, categories of work for each direct care staff member, resident census data and information on direct care turnover and tenure, and hours of care provided by each category of staff per resident per day. The facility policy titled Nursing Services and Sufficient Staff, implemented on 10/2022, documented the facility would provide sufficient staffing to assure resident safety and attain or maintain the highest practicable physical, mental and psychological well-being of each resident. The facility census, acuity and diagnoses of the resident population would be considered based on the facility assessment. The facility would provide a sufficient number of staff on a 24 hour basis to provide nursing care to all residents in accordance with the resident care plans.

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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 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** 49557 Based on observation, interview, clinical record review, and document review the facility failed to ensure physician ordered medications were available and administered for 2 of 5 residents observed for medication administration (Resident #1 and #47) and 1 of 14 sampled residents (Resident #403). Findings include: Resident #1 Resident #1 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side. On 02/15/24 at 8:31 AM, a Licensed Practical Nurse (LPN) administered medications to Resident #1. The LPN explained one of the physician ordered medications, senna, was not available in the facility and was on order from the pharmacy. A physician's order dated 02/09/24 documented senna tablet 8.6 milligrams (mg), give two tablets by mouth every day and at bedtime for constipation. Resident #1's Medication Administration Record (MAR) documented senna 8.6 mg was not administered to Resident #1 during the 9:00 AM med pass on 02/15/24 and was documented as MN. The legend on the MAR indicated a response of MN equated to Medication Not Available. Resident #47 Resident #47 was admitted to the facility on [DATE] with a diagnosis of vitamin d deficiency, unspecified. On 02/14/24 at 8:17 AM, a Licensed Practical Nurse (LPN) administered medications to Resident #47. The LPN explained one of the physician ordered medications, ergocalciferol oral capsule 1.25 mg, was not available in the facility and the LPN would contact the pharmacy. A physician's order dated 01/04/24, with a start date of 01/10/24, documented ergocalciferol oral capsule 1. 25 mg, give one capsule by mouth one time a day every seven days for vitamin d deficiency. Resident #47's Medication Administration Record (MAR) documented ergocalciferol 1.25 mg was not administered to Resident #47 during the 9:00 AM medication pass on 02/14/24 and was documented as MN equated to Medication Not Available. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/20/24 at 2:59 PM, the Director of Nursing (DON) explained the expectation of nursing staff if a medication was not available in the facility was to check the med bank, call the pharmacy to determine when the medication would be delivered, notify the provider of the missed dose, and document in the resident's clinical record. The DON verbalized if the medication unavailable in the facility was a house stock medication, nursing staff were expected to notify the DON and the DON would check alternate med carts in the facility or obtain the medication from a local pharmacy. The DON confirmed the MAR for Resident #1 documented Resident #1 did not receive the physician ordered senna 8.6 mg during the 9:00 AM medication pass on 02/15/24 and the medication was documented as not available. The DON confirmed the MAR for Resident #47 documented Resident #47 did not receive the physician ordered ergocalciferol 1.25 mg during the 9:00 AM medication pass on 02/14/24 and was documented as not available. 50210 Resident #403 Resident #403 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of encounter for orthopedic aftercare following surgical amputation. On 02/12/24 at 11:46 AM, Resident #403 verbalized the resident had not received hydrocodone since admittance on 02/10/24. On 02/12/24 at 3:36 PM, Resident #403 recounted being told the resident was unable to receive hydrocodone-acetaminophen (hydrocodone) because the facility was having trouble getting the medication from the pharmacy. A physician's order dated 02/10/24, with a discontinue date of 02/13/24, documented hydrocodone oral tablet 10-325 milligrams (mg), give one tablet by mouth every four hours as needed for severe pain seven through ten for three days. A physician's order dated 02/13/24, documented hydrocodone oral tablet 10-325 mg, give one tablet by mouth every four hours as needed for moderate to severe pain. Resident #403's MAR dated 02/13/24, lacked documentation for the administration of hydrocodone-acetaminophen 10-325 mg on 02/10/24, 02/11/24, 02/12/24, and 02/13/24. On 02/13/24 at 3:26 PM, a Licensed Practical Nurse (LPN) explained the facility was unable to receive the prescription for Resident #403 because the pharmacy did not sign the order. The LPN verbalized the resident was admitted with an order for hydrocodone, the resident never received the medication, and the active physician's order was not issued until 02/13/24. On 02/13/24 at 3:49 PM, the DON confirmed there was a physician's order for hydrocodone and no hydrocodone administration was documented on the resident's MAR. On 02/13/24 at 4:45 PM, the DON confirmed Resident #403 had not been given hydrocodone since admittance on 02/10/24. The DON explained the DON asked the LPN to administer hydrocodone on 02/12/24. The DON recounted following up with the LPN on 02/13/24 and was told the LPN got busy and forgot to administer the hydrocodone. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carson Nursing and Rehabilitation Center	2898 Highway 50 East Carson City, NV 89701

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Medication Administration, dated 10/15/19, documented medications were administered as ordered by the physician. Cross reference with tag F697, F757, and F760.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50210 Based on interview, clinical record review, and document review, the facility failed to administer pain medication per the physician's order resulting in unnecessary medication administration for 1 of 14 sampled residents (Resident #403). Findings include: Resident #403 Resident #403 was admitted tot the facility on 12/29/22, and readmitted on [DATE], with a diagnosis of encounter for orthopedic aftercare following surgical amputation. On 02/12/24 at 3:38 PM, Resident #403 reported pain to be at a level of nine. On 02/13/24 at 1:16 PM, Resident #403 verbalized being given acetaminophen the morning of 02/13/24 and described pain as high. On 02/13/24 at 1:22 PM the resident pressed the call light and requested pain medication. On 02/13/24 at 3:06 PM the resident confirmed receiving acetaminophen. A physician's order dated 02/10/24, documented acetaminophen tablet 325 milligrams (mg), give two tablets by mouth every six hours as needed for mild pain one through three on the pain scale, not to exceed three grams of acetaminophen in 24 hours. The Medication Administration Record dated 02/20/24, documented the acetaminophen was administered on the following occasions when pain levels were higher than ordered parameters: -On 02/11/24 at 12:01 AM, pain was 8 -On 02/11/24 at 6:57 AM, pain was 8 -On 02/11/24 at 8:50 PM, pain was 6 -On 02/12/24 at 5:32 AM, pain was 6 -On 02/13/24 at 12:30 PM, pain was 7 On 02/13/24 at 3:49 PM, the Director of Nursing (DON) verbalized Resident #403's clinical record documented an average pain of six and eight and the resident had a physician's order documented for the administration of acetaminophen for a pain rating of one through three. The DON confirmed acetaminophen was not an acceptable pain medication to manage the pain level reported by the resident. The facility policy titled Medication Administration, dated 10/15/2019, documented medications were to be administered as ordered by the physician. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cross reference with tag F658, F697, F755 and F760.

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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** 49557 Based on observation, interview, clinical record review, and document review the facility failed to ensure medication was administered with an error rate of less than five percent (%). There were 30 opportunities and three medication errors. The medication error rate was 10%. Findings include: Resident #1 Resident #1 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. On 02/15/24 at 8:31 AM, a Licensed Practical Nurse (LPN) administered medications to Resident #1. The LPN explained one of the physician ordered medications, senna, was not available in the facility and was on order from the pharmacy. A physician's order dated 02/09/24, documented senna tablet 8.6 milligrams (mg), give two tablets by mouth every day and at bed time for constipation. Resident #1's Medication Administration Record (MAR) documented senna 8.6 mg was not administered to Resident #1 during the 9:00 AM med pass on 02/15/24, and was documented as MN. The legend on the MAR indicated a response of MN equated to Medication Not Available. Resident #47 Resident #47 was admitted to the facility on [DATE] with a diagnosis of vitamin d deficiency, unspecified. On 02/14/24 at 08:17 AM, a Licensed Practical Nurse (LPN) administered medications to Resident #47. The LPN explained one of the physician ordered medications, ergocalciferol oral capsule 1.25 milligrams (mg), was not available in the facility. The LPN verbalized the LPN would contact the pharmacy. A physician's order dated 01/04/24, with a start date of 01/10/24, documented ergocalciferol oral capsule 1. 25 mg, give one capsule by mouth one time a day every seven days for vitamin d deficiency. Resident #47's Medication Administration Record (MAR) documented ergocalciferol 1.25 mg was not administered to Resident #47 during the 9:00 AM medication pass on 02/14/24, and was documented as MN. The legend on the MAR indicated a response of MN equated to Medication Not Available. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/20/24 at 2:59 PM, the Director of Nursing (DON) verbalized failing to administer an ordered medication would be a medication error unless there were written parameters to hold the medication. The DON confirmed the MAR for Resident #1 documented Resident #1 did not receive the physician ordered senna 8.6 mg during the 9:00 AM medication pass on 02/15/24 and the medication was documented as not available. The DON confirmed the MAR for Resident #47 documented Resident #47 did not receive the physician ordered ergocalciferol 1.25 mg during the 9:00 AM medication pass on 02/14/24 and was documented as not available. Resident #31 Resident #31 was admitted to the facility on [DATE], and readmitted on [DATE] and 04/04/23, with a diagnosis of vitamin d deficiency, unspecified. On 02/15/24 at 8:20 AM, an LPN administered medications to Resident #31. Medications administered included 1 capsule of vitamin D3 25 micrograms (MCG). The LPN verbalized the resident's order for vitamin D did not contain a dose however the nurses knew to give 25 mcg. A physician's order dated 01/27/24, documented vitamin D3 oral tablet, give one tablet by mouth one time a day for supplement. The physician's order lacked a dose. On 02/15/24 at 2:03 PM, the LPN explained a medication order required the method for administration, dose, indication, and the resident's name. The LPN explained the process if a medication order did not contain all required elements was to call the physician to clarify and get a verbal or telephone order. Resident #31's order for vitamin D3 lacked a dose. The LPN explained the LPN should have contacted the physician to clarify the dose. On 02/20/24 at 11:08 AM, the Director of Nursing (DON) verbalized a medication order was required to contain the medication name, form, strength, directions, dose, route, and frequency. The DON explained the expectation of nursing staff if a medication order did not contain all required elements was to contact the physician for clarification. The DON verbalized a medication error included wrong dose. The DON reviewed the clinical record for Resident #31. The DON confirmed the MAR documented vitamin D3 was administered to the resident on 02/14/24 and the order lacked a dose. The facility policy titled Medication Administration, dated 10/15/19, documented to compare the medication source (bubble pack, vial, etc.) with the MAR to verify resident name, medication name, form, dose, route, and time. The facility policy titled Medication Orders, dated 10/15/19, documented elements of a medication order included dosage. Cross reference with F755

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50210 Based on interview, clinical record review, and document review, the facility failed to ensure a resident admitted for orthopedic aftercare following a surgical amputation had the physician ordered medication available and administered to treat significant pain when the resident experienced significant pain levels and was not administered medication ordered to treat moderate pain for 1 of 14 sampled residents (Resident #403). Findings include: Resident #403 Resident #403 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of encounter for orthopedic aftercare following surgical amputation. On 02/12/24 at 11:46 AM, Resident #403 verbalized the resident had not received hydrocodone since admittance on 02/10/24. On 02/12/24 at 11:46 AM, the resident was seen grimacing in pain. On 02/13/24 at 1:16 PM, Resident #403 verbalized being given acetaminophen the morning of 02/13/24 and described pain as high. On 02/13/24 at 1:22 PM the resident pressed the call light and requested pain medication. On 02/13/24 at 3:06 PM the resident confirmed receiving acetaminophen. On 02/12/24 at 3:36 PM, Resident #403 recounted being told the resident was unable to receive hydrocodone because the facility was having trouble getting the medication from the pharmacy. The resident reported pain at a level of nine. The Medication Administration Record (MAR) dated 02/20/24, documented the acetaminophen was administered on the following occasions when pain levels were higher than ordered parameters: -On 02/11/24 at 12:01 AM, pain was 8 -On 02/11/24 at 6:57 AM, pain was 8 -On 02/11/24 at 8:50 PM, pain was 6 -On 02/12/24 at 5:32 AM, pain was 6 -On 02/13/24 at 12:30 PM, pain was 7 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 02/10/24, documented acetaminophen tablet 325 milligrams (mg), give two tablets by mouth every six hours as needed for mild pain one through three on the pain scale, not to exceed three grams of acetaminophen in 24 hours. A physician's order dated 02/10/24 with a discontinue date of 02/13/24, documented hydrocodone-acetaminophen (hydrocodone) oral tablet 10-325 milligrams (mg), give one tablet by mouth every four hours as needed for severe pain seven through ten for three days. A physician's order dated 02/13/24, documented hydrocodone oral tablet 10-325 mg, give one tablet by mouth every four hours as needed for moderate to severe pain. Resident #403's Medication Administration Record (MAR) dated 02/13/24, lacked documentation for the administration of hydrocodone-acetaminophen 10-325 mg on 02/10/24, 02/11/24, 02/12/24, and 02/13/24. On 02/13/24 at 3:26 PM, a Licensed Practical Nurse (LPN) explained the facility was unable to receive the prescription for Resident #403 because the pharmacy did not sign the order. The LPN verbalized the resident was admitted with an order for hydrocodone, the resident never received the medication, and the active physician's order was not issued until 02/13/24. On 02/13/24 at 3:49 PM, the Director of Nursing (DON) verbalized Resident #403's clinical record documented an average pain of six and eight and the resident had a physician's order documented for the administration of acetaminophen for a pain rating of one through three. The DON confirmed acetaminophen was not an acceptable pain medication to manage the pain level reported by the resident. The DON confirmed there was a physician's order for hydrocodone and no medication administration was documented on the resident's MAR. On 02/13/24 at 4:45 PM, the DON confirmed Resident #403 had not been given hydrocodone since admittance on 02/10/24. The DON explained the DON asked the LVN to administer hydrocodone on 02/12/24. The DON recounted following up with the LVN on 02/13/24 and was told the LVN got busy and forgot to administer the hydrocodone. The facility policy titled Medication Administration, dated 10/15/2019, documented medications were to be administered as ordered by the physician. Cross reference with tag F55 and F757.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 49557 Based on interview and document review, the facility failed to demonstrate effective and knowledgeable administration by not ensuring a policy and process was in place to assess for restraint and risk of entrapment prior to placing residents' beds against the wall (see tags F552, F656, and F689). Findings include: On 02/14/24 at 3:29 PM, the DON verbalized the facility did not use physical restraints. The DON verbalized a restraint was anything impeding a resident's movement or normal access to the resident's body. The DON explained a bed against a wall would be considered a restraint if a full bed rail was present on the open side or if the resident had a stroke and had deficits/weakness on the open side of the bed. The DON confirmed an assessment for risk of entrapment, physician order, care plan and informed consent was required for the use of physical restraints. The DON confirmed, with a bed against a wall, the wall was adjacent to the resident's body while the resident was in bed, could not be easily moved by the resident and restricted the resident's freedom of movement. On 02/14/24 at 3:40 PM, the DON confirmed the facility lacked a policy or formal process regarding placement of beds against the wall and for determining if the bed against the wall restricted movement and acted as a restraint. The DON confirmed if a resident needed to get out of the bed on the side placed against the wall, it would be considered a restraint. On 02/14/24 at 3:42 PM, the DON explained the process the facility had in place to ensure a resident was not restrained upon admission by being placed in a bed positioned against a wall was communication between staff members. The DON confirmed there was not a formal process in place. Regarding how the facility determined appropriateness of beds against the wall and bedrails for residents with cognitive disabilities the DON verbalized, I do not know, I will have to think about that one for a second. The facility policy titled Proper Use of Bed Rails, dated 10/2022, defined a physical restraint as any manual method, physical or mechanical device, equipment, or material which met all the following criteria: Was attached to or adjacent to the resident's body, could not be removed easily by the resident, and restricted the resident's freedom of movement or normal access to the resident's body. The facility policy titled Restraint Policy, revised 10/2017, documented residents would be free from physical restraints not required to treat the resident's medical symptoms. If the use of restraints was indicated, the facility would document ongoing re-evaluation of the need for restraints. The purpose of the policy was to avoid the unnecessary restriction to freedom of movement while facilitating the proper use of a device according to the resident's assessed needs and conditions. Assessment guidelines included but were not limited to safety needs and prior alternatives attempted. Procedure included but was not limited to assessing the resident's need for use of a restraint, identifying the least restrictive option, obtaining a physician's order, developing a comprehensive care plan, and obtaining informed consent. Documentation guidelines included restraint assessment, admission assessment and informed consent.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30748 Based on interview and document review, the facility failed to ensure the Facility Assessment included staffing requirements based on the average census of the facility. Findings include: The Facility assessment dated [DATE], lacked documented evidence for adequate staffing levels related to the average census of the facility. On 02/15/24 at 9:41 AM, the Administrator confirmed the Facility Assessment staffing plans did not include an average census and staffing levels per shift to be able to meet the care needs of each resident. The facility policy titled Facility Assessment, implemented on 10/25/20, documented the facility assessment would include, at a minimum, the facility's resident populations, staffing needs, physical resources and risk assessments.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31739 Based on clinical record review, document review, and interview, the facility failed to complete Medication Administration Records (MAR) for the administration of an anti-diabetic medication, and two antibiotic medications for 1 of 14 sampled residents (Resident #21). Findings include: Resident #21 Resident #21 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, unspecified, bi-polar disorder, unspecified, major depressive disorder, recurrent, unspecified, chronic kidney disease, stage three unspecified, and type II diabetes mellitus with diabetic neuropathy, unspecified. A physician's order dated 09/07/23, documented glipizide tablet, five milligrams (mg). Give one half tablet by mouth one time a day for diabetes. Resident #21's MAR dated September and October 2023 lacked documented evidence the medication had been administered per the physician's order on 09/09/23, 10/05/23, 10/20/23, 10/23/23, 10/26/23, 10/28/23, and 10/31/23. A physician's order dated 11/14/23, documented ciprofloxacin hydrochloride tablet, 250 mg. Give one tablet by mouth every 12 hours for infection for seven days. Resident #21's MAR dated November 2023 lacked documented evidence the medication had been administered per the physician's order for the evening shift on 11/14/23, the morning and evening shifts on 11/15/23, and the morning shift on 11/16/23. A physician's order dated 01/18/24, documented cefdinir capsule 300 mg. Give one capsule by mouth two times a day for infection for ten days. Resident #21's MAR dated January 2024 lacked documented evidence the medication had been administered per the physician's order for the evening shift on 01/24/24, and the evening shift on 01/26/24. On 02/20/24 at 8:28 AM, the Director of Nursing (DON), confirmed Resident #21's MAR dated September and October 2023 lacked documented evidence the glipizide medication had been administered per the physician's order on 09/09/23, 10/05/23, 10/20/23, 10/23/23, 10/26/23, 10/28/23, and 10/31/23. The DON confirmed Resident #21's MAR dated November 2023 lacked documented evidence the ciprofloxacin hydrochloride medication had been administered per the physician's order for the evening shift on 11/14/23, the morning and evening shifts on 11/15/23, and the morning shift on 11/16/23. The DON confirmed Resident #21's MAR dated January 2024 lacked documented evidence the cefdinir medication had been administered per the physician's order for the evening shift on 01/24/24, and the evening shift on 01/26/24. The DON verbalized it was the DON's expectation nursing staff were to document in the resident's clinical record the administration of a medication at the time of administration. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled, Medication Administration, dated 10/15/19, documented upon administration of a medication, nursing staff were to document in the resident record and sign the electronic MAR after administration.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 30748 Based on interview and document review, the facility failed to accurately report staffing requirements to adequately cover resident population of care during weekends documented on the payroll-based journal (PBJ) requirements submitted to Center for Medicare and Medicaid Services (CMS). Findings include: Review of the facility Certification and Survey Provider Enhanced Reporting System (CASPER) the facility had excessively low weekend staffing for the months of July 2023, August 2023, and September 2023. A Staffing Plan, undated, documented the facility would require 3 licensed nurses for the day shift and a 1:12 ratio for CNA coverage during the day. Facility nursing schedules and timesheets documented the facility lacked adequate staffing coverage on the following dates during the day shift: -July 1, 2023, with a census of 51, the facility had two Certified Nursing Assistants (CNA) working the day shift. -July 2, 2023, with a census of 51, the facility had three CNAs working the day shift. -July 8, 2023, with a census of 52, the facility had three CNAs working the day shift. -July 9, 2023, with a census of 52, the facility had three CNAs working the day shift. -July 15, 2023, with a census of 50, the facility had 2 CNAs working the day shift. -August 5, 2023, with a census of 53, the facility had two Licensed Practical Nurses (LPN) working the day shift. -August 6, 2023, with a census of 52, the facility had two LPNs working the day shift. -August 12, 2023, with a census of 49, the facility had two LPNs working the day shift. -August 13, 2023, with a census of 49, the facility had two LPNs working the day shift. -August 26, 2023, with a census of 58, the facility had four CNAs working the day shift. -August 27, 2023, with a census of 56, the facility had four CNAs working the day shift. -September 2, 2023, with a census of 53, the facility had two LPNs working the day shift. -September 3, 2023, with a census of 53, the facility had three CNAs working the day shift. (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-September 23, 2023, with a census of 50, the facility had two CNAs working the day shift. A Staffing Plan, undated documented the facility would require two licensed nurses for night shift and a 1:16 ratio for CNA coverage for the night shift. Facility nursing schedules and timesheets documented the facility lacked adequate staffing coverage on the following dates during the night shift: -July 30, 2023, with a census of 52, the facility had two CNAs working the night shift. On 02/14/24 at 1:27 PM, the Administrator explained the Payroll Clerks were responsible for PBJ reporting to CMS. On 02/15/24 at 2/15/24, the Payroll Clerk 1 verbalized not being trained on the PBJ staffing reporting requirements and was not sure if staff were reviewing any information prior to being reported to CMS. On 02/15/24 at 8:05 AM, the Payroll Clerk 2 explained when reporting PBJ to CMS, the facility reported hours, staffing reports and therapy reports. The Payroll Clerk 2 was unsure if an average census per staff calculation was to be submitted to CMS. On 02/15/24 at 9:41 AM, the Administrator verbalized the facility assesses staffing levels and capabilities to determine proper staffing levels per shift and was not sure if the staffing requirements were accurately reported to CMS. In addition, the Staffing Plan provided to the survey team was not a part of the Facility Assessment and should have been to accurately reflect the staffing needs for the facility. On 02/15/24 at 2:01 PM, the Clinical Operations Analyst explained the Clinical Operations Analyst was responsible for reporting PBJ to CMS, however did not report CMS requirements for the PBJ report. The Clinical Operations Analyst verbalized not reporting an average census and staffing requirements and CMS was able to figure out the staffing requirements for the facility because census staffing needs were not required to be reported to CMS. The facility policy titled Payroll Based Journal (PBJ)-Direct Care Hours Reporting, implemented 10/2022, documented the facility was required to electronically submit timely information to CMS. The reporting must include complete and accurate direct care staffing information, categories of work for each direct care staff member, resident census data and information on direct care turnover and tenure, and hours of care provided by each category of staff per resident per day.

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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. 31739 Based on observation, clinical record review, document review, and interview, the facility's Quality Assurance and Performance Improvement (QAPI)/Quality Assessment and Assurance (QAA) Committee failed to identify, develop and implement plans of action for systemic issues related to beds placed against the walls for 37 of 49 residents (Resident #21, #38, #22, #1, #31, #32, #26, #2, #29, #153, #36, #37, #25, #42, #18, #7, #34, #28, #19, #39, #47, #303, #305, #306, #307, #308, #3, #12, #13, #20, #27, #40, #45, #354, #355, #403, and #404), the use of enhanced barrier precautions, and wound care. Findings include: Beds Against the Wall On 02/14/24 at 4:21 PM, during a tour of the facility, Resident #21, #38, #22, #1, #31, #32, #26, #2, #29, #153, #36, #37, #25, #42, #18, #7, #34, #28, #19, #39, #47, #303, #305, #306, #307, #308, #3, #12, #13, #20, #27, #40, #45, #354, #355, #403, and #404's beds were against the wall. On 02/20/24 at 4:18 PM, the Executive Director verbalized the facility had not identified or developed a plan for resident beds against the wall. The Executive Director verbalized the QAPI Committee included a Safety Sub-Committee and the Safety Sub-Committee mostly discussed employee safety in the QAPI Committee meetings. On 02/20/24 at 4:22 PM, the Director of Nursing (DON), confirmed the QAPI Committee had not identified or developed a plan for resident beds against the wall. The DON verbalized the Safety Sub-Committee had to assist in identifying and making recommendations to improve resident safety and to monitor implemented improvements. The facility's Quality Assurance Performance Improvement (QAPI) Plan revised January 2024, documented in section 1.6.3, the definition of a resident safety event was an adverse or potentially adverse event, and the Safety Plan was to improve the safety of residents and reduce preventable resident safety events. Section 1. 6.3 documented the Safety Committee would make recommendations to improve patient safety and monitor implementation of corrective actions. The QAPI Plan documented the QAPI Committee would oversee the work of all quality improvement sub-committees. Enhanced Barrier Precautions The Resident Matrix dated 02/12/24, documented one resident with a wound infection, two residents with a urinary tract infection, one resident with a Multidrug-resistant organism and pneumonia, one resident with viral hepatitis, and four residents with indwelling catheters. On 02/12/24 at 7:30 AM, the facility lacked any enhanced barrier precautions in place. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/20/24 at 4:23 PM, the DON confirmed the QAPI Committee had not identified or developed a plan for enhanced barrier precautions related to resident infections and had not completed enhanced barrier precautions training to staff members. Wounds Resident #2 and #403 were admitted with pressure injuries. The resident's clinical records lacked documented evidence wound care orders had been obtained at the time of admission. On 02/20/24 at 4:28 PM, the DON confirmed the QAPI Committee had not identified any issues with wound care orders or developed a plan for ensuring wound care orders were obtained upon admission. The DON verbalized treatment of a wound required an order be obtained prior to treatment. The facility's Quality Assurance Performance Improvement (QAPI) Plan revised January 2024, documented the QAPI Program objectives was to coordinate quality improvement activities and resident safety and develop monitoring tools to provide each resident the necessary care and services to attain their highest practical physical, mental, and psychosocial well-being.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 31739 Based on document review and interview the facility failed to maintain the required Quality Assurance and Performance Improvement (QAPI)/Quality Assessment and Assurance (QAA) committee members to include the Medical Director. Findings include: The QAPI Committee meeting attendee's sheets dated 10/27/23 and 11/22/23 lacked documented evidence the Medical Director had participated. On 02/20/24 at 4:14 PM, the Director of Nursing (DON), verbalized the facility did not hold a QAPI Committee meeting in December 2023. The DON confirmed the Medical Director had not participated in the QAPI Committee meetings held on 10/27/23 and 11/22/23. The DON confirmed the meetings for the last quarter of 2023 should have included the Medical Director or the Medical Director's designee. On 02/20/24 at 4:30 PM, the Executive Director verbalized it was difficult to get a hold of the Medical Director during the last months of 2023 and confirmed the Medical Director had not participated in the QAPI Committee meetings held on 10/27/23 or 11/22/23. The facility's Quality Assurance Performance Improvement (QAPI) Plan revised January 2024, documented the QAPI Committee shall consist if the Executive Director, the Director of Nursing, the Medical Director, facility staff, and external consultants.

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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** 43310 Based on observation, interview and document review, the facility failed to ensure 1) the facility's Infection Prevention and Control Plan (IPCP) was reviewed and/or updated annually to included current infection control standards and 2) a Licensed Practical Nurse (LPN) did not perform a finger stick/ blood sugar (FSBS) for one unsampled resident (Resident #19) while the resident was seated at a table in the community dining room. Findings include: Infection Prevention and Control Plan The facility policy titled Infection Prevention and Control Plan documented the IPCP was last reviewed on 10/19/22. The policy lacked documented evidence the policy was updated and/or reviewed at any time after 10/19/22. The policy failed to address the following infection prevention and control concerns: -The different types of transmission-based precautions (TBP) and how they should be utilized including personal protective equipment (PPE) selection, hand hygiene, and cohorting. -Environmental cleaning and disinfection including routine cleaning and disinfection of high touch areas, visibly soiled surfaces, resident rooms including after discharge, and cleaning of items such as privacy curtains. -The routine cleaning and disinfection of resident care equipment including blood pressure cuffs, therapy equipment, and glucometers. -A list of reportable communicable diseases, a system for communicating concerns related to communicable diseases withing the facility, and a process for reporting the communicable diseases to local and/or state agencies. -A process for monitoring staff illnesses, reporting as indicated, and work restrictions per nationally recognized standards and practices. On 02/15/24 at 12:12 PM, the Director of Nursing (DON) confirmed the policy provided was the most current version of the policy, was last reviewed on 10/19/22, and should have been reviewed on or before 10/19/23. The facility policy titled Infection Prevention and Control Plan, last reviewed 10/19/22, documented the facility conducted an annual review of the IPCP. Following review, the IPCP was updated as necessary. Resident #19 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #19 was admitted to the facility on [DATE], with diagnoses including type II diabetes mellitus without complications, acute kidney failure, unspecified, and chronic obstructive pulmonary disease, unspecified. On 02/15/24 at 12:05 PM, an LPN approached Resident #19 in the B Station dining room and performed an FSBS at the dining room table. The glucometer was placed on the table without a barrier. After performing the finger stick the nurse placed the used lancet on the dining room table and transferred the blood sample from the resident's finger to the glucometer strip. The Glucometer was placed back on the table with the test strip/blood sample in place. The LPN gathered the glucometer, test strip/blood sample and lancet from the dining table and walked away from the dining area. The nurse did not disinfect the glucometer or the dining room table. On 02/15/24 at 12:07 PM, the LPN confirmed the nurse checked Resident #19's FSBS at a dining room table in the B Wing dining room. The LPN confirmed the LPN placed the glucometer and lancet on the table and did not disinfect the table afterwards. The LPN explained placing the glucometer and lancet on the table could lead to the transmission of infections in the facility. On 02/15/24 at 12:55 PM, the Director of Nursing (DON) verbalized the expectation was FSBS would not be performed in common areas of the facility to maintain infection control standards and preserve the resident's dignity. The DON confirmed FSBS should not occur in common areas. On 02/15/24 at 12:56 PM, the Infection Preventionist (IP) confirmed the standard of practice was glucometers would be disinfected between each use. FSBS were not to be performed in common areas, including the dining areas, and confirmed when the glucometer and the used lancet were placed on the dining room table, the table should have been disinfected. The facility policy titled Glucose Meter, Cleaning/Disinfecting, dated 12/2017, documented the exterior of the glucometer and strip housing were to be disinfected after each use with an EPA registered hospital grade disinfectant. The facility policy titled Infection Prevention and Control Program, dated 10/19/22, documented all staff were to assume each resident was potentially infected or colonized with an organism which could be transmitted during the course of providing care. Licensed staff adhered to safe injection and medication administration practices.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 43310 Based on document review and interview, the facility failed to ensure the Antibiotic Stewardship Program (ASP) policy was reviewed and/or update annually with the potential to affect the facility's entire resident census of 49. The facility policy titled Antibiotic Stewardship Program (ASP), last reviewed 11/2017, lacked documented evidence the policy was reviewed and/or updated annually. The policy did not include the following items. -A process for trending and reporting staff and resident infections. -A process for communicating information at the time of transfer when a resident had an infection or was colonized. -A process for surveillance including outcomes such as SHEA's criteria. On 02/15/24 at 12:12 PM, the Director of Nursing (DON) confirmed the policy provided was the most current version of the policy and was last reviewed 11/2017. The DON confirmed the policy should have been reviewed annually. The facility policy titled Antibiotic Stewardship Program (ASP), last reviewed 11/2017, documented the ASP policy would be reviewed annually and as needed.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310 Based on clinical record review, interview, and document review the facility failed to ensure 1 of 5 residents sampled for vaccinations (Resident #12) was screened for eligibility to receive an influenza vaccine, education regarding the vaccine was provided to the resident and/or the Resident Representative, and the vaccine was offered and either administered or declined. Findings include: Resident #12 Resident #12 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease, unspecified, chronic respiratory failure, unspecified whether with hypoxia or hypercapnia, age related physical debility, and adult failure to thrive. Resident #12's clinical record lacked documented evidence the resident was screened in 2023 for eligibility to receive influenza vaccine, education regarding the vaccine was provided to Resident #12 and/or the resident's representative, and the vaccine was either administered or declined. Resident #12's state immunization record downloaded and printed on 02/13/24 at 1:31 PM, by the facility, documented the resident last received an influenza vaccine on 10/21/19. The resident's state immunization record lacked documented evidence the resident was administered an influenza vaccine during the 2023/2024 influenza season. On 02/15/24 at 12:20 PM, the Director of Nursing (DON) recalled Resident #12 had requested to be administered an influenza vaccine and confirmed the vaccine was not administered for the 2023/2024 influenza season. The facility was not able to provide documented evidence the resident was screened for eligibility to receive the vaccine, education related to the vaccine was provided, and the resident either received or declined the vaccine. The facility policy titled Influenza Vaccination, revised on 10/22/22, documented influenza vaccinations were routinely offered annually from October 1st through March 31st, unless the vaccine was medically contraindicated, the individual had already been vaccinated, or declined to receive the vaccine. Prior to being vaccinated the resident and/or the resident's representative were provided with a copy of the Centers for Disease Control and Prevention's (CDC) current vaccine information statement (VIS). A consent form was signed by the resident or resident representative prior to the administration of the vaccine and filed in the resident's clinical record. The resident's clinical record included documentation the resident and/or the resident's representative was provided education regarding the risk and benefits of the vaccine and if the resident received or did not receive the vaccine. If the vaccine was not administered the reason such as medically contraindicated or declined by the resident was documented in the resident's clinical record.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 43310 Based on clinical record review, interview, and document review the facility failed to ensure a Certified Nursing Assistant (CNA) was screened for eligibility to receive a COVID-19 (COVID) booster vaccine, education regarding the vaccine was provided, and the vaccine was offered and either administered or declined. Findings include: Employee #1 was hired as a CNA on 10/09/22. Employee #1's COVID-19 Vaccination Record Card documented Employee #1 was administered a COVID vaccine on 02/01/21 and 02/22/21. Employee #1's personnel record documented the CNA received a COVID vaccine on 02/21/21 and 02/22/21. The facility was not able to provide documented evidence Employee #1 was screened for eligibility to receive the most recent COVID vaccine, provided education regarding the vaccine, and if the vaccine was offered and administered or declined. The facility policy titled COVID-19 Vaccination Program, dated 08/2023, documented the facility maintained an immunization program against COVID-19 disease in accordance with national standards of practice, and offered COVID vaccinations approved for current use. The facility educated and offered the COVID vaccine to staff. The facility maintained documentation related to staff COVID vaccinations including the following: -Education regarding risk, benefits, and potential side effects of COVID vaccines, -The COVID vaccination offered or information on obtaining COVID vaccine, -The COVID vaccination status of staff and related information as indicated by the National Healthcare Safety Network (NHSN), -Signed consent forms for COVID vaccination. A CDC document titled Staying Up to Date with COVID-19 Vaccines, last updated on 01/18/24, documented as of 09/12/23, the 2023-2024 updated Pfizer-BioNTech and Moderna COVID vaccines were recommended for use in the United States, and as of 10/03/23, the 2023-2024 updated Novavax vaccine was recommended by the CDC for use in the United States. The 2023-2024 updated COVID vaccines more closely targeted the XBB lineage of the Omicron variant and could restore protection against severe COVID that may have decreased over time. Individuals aged [AGE] years and older who were vaccinated with COVID vaccines prior to 09/12/23, should get one updated Pfizer-BioNTech, Moderna or Novavax COVID vaccine.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 30748 Based on personnel record review, interview and document review, the facility failed to ensure communications training was completed by staff for 20 of 20 sampled employees (Employee #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20). Findings include: Employee #1 Employee #1 was hired as the Administrator on 07/31/23. Employee #1's personnel record lacked documented evidence of communication training. Employee #2 Employee #2 was hired as the Director of Nursing (DON) on 07/07/20. Employee #2's personnel record lacked documented evidence of communication training. Employee #3 Employee #3 was hired as the Activity Manager on 09/28/20. Employee #3's personnel record lacked documented evidence of communication training. Employee #4 Employee #4 was hired as the Registered Dietician on 02/20/23. Employee #4's personnel record lacked documented evidence of communication training. Employee #5 Employee #5 was hired as the Assistant Social Worker on 08/22/23. Employee #5's personnel record lacked documented evidence of communication training. Employee #6 Employee #6 was hired as the Dietary Manager on 11/09/23. Employee #6's personnel record lacked documented evidence of communication training. Employee #7 (continued on next page)

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employee #7 was hired as a Certified Nursing Assistant (CNA) on 12/05/22. Employee #7's personnel record lacked documented evidence of communication training. Employee #8 Employee #8 was hired as a CNA on 09/16/22. Employee #8's personnel record lacked documented evidence of communication training. Employee #9 Employee #9 was hired as a CNA on 05/30/18. Employee #9's personnel record lacked documented evidence of communication training. Employee #10 Employee #10 was hired as the Minimum Data Set (MDS) Coordinator, Registered Nurse (RN). Employee #10's personnel record lacked documented evidence of communication training. Employee #11 Employee #11 was hired as the Wound Care Nurse, Licensed Practical Nurse (LPN) on 01/18/12. Employee #11's personnel record lacked documented evidence of communication training. Employee #12 Employee #12 was hired as the Infection Preventionist on 09/07/23. Employee #12's personnel record lacked documented evidence of communication training. Employee #13 Employee #13 was hired as an RN on 08/03/23. Employee #13's personnel record lacked documented evidence of communication training. Employee #14 Employee #14 was hired as an LPN on 11/09/23. Employee #14's personnel record lacked documented evidence of communication training. Employee #15 (continued on next page)

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employee #15 was hired as an LPN on 08/01/23. Employee #15's personnel record lacked documented evidence of communication training. Employee #16 Employee #16 was hired as a CNA on 12/26/23. Employee #16's personnel record lacked documented evidence of communication training. Employee #17 Employee #17 was hired as a CNA on 10/10/23. Employee #17's personnel record lacked documented evidence of communication training. Employee #18 Employee #18 was hired as a Cook on 01/09/24. Employee #18's personnel record lacked documented evidence of communication training. Employee #19 Employee #19 was hired as a Dietary Aide on 12/05/23. Employee #19's personnel record lacked documented evidence of communication training. Employee #20 Employee #20 was hired as a Housekeeper on 04/10/22. Employee #20's personnel record lacked documented evidence of communication training. The Facility Assessment, last reviewed on 01/17/24, lacked documented evidence of staff completing communication training nor a plan for communication training. On 02/20/24 at 2:34 PM, the Business Office Manager verbalized all staff were required to take communication training upon hire and as needed and acknowledged the training was required to effectively be able to communicate with residents having communication deficits. The Business Office Manager confirmed Employee #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20 did not receive communications training. The facility policy titled Covenant Care Employee Training Requirements: State & Federal Mandatory in-services, last updated 12/2022, documented all staff were required to take Effective Communications training to be able to demonstrate competency and skills necessary for resident care and the training would reflect the needs of residents and staff to correlate with the facility assessment.

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	295023	A. Building B. Wing	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carson Nursing and Rehabilitation Center	2898 Highway 50 East Carson City, NV 89701

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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 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 49557 Based on personnel record review, interview, and document review the facility failed to ensure resident rights training was completed timely for 2 of 20 sampled employees (Employee #4 and #12). Findings include: Employee #4 Employee #4 was hired as the Registered Dietician on 02/20/23. Employee #4's personnel record documented resident rights training was completed on 06/05/23. Employee #12 Employee #12 was hired as the Infection Preventionist on 09/07/23. Employee #12's personnel record documented resident rights training was completed on 09/14/23. On 02/20/24 at 2:34 PM, the Business Office Manager verbalized resident rights training was required for all staff one time, upon hire. The Business Office Manager confirmed Employees #4 and #12 did not complete resident rights training in time. The facility policy titled Resident Rights, dated 10/2022, documented the facility would ensure all direct care staff and indirect care staff members were educated on the rights of residents and the responsibility of the facility to properly care for its residents. The facility document titled Covenant Care Employee Training Requirements, updated 12/2022, documented training programs for new/existing staff, contractors, and volunteers included but was not limited to the following required topic: resident rights and facility responsibilities.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 40377 Based on personnel record review, interview, and document review, the facility failed to ensure elder abuse training was completed timely for 3 of 20 sampled employees (Employee #4, #9, and #30). Findings include: Employee #4 Employee #4 was hired as the Registered Dietitian with a start date of 02/20/23. Employee #4's personnel record documented elder abuse prevention training was completed on 06/05/23. Employee #9 Employee #9 was hired as a Certified Nursing Assistant with a start date of 05/30/18. Employee #9's personnel record lacked documented evidence elder abuse prevention training was completed for 2023. Employee #30 Employee #30 was hired as a Laundry Aide with a start date of 07/11/23. Employee #30's personnel record lacked documented evidence elder abuse prevention training was completed. On 02/14/24 at 2:23 PM, the Human Resources Payroll Clerk verbalized elder abuse training was to be completed in employee orientation and annually thereafter. The Payroll Clerk confirmed Employees #4, #9, and #30 lacked timely elder abuse prevention training. The facility policy titled Abuse: Prevention, Intervention, Investigation and Crime Reporting, dated 10/09/14, documented upon hire and annually, and additionally if determined appropriate by facility management, employee's will be provided training on the following topics such as: - facility abuse prevention, intervention, investigation and criminal reporting policy - what constitutes abuse, neglect, involuntary seclusion, and misappropriation of resident property - employee's responsibility as a mandated reporter.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 30748 Based on interview and document review, the facility failed to ensure Quality Assurance Performance Improvement (QAPI) training had been completed to include objectives of resident care needs for 11 of 20 sampled employees (Employee #1, #4, #7, #11, #12, #13, #15, #16, #17, #18, and #20) Findings include: Employee #1 Employee #1 was hired as the Administrator on 07/31/23. Employee #1's personnel record lacked documented evidence QAPI training had been completed. Employee #4 Employee #4 was hired as the Registered Dietician on 02/20/23. Employee #4's personnel record lacked documented evidence QAPI training had been completed. Employee #7 Employee #7 was hired as a Certified Nursing Assistant (CNA) on 12/05/22. Employee #7's personnel record lacked documented evidence QAPI training had been completed. Employee #11 Employee #11 was hired as the Wound Care Nurse, Licensed Practical Nurse (LPN) on 01/18/12. Employee #11's personnel record lacked documented evidence QAPI training had been completed. Employee #12 Employee #12 was hired as the Infection Preventionist on 09/07/23. Employee #12's personnel record lacked documented evidence QAPI training had been completed. Employee #13 Employee #13 was hired as a Registered Nurse (RN) on 08/03/23. Employee #13's personnel record lacked documented evidence QAPI training had been completed. Employee #15 (continued on next page)

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employee #15 was hired as a LPN on 08/01/23. Employee #15's personnel record lacked documented evidence QAPI training had been completed. Employee #16 Employee #16 was hired as a CNA on 12/26/23. Employee #16's personnel record lacked documented evidence QAPI training had been completed. Employee #17 Employee #17 was hired as a CNA on 10/10/23. Employee #17's personnel record lacked documented evidence QAPI training had been completed. Employee #18 Employee #18 was hired as the Cook on 01/09/24. Employee #18's personnel record lacked documented evidence QAPI training had been completed. Employee #20 Employee #20 was hired as a Housekeeper on 04/10/22. Employee #20's personnel record lacked documented evidence QAPI training had been completed. On 02/20/24 at 2:34 PM, the Business Office Manager verbalized all staff were required to take QAPI training only once, upon hire. The Business Office Manager confirmed Employee #1, #4, #7, #11, #12, #13, #15, #16, #17, #18, and #20 lacked required QAPI training. The facility policy titled Covenant Care Employee Training Requirements: State & Federal Mandatory in-services, last updated 12/2022, documented all staff were required to take QAPI training. The facility policy titled QAPI Plan, last revised January 2024, documented all staff were required to take QAPI training during new hire orientation and annually thereafter. The training provided would cover how to access the committee for quality concerns or to make recommendations for quality improvement projects.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 30748 Based on interview and document review, the facility failed to provide timely infection control training to all staff to ensure proper procedures and standards of the program for 3 of 20 sampled employees (Employee #4, #6, and #12). Findings include: Employee #4 Employee #4 was hired as the Registered Dietician on 02/20/23. Employee #4's personnel record lacked documented evidence of infection control training for 2023. Employee #6 Employee #6 was hired as the Dietary Manager on 11/09/23. Employee #6's personnel record documented infection control training completed on 11/10/23, a day late. Employee #12 Employee #12 was hired as the Infection Preventionist on 09/07/23. Employee #12's personnel record documented infection control training completed on 09/14/23, seven days late. On 02/20/24 at 2:34 PM, the Business Office Manager verbalized all staff were required to complete infection control training upon hire. The Business Office Manager confirmed Employees #4, #6 and #12 did not complete infection control training timely. The facility policy titled Covenant Care Employee Training Requirements: State & Federal Mandatory in-services, last updated 12/2022, documented all direct care staff were required to take sufficient infection control training and be able to demonstrate competency and skills necessary for infection control.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. 49557 Based on personnel record review, interview, and document review the facility failed to ensure compliance and ethics training was completed timely for 5 of 20 sampled employees (Employee #2, #3, #4, #9, and #20). Findings include: Employee #2 Employee #2 was hired as the Director of Nursing on 07/07/20. Employee #2's personnel record lacked documented evidence of compliance and ethics training. Employee #3 Employee #3 was hired as the Activity Manager on 09/28/20. Employee #3's personnel record documented compliance and ethics training was completed on 02/20/23. Employee #4 Employee #4 was hired as the Registered Dietician on 02/20/23. Employee #4's personnel record lacked documented evidence of compliance and ethics training. Employee #9 Employee #9 was hired as a Certified Nursing Assistant on 05/30/18. Employee #9's personnel record documented compliance and ethics training was completed on 04/09/19. Employee #20 Employee #20 was hired as a Housekeeper on 04/10/22. Employee #20's personnel record lacked documented evidence of compliance and ethics training. On 02/20/24 at 2:34 PM, the Business Office Manager verbalized compliance and ethics training was required for all staff one time, upon hire. The Business Office Manager confirmed Employee #2, #3, #4, #9, and #20 did not complete compliance and ethics training timely. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility document titled Covenant Care Employee Training Requirements, updated 12/2022, documented training programs for new/existing staff, contractors, and volunteers included but was not limited to the following required topic: compliance and ethics.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 49557 Based on personnel record review, interview, and document review the facility failed to ensure behavioral health training was completed for 7 of 20 sampled employees (Employee #1, #3, #4, #6, #10, #12, and #16). Findings include: Employee #1 Employee #1 was hired as the Executive Director on 07/31/23. Employee #1's personnel record lacked documented evidence of behavioral health care training. Employee #3 Employee #3 was hired as the Activity Manager on 09/28/20. Employee #3's personnel record lacked documented evidence of behavioral health care training. Employee #4 Employee #4 was hired as the Registered Dietician on 02/20/23. Employee #4 's personnel record lacked documented evidence of behavioral health care training. Employee #6 Employee #6 was hired as the Dietary Manager on 11/09/23. Employee #6's personnel record lacked documented evidence of behavioral health care training. Employee #10 Employee #10 was hired as the Minimum Data Set (MDS) Coordinator, Registered Nurse on 07/25/22. Employee #10's personnel record lacked documented evidence of behavioral health care training. Employee #12 Employee #12 was hired as the Infection Preventionist (IP) on 09/07/23. Employee #12's personnel record lacked documented evidence of behavioral health care training. Employee#16 (continued on next page)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employee#16 was hired as a Certified Nursing Assistant (CNA) on 12/26/23. Employee#16's personnel record lacked documented evidence of behavioral health care training. On 02/20/24 at 2:34 PM, the Business Office Manager verbalized behavioral health training was required for all staff. The Business Office Manager confirmed Employees #1, #3, #4, #6, #10, #12, and #16 did not receive behavioral health training. The facility document titled Covenant Care Employee Training Requirements, updated 12/2022, documented training programs for new/existing staff, contractors, and volunteers included but was not limited to the following required topic: behavioral health.