STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295029	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Pine Care Center	1500 Avenue G Ely, NV 89301

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on interview, record review, and review of the RAI (Resident Assessment Instrument) manual, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessment for 1 of 17 sampled residents (Resident (R) 5). The facility failed to accurately assess a fall with injury and this failure placed R5 at risk of having unmet care needs and a diminished quality of life. Findings include: The RAI Manual 3.0, dated 10/23, revealed .If an MDS assessment is found to have errors that incorrectly reflect the resident's status, then that assessment must be corrected . R5's Admission Record provided by the Director of Nursing (DON), revealed R5 was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease. The quarterly MDS, with an Assessment Reference Date (ARD) of 02/12/24, revealed R5 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated the resident was severely impaired in cognition and had no falls since the previous assessment. Review of a Transfer to Hospital Summary, dated 01/17/24, revealed R5 was found on the floor mat with a small laceration on the top of head. On 04/18/24 at 8:43 AM, the DON was asked if the quarterly MDS coding was accurate for falls. The DON stated, It was a coding error.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2024
NAME OF PROVIDER OR SUPPLIER White Pine Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 Avenue G Ely, NV 89301	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on observations, interviews, record review, review of the Resident Assessment Instrument (RAI) Manual, and facility policy review, the facility failed to ensure that 1 of 17 sampled residents (Resident (R) 10) had a comprehensive care plan developed that addressed communication needs and failed to ensure 2 of 17 sampled residents (R19 and R28) had a comprehensive care plan developed that addressed nutrition. The deficient practices placed the residents at risk for not receiving appropriate patient centered care. Findings include: Review of the Long-term Care Facility Resident Assessment Instrument 3.0 User's Manual, revised October 2023, revealed, Chapter 4: Care Area Assessment (CAA) Process and Care Planning, 4.1 Background and Rationale .Regulations require facilities to complete, at a minimum and at regular intervals, a comprehensive, standardized assessment of each resident's functional capacity and needs, in relation to a number of specified areas (e.g., customary routine, vision, and continence). The results of the assessment, which must accurately reflect the resident's status and needs, are to be used to develop, review, and revise each resident's comprehensive plan of care. Resident 10 (R10) R10's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/31/24, revealed R10 had an admitted [DATE]. R10 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating R16 had moderate cognitive impairment and diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, stroke, and aphasia. R10's Care Area Assessment (CAA) Summary with an ARD date of 01/31/24, revealed 4. Communication triggered for a care plan. R10's Personal Directives for Quality of Living, dated 01/29/24 documented, I want my care partners to know A. I communicate better with pictures and A Good Day for me would be (things I value about my day) F. unable to answer. R10's care plan, dated 02/01/24, revealed R10's Personal Directives for Quality of Living, with an intervention that documented, I want my Care Partners to know I communicate better with photos. No care plan was found addressing R10's communication deficit that included measurable objectives and timeframes. On 04/18/24 at 12:23 PM, R10 was sitting in the wheelchair in the resident's room watching TV. R10 was asked questions about lunch and R10 was having difficulty communicating. R10 was then asked if the resident had a communication board with pictures to make communication easier and R10 said, no. R10 was then asked if the resident would like one and responded yes. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/18/24 at 12:39 PM, Social Services Designee (SSD) was asked who was responsible for care planning communication. SSD stated either nursing, social services, or activities. SSD reviewed the EMR and confirmed there was no care plan addressing R10's communication deficit that included measurable objectives and timeframes. On 04/19/24 at 11:59 AM, Director of Nursing (DON) was asked who developed the care plans. DON stated the MDS coordinator, but the coordinator was unavailable. DON was asked if there was a care plan addressing R10's communication deficit as the MDS triggered for a care plan. DON reviewed the EMR and the CAA and confirmed it should have been fully care planned. Resident 19 (R19) Review of the Admission Record, provided by the DON, revealed R19 was admitted to the facility on [DATE] with diagnoses that included dehydration, urinary tract infection, and diarrhea. A Nutrition/Dietary Note, dated 03/15/24 revealed, .Diet: NAS [no added salt], chopped meat, thin liquids . Able to feed self with tray set-up. No swallowing issues noted .Allergies; citrus products, strawberry, tomato, turkey . A Nutrition/Dietary Note, dated 03/17/24 revealed, .Pt. requested soft and bite sized texture, allow bread-pref (sic) for white bread; rt [related to] chewing difficulties, missing teeth. Requested ice cream .No seeds/nuts rt diverticulitis (an inflammation in the colon) . The admission MDS with an ARD of 03/19/24, revealed R19 had a BIMS score of 13 out of 15 which indicated R19 was cognitively intact. The admission MDS titled, CAA (Care Area Assessment) determined that nutrition was triggered and that a care plan would be developed. Review of the Comprehensive Care Plan revealed no Nutrition Care Plan was developed. On 04/16/24 at 2:57 PM, R19 stated, The food is good, but it's my diet. I don't think I am served food that meets my sensitive stomach. On 04/18/24 at 2:15 PM, the Registered Dietician (RD) was asked if the RD was responsible for developing the Nutrition Care Plan. The RD stated, no, it would be the CDM (Dietary Manager-DM). On 04/18/24 at 2:31 PM, the DM was asked if the DM was responsible for developing the Nutrition Care Plan. The DM stated, yes, I do the care plans. The DM was asked if a Nutrition Care Plan had been developed for R19. The DM confirmed that there was no Nutrition Care Plan for R19. Resident 28 (R28) R28's Admission Record, undated, indicated R28 was admitted to the facility on [DATE] with diagnoses of acute hepatitis C without hepatic coma, colon and rectal cancer, and diabetes. R28's Care Plan revealed R28's comprehensive care plan dated 09/22/23, did not include prevention for weight loss, refusals of meals or interventions to prevent weight loss. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/18/24 at 2:15 PM, the RD stated the RD does not implement, complete or revise care plans for nutritional issues and that was completed by the DM. The RD also stated would not be aware if the care plan did not include nutritional concerns. On 04/18/24 at 3:00 PM, the DM confirmed was responsible for resident care plans related to nutritional issues but was unable to state why R28 did not have care plan interventions for weight loss. 36190 36461

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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** 25232 Based on observations, interviews, record review, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure one resident (Resident (R) 13) reviewed for range of motion (ROM) and nutrition, had the care plans revised, and one resident (R5) reviewed for falls, had the care plan revised out of 17 sampled residents. The deficient practices placed the residents at risk for not receiving the care based upon their needs. Findings include: Review of the Long-term Care Facility Resident Assessment Instrument 3.0 User's Manual, revised October 2023, revealed Chapter 4: Care Area Assessment (CAA) Process and Care Planning, 4.1 Background and Rationale .Regulations require facilities to complete, at a minimum and at regular intervals, a comprehensive, standardized assessment of each resident's functional capacity and needs, in relation to a number of specified areas (e.g., customary routine, vision, and continence). The results of the assessment, which must accurately reflect the resident's status and needs, are to be used to develop, review, and revise each resident's comprehensive plan of care. Resident 13 (R13) R13's Face Sheet indicated R13 was admitted on [DATE] with diagnoses of cerebral palsy (CP), autistic disorder, and severe intellectual disabilities. R13's Care Plan revised 12/22/21, revealed R13 could have nutrition, hydration status altered or at risk for alteration related to cognitive/intellectual disability, behavior issues, potential for dehydration. Interventions: Adaptive devices used, scoop plate, etc .house supplements to be added to all meals .magic cup supplement to be added to all meals. During breakfast meal observation on 04/18/24 at 8:13 AM and on 04/19/24 at 9:30 AM, R13's tray had no scoop plate, house supplement and/or magic cup. During lunch meal observation on 04/18/24 at 11:55 AM and 04/19/24 at 12:01 PM, R13's tray had no scoop plate, house supplement and/or magic cup. During breakfast meal observation on 04/18/24 at 8:13 AM, R13's tray was sitting on a table in the main dining room without a scoop plate, house supplement, and/or magic cup. During lunch meal observation on 04/18/24 at 11:55 AM, R13's untouched tray was sitting on R13's overbed table without a scoop plate, house supplement and/or magic cup. During breakfast meal observation on 04/19/24 at 9:30 AM, R13's finished tray was sitting on R13's overbed table without a scoop plate, house supplement and/or magic cup. During lunch meal observation on 04/19/24 at 12:01 PM, R13's untouched tray was sitting on R13's overbed table without a scoop plate, house supplement and/or magic cup. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician Orders dated 05/15/18 documented, house supplements with meals discontinued. Physician Orders dated 03/26/19 documented, magic cup with meals discontinued. Physician Orders dated 05/30/23 documented, nutritional enhanced meal (NEM) diet, regular texture .scoop plate discontinued. R13's Care Plan revised 08/13/20, revealed R13 had limited physical mobility related to Cerebral palsy, seizure disorder, and behaviors that prevent care at times. Interventions: Nursing rehab/restorative: AROM program and PROM program. Physician Orders revealed, Restorative Nursing program to include active range of motion (AROM), passive ROM (PROM) was discontinued on 12/21/23. On 04/18/24 at 1:21 PM, the Director of Nursing (DON) confirmed R13's care plan for AROM and PROM has not been updated and indicated it should have been. At 4:19 PM, the DON confirmed R13's nutritional care plan has not been updated for scoop plate, and nutritional supplements that were discontinued. 32513 Resident 5 (R5) R5's Admission Record revealed R5 was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease. R5's Fall Care Plan, dated 08/05/22 and revised on 05/09/23 revealed, R5 is HIGH risk for falls r/t [related to] confusion, poor communication/comprehension, unaware of safety needs, vision/hearing problems. R5 had two unwitnessed falls without injury on 08/14/22 and on 05/08/23. A Transfer to Hospital Summary dated 01/17/24, revealed R5 was found on the floor mat with a small laceration on the top of head. The Fall Care Plan was not updated/revised with the 01/17/24 fall with injury. In addition, there were no approaches developed to keep R5 safe. The quarterly MDS with an ARD of 02/12/24 revealed, R5 had a BIMS score of 3 out of 15 which indicated R5 was severely impaired in cognition. On 04/17/24 at 3:02 PM, the DON confirmed the Fall Care Plan for R5 was not updated/revised after the 01/17/24 fall with injury.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on observation, interview, record review, and facility policy review, the facility failed to assist with a communication deficit for one of one resident (Resident (R) 10), reviewed for communication out of 17 sampled residents. Findings include: The facility's policy titled, Activities of Daily Living [ADL], Supporting, revised 03/03/24 revealed, Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: .e. communication (speech, language, and any functional communication systems). Resident 10 (R10) R10's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/31/24, revealed R10 had an admitted [DATE]. R10 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating R10 had moderately impaired cognition, and diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, stroke, and aphasia. R10's Personal Directives for Quality of Living, dated 01/29/24 documented, I want my care partners to know A. I communicate better with pictures and A Good Day for me would be (things I value about my day) F. unable to answer. R10's Care Plan, dated 02/01/24 revealed, R10's Personal Directives for Quality of Living with an intervention that included I want my Care Partners to know: I communicate better with photos. A progress note, dated 04/12/24 revealed, Dx. [diagnosis] Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. Patient with unclear speech at times but able to make needs known. Usually understood and usually understands others. Hearing adequate. Vision impaired-wears glasses. Patient unable to read words aloud however was able to decipher small print shapes. DX [diagnosis] of aphasia . During an observation and interview on 04/18/24 at 12:23 PM, R10 was sitting in the wheelchair in the resident's room watching television. R10 was asked questions about lunch and R10 was having difficulty communicating. R10 was then asked if the resident had a communication board with pictures to make communication easier and R10 said, no. R10 was then asked if would like one and the resident replied,yes. On 04/18/24 at 12:39 PM, Social Services Designee (SSD) was asked if R10 had a communication board with pictures to enhance R10's communication. SSD stated not aware of the resident having one. SSD stated R10 communicated pretty well with staff, but R10 couldn't read or write. SSD was informed R10 stated a communication board with pictures would improve communication. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/18/24 at 1:21 PM, Certified Nurse Aide (CNA) 2 was asked if R10 had a communication board with pictures and CNA2 stated no. CNA2 was asked if thought R10 would benefit from a communication board with pictures. CNA2 stated yes, because R10 could only say yes, no and a few other words such as shower. CNA2 stated thought the facility had a board R10 could use. On 04/19/24 at 10:30 AM, Hospitality Aide (HA) 3 was asked if R10 had limited speech and did R10 have difficulty communicating. HA3 stated yes, R10 could only say yes, no, water, and just a few other words so the HA3 tried to simplify communication with R10. HA3 was asked if R10 had an alternative way to communicate and HA3 stated, no. HA3 was asked if R10 had a communication board with pictures and HA3 stated, no. HA3 was asked if a board with pictures would help with R10's communication and HA3 stated definitely. On 04/19/24 at 11:20 AM, Licensed Practical Nurse (LPN) 1 stated R10 had a communication deficit and could make needs known in the resident's normal realm but outside of the resident's norm,had trouble communicating. LPN1 stated for example, R10 came to the LPN a little while ago trying to communicate was having trouble with a roommate and holding up fist to express anger. LPN1 went on to say, at times some staff struggle to understand R10. LPN1 recommended staff use a white board when communicating with R10.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 Based on observations, interviews, record review, and facility policy review, the facility failed to provide an ongoing program of activities designed to support the physical, mental, and psychosocial well-being for 1 of 17 sampled residents (Resident (R) 13). This failure had the potential to negatively impact R13's quality of life. Findings include: Review of facility's policy titled, Activity Evaluation, revised 03/03/24, revealed Policy Interpretation and Implementation .The activity evaluation is used to develop individual activities care plan (separate from or as part of the comprehensive care plan) that will allow the resident to participate in activities of his/her choice and interest .Each resident's activities care plan relates to his/her comprehensive assessment and reflects his/her individual needs .Through the interdisciplinary process, the activity evaluation and activities care plan identify if a resident is capable of pursuing activities independently, or if supervision and assistance are needed .The completed activity evaluation is part of the resident's medical record and is updated as necessary, but at least quarterly. Resident 13 (R13) R13's Face Sheet indicated R13 was admitted on [DATE] with diagnoses of cerebral palsy (CP), autistic disorder, and severe intellectual disabilities. R13's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/15/24, indicated R13 had a Brief Interview for Mental Status (BIMS) score of zero of 15 which indicated R13 had severely impaired cognition. The assessment indicated R13 preferred staying up past 8:00 PM, receiving a shower, snacks between meals, participating in favorite activities and listening to music. R13's Care Plan revised 07/17/23, indicated R13 is dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits, immobility, physical limitations .Intervention: R13 has graduated from public school. In order to maintain mental and social stimulation R13 will have 1:1 meaningful activities at least five times per week. During the initial observational tour of the facility on 04/16/24 at 9:56 AM, R13 was lying in bed, asleep. At 1:00 PM, R13 was lying in bed, alert and awake. No evidence of R13 participating in activities on day one of the survey. During observations on 04/17/24 at 12:30 PM, R13 was lying in bed with a stuffed animal, saying baby when approached. At 4:28 PM and 5:23 PM, R13 was lying in bed asleep. No evidence of R13 participating in activities on day two of the survey. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/17/24 at 3:55 PM, R13's guardian indicated was concerned with R13 not getting out of the room for activities. The guardian indicated R13 loved water, and the facility had a plastic pool and last summer they allowed R13 to play in the pool. Additionally, the guardian indicated R13 had a mat which staff used to bring out of the resident's room and place at the nursing station, which allowed R13 to interact with others. The guardian verbalized this had not been happening. During observations on 04/18/24 at 7:50 AM, R13 was sitting on the bed alert, calling out baby. At 8:13 AM, after R13 ate breakfast in the main dining room, staff removed R13 from the dining room and placed resident back into bed. At 9:20 AM, R13 was asleep in bed. During additional observations on 04/18/24 at 11:40 AM, R13 was lying on the bed, awake and at 11:55 AM, R13 was asleep. At 12:26 PM, R13 was in bed, asleep. No evidence of R13 participating in activities on day three of the survey. During observations on 04/19/24 at 9:30 AM, R13 was observed asleep in bed. At 12:01 PM, R13 was observed asleep in bed. No evidence of R13 participating in activities on day four of the survey. R13's Record of one-on-one Activities, provided by the facility, revealed R13 received one to one activity on the following dates: 01/06/24, 01/18/24, 01/29/24, 02/02/24, 02/19/24, 02/23/24, 02/29/24, 03/03/24, 03/14/24, 03/21/24, 03/24/24, 03/29/24, 04/04/24, and 04/12/24. This resulted in 13 out of 80 visits conducted, resulting in a 16.25% participation rate. R13's Record of one-on-one Activities, provided by the facility, revealed R13 did not receive one to one activities, five times a week, during the following weeks: 12/31/23-01/06/24, 01/07/24-01/13/24, 01/21/24-01/27/24, 02/04/24-02/10/24, 02/11/24-02/17/24, and 04/14/24-04/20/24. This resulted in 65 out of 80 visits not being conducted, resulting in an 81.25% non-participation rate. R13's Activities-Quarterly/Annual Participation Review dated 03/22/24, revealed R13 does activities when the resident wants to. Forcing R13 is not in the resident's best interest. Reading to the resident with a book the resident likes could last up to 15-20 minutes .The resident enjoys listening to music and dancing (swaying back and forth) to the songs the resident likes . R13 still loves to play in the water. R13 has 1:1's with activities five times a week. On 04/18/24 at 10:00 AM, the Activity Director (AD) indicated R13 was to get one to one activities five times a week and the AD confirmed R13 had not received one to one activity since 01/24. The AD indicated R13 was not able to join in the scheduled activities of the facility. The AD stated R13 liked water, reading books, musical instruments, singing and dancing. The AD indicated if R13 was asleep when staff went by the resident's room to do a one to one, there should have been a follow up visit conducted that day and confirmed that this was not happening. On 04/19/24 at 10:00 AM, Licensed Practical Nurse (LPN) 1 indicated R13 did not get the activities as the resident should have. The LPN confirmed R13 loved water, music, and loved to dance.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on observation, interview, record review, and facility policy review, the facility failed to provide treatment to maintain or prevent further decrease in range of motion for 1 of 2 residents (Resident (R) 10) reviewed for range of motion out of 17 sampled residents. The deficient practice placed the resident at risk for developing decreased motion or contractures. Findings include: Facility policy titled, Restorative Nursing Services, revised 03/03/24 revealed, 1. Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services (e. g., physical, occupational or speech therapies). 2. Residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative care . 5. Restorative goals may include, but are not limited to supporting and assisting the resident in: a. adjusting or adapting to changing abilities; b. developing, maintaining or strengthening his/her physiological and psychological resources; c. maintaining his/her dignity, independence and self-esteem . Facility policy titled, Rehabilitation Services, revised 03/03/24 revealed, 1. The rehabilitative potential and requirements for residents are noted on the initial nursing assessments/evaluations completed by the RN [Registered Nurse] within 30 days of move-in or as required by state regulations. Resident 10 (R10) R10's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/31/24, revealed R10 had an admitted [DATE]. R10 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating the resident had moderate cognition impairment and diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side. R10's care plan, dated 01/29/24, revealed R10 has an ADL self-care performance deficit r/t [related to] Stroke, with an intervention of Contractures: R10 has contractures of the right hand. On 04/17/24 at 11:56 AM, R10 was in the dining room sitting in the wheelchair with right hand contracted. No positioning device in place and resident was feeding self with the left hand. R10's right leg was noted to be strapped to the wheelchair bar. On 04/18/24 at 11:23 AM, the Physical Therapist (PT) was asked about R10. PT stated R10 was not receiving therapy at this time, but at previous nursing homes R10 did receive therapy services and was prescribed a splint. PT stated wasn't sure if R10 still had the splint. PT stated R10 wasn't compliant at the previous nursing home. PT went on to say R10 didn't need additional services from therapy because the resident was maintaining range of motion with the activities program exercise. PT was asked if the facility had a restorative nursing program (RNP) and PT stated yes, but wasn't sure if R10 was on the RNP. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER White Pine Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 Avenue G Ely, NV 89301	

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/18/24 at 11:34 AM, Certified Nurse Aide (CNA 1) stated was the restorative nurse aide. CNA1 was asked about the RNP. CNA1 stated if a resident was on the RNP it would have been reflected in the task tab in the EMR. CNA1 then reviewed the EMR and did not find the task for the RNP for R10. CNA1 confirmed R10 was not on RNP and stated it was because there was no order. CNA1 stated the order would have to come from therapy with specific instructions. On 04/18/24 at 12:23 PM, R10 was asked if received exercise beyond the activity program and R10 said no. R10 was asked if that was sufficient and R10 said, no. R10 then pointed to the leg that was strapped to the bar of the wheelchair and picked up the right hand with the left hand and let it drop on the lap. R10 was asked if had a hand splint for the right hand and the resident said, no. On 04/19/24 at 11:27 AM, Licensed Practical Nurse (LPN1) was asked about R10's right side impairment. LPN1 stated R10's right hand was contracted, and a brace may help with preventing further contractures. LPN1 stated physical therapy didn't have to be the one to write an order for RNP, the doctor could write it. LPN1 was asked, according to facility's rehabilitation services policy, if R10 should have been assessed within 30 days of admission. LPN1 stated physical therapy would have completed one. During a follow up interview on 04/19/24 at 12:17 PM, PT was asked if an assessment had been conducted for R10 per facility policy. PT stated would have needed an order from nursing to conduct an assessment for therapy. PT stated could tell R10 hadn't declined because the PT was familiar with R10 from another facility. PT was asked how it was known R10 hadn't declined and if the PT used measurements. PT stated, no, didn't use measurements, just observation.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on interview, record review, and facility policy review, the facility failed to ensure an investigation was performed and a root cause analysis was established for 1 of 1 residents (Resident (R) 5) reviewed for falls out of 17 sampled residents. This failure placed the resident at risk for unmet care needs and a diminished quality of life. Findings include: Facility's policy titled, Fall Evaluation and Management, dated 03/03/24 revealed, .Post-Fall Documentation . After the resident has been evaluated and cared for and appropriate notifications have been made, the licensed nurse .Completes an interdisciplinary progress note, including a brief summary of the fall, the nursing evaluation, actions taken, who was notified and resident's condition .The nurse completes orthostatic vital signs as able .The LN [licensed nurse] evaluated neuro checks for 72 hours for all falls unwitnessed by staff or falls that involve the resident's head striking a surface .The nurse completes a blood glucose reading at the time of the fall (if diagnoses diabetic) .Updates the Morse Scale .Reviews and updates the care plan with newly identified interventions, as needed .Updates Care Directives with new interventions, as needed . Alerts following shifts to fall and care plan/care directive changes by verbal report as well as documentation in the 24-hour report .Resident is monitored for 72 hours post fall .Follows up with the physician and responsible party, as needed, to provide updates .Continues to follow the resident every shift for the next 72 hours, documents findings and resident's condition in the Nurse's Notes . Resident 5 (R5) R5's Admission Record, provided by the Director of Nursing (DON) revealed R5 was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease, dementia, adult failure to thrive, and blindness. R5's Fall Care Plan, dated 08/05/22 and revised on 05/09/23 included: -R5 is HIGH risk for falls r/t [related to] confusion, poor communication/comprehension, unaware of safety needs, vision/hearing problems. R5 had two unwitnessed falls without injury on 08/14/23 and a fall on 05/08/23.Approaches included to anticipate and meet R5's needs. Entry dated 08/05/22 and revised on 05/15/23. -Educate R5, family/caregivers about safety reminders and what to do if a fall occurs. Dated 08/05/22 and revised on 05/15/23. -Grab bars and assistive devices are wrapped in bright green tape to assist as visual aid. Dated 08/10/22. -Hi-Lo bed with landing mats for injury prevention. Dated 08/05/22. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-PT/OT [Physical Therapy/Occupational Therapy] to evaluate and treat as ordered or PRN [as needed]. Dated 08/05/22 and revised on 05/15/23. -R5 needs a landing mat in front of the w/c [wheelchair] to prevent injuries and should be supervised at all times while up in chair. Dated 08/05/22. -R5 needs a safe environment with the bed in low position at all times; personal items within reach; fall mats on floor. Dated 08/05/22 and revised on 05/15/23. -R5 needs activities that minimize the potential for falls while providing diversion and distraction. Dated 08/05/22 and revised on 05/15/23. -R5 will sit at the nurses' station for 1:1 when able. Dated 05/15/23. R5's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/12/23, revealed R5 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated the resident was severely impaired in cognition, required assistance for transfers, did not ambulate, and had no falls since previous assessment. Review of the Transfer to Hospital Summary, dated 01/17/24, revealed R5 was found on the floor mat with a small laceration on the top of head. A General Note, dated 01/17/24 revealed, ambulance returned R5 from ER [emergency room]. Head bandaged to keep resident from playing with staples .Resident was put to bed with 1:1 observation for safety. An MD Visit Note dated 01/17/24, revealed .Patient was seen today for fall yesterday, sent to ER with now three staples. No CT [cat scan] was done .Staple removal in 7 to 10 days, continue neuro check for three days. Have discussion with family in case of hemorrhagic stroke if they want further intervention . During an initial observation on 04/16/24 at 12:18 PM, R5 was seated in a recliner in room. There was music playing on the CD player on the table next to the resident. R5 was asked how the resident was doing today. R5 stated, I'm lonely and there was no one to talk to. A fall mat was observed on the floor underneath the raised footrest of the recliner. On 04/17/24 at 1:19 PM, R5 was observed asleep in the wheelchair, in the resident's room. The fall mat was angled off to the left side of the wheelchair. R5 was unsupervised. On 04/17/24 at 2:51 PM, Certified Nurse Aide (CNA 4) was asked why R5 was unsupervised while alone in the room when R5's care plan documented the resident needed supervision. CNA 4 stated wasn't aware of that intervention. CNA 4 was told of R5's fall care plan approaches, dated 05/15/23. CNA 4 indicated when the resident is in the room, I will attach the call light to the resident's pants, so when the resident tries to stand up or move away from the wall, the light gets pulled out and the call light goes off. CNA 4 was asked how the CNA is made aware of the care plan approaches, especially updates. CNA 4 stated, I will review them if I know someone has a change, but I was not told about this. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/17/24 at 3:02 PM, the DON was asked if there had been daily charting, by nursing, to monitor for a change in condition. The DON stated, I was not here at the time of R5's fall, and I did not see it in the Progress Notes. The DON further stated, It is my expectation that nursing is to document for 72 hours on the resident, after a fall or change in condition. On 04/18/24 at 8:49 AM, The DON was asked if there was a fall investigation, as the DON had only provided copies of the Progress Notes. The DON stated, There was no investigation on the fall from 01/17/24, no care plan revision or root cause analysis was established.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 Based on observations, interview, record review, and facility policy review, the facility failed to provide interventions and meal assistance to address significant weight loss for one resident (Resident (R) 13) and ensure consistent weighing methods for one resident (R16) of the eight residents reviewed for nutritional status out of 17 sampled residents. This deficient practice placed the residents at risk for new or continued weight loss potentially impacting the resident's quality of life. Findings include: Facility policy titled, Nutrition (Impaired)/Unplanned Weight Loss Clinical Protocol, revised 03/03/24, revealed: 1. The staff and physician will identify pertinent interventions based on identified causes and overall resident condition, prognosis, and wishes. a. Treatment decisions should consider all pertinent evidence and relevant issues (e.g., food intake, resident patient wishes, overall condition and prognosis, etc.), and should not be based solely on lab [laboratory] or diagnostic test results (albumin, cholesterol, swallowing studies, etc.). 2. The physician will authorize appropriate interventions, as indicated. a. This may include tapering, stopping, or switching medications known to be associated with undesirable weight gain or anorexia or weight loss. b. The physician will document if cause-specific interventions could not be identified or are not feasible. Facility policy titled, Weights, revised 03/03/24, revealed: For residents on dialysis, the center uses weights from the dialysis center. Any weight with a 5-lb. variance is re-weighed within 24 hours. Only after a re-weight has been completed, will a weight be recorded on the permanent Weight Record. Resident 13 (R13) R13's Face Sheet documented R13 was admitted on [DATE] with diagnoses of cerebral palsy (CP), autistic disorder, and severe intellectual disabilities. R13's quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 07/17/23 revealed, R13 needed limited assistance eating with one person assist. R13's Brief Interview for Mental Status (BIMS) was a zero, meaning that R13 was not able to be interviewed. Physician order dated April 2024, documented Regular, finger foods diet, soft and bite sized texture diet. No evidence of an appetite stimulant and/or supplements were ordered. Physician orders dated 04/01/23-present, revealed no evidence of an appetite stimulant and/or tube feeding being ordered. This included current and discontinued orders. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/17/24 at 3:55 PM, R13's guardian indicated a major concern was R13's constant weight loss. The guardian verbalized at the last two care conferences had asked the facility for a list of snacks and/or food that R13 would eat, and the guardian would provide to the facility; however, to this date, the guardian had not received anything from the facility. R13's guardian stated the facility did not inform the guardian when R13 began losing weight and had attended the care conferences all the time. The guardian indicated the facility had not talked with the guardian about tube feeding (TF). The guardian indicated the former Director of Nursing (DON) stated that R13 had outlived the life expectancy based on the resident's diagnosis. The guardian expressed feelings that the facility forgets about R13. A Nutrition/Dietary Note dated 10/11/23, revealed Quarterly Registered Dietitian (RD) note .Significant weight loss x six months likely related to poor by mouth (PO) intake .Have trialed magic cup, did not like .10/03/23 weight: 79.8 pound (lb.), 09/07/23 weight: 80 lb. (-.25% x one month), 07/18/23 weight: 83.8 lb. (-4.7% x three months), 04/03/23 weight: 90.8 lb. (-12.1% x six months) .Continue plan of care (POC). A Physician Visit note dated 11/08/23, revealed .Oral surgery with total teeth removed on 05/11/23. Has been eating ok now. Revealed no evidence of weight loss was mentioned. A Nutrition/Dietary Note dated 12/06/23, revealed Weight change .Per nursing, patient does not like to eat much .Have trialed magic cup, did not like. Dietary Manager (DM) has trialed house protein shakes with little to no intake .Appetite stimulant and tube feeding (TF) discussed; however, denied at this time due to previous attempts and failures .12/06/23 weight: 74.4 lb., 11/07/23 weight: 75.2 lb. (-1.1% x one month), 09/07/23 weight: 80 lb. (-7.0% x three months and 06/07/23 weight: 85.8 lb. (-13.3% x six months) .Continue POC. A Physician Note dated 04/03/24, revealed R13 was noted by nutritionist and pharmacy to have ongoing weight loss over the last year 2023 after starting Topamax 200 milligrams (mg) for R13's seizure control. No seizures since 03/12/23 .Decrease Topamax to 150 mg, encouraging oral diet. A Nutrition/Dietary Note dated 04/04/24, revealed Quarterly RD note PO intake variable, refusing meals at times. Have trialed supplements, special meals .discussed tube feeding with the DON/MD, declined. Enjoys ice cream, apple juice. DON will occasionally bring [name of outside food restaurant] for R13, which R13 enjoys Requires supervision with meals. Body mass index (BMI) is 15.0, underweight. Significant weight loss for six months is likely related to poor PO intake. Encourage PO intake. Offer snacks between meals . 03/07/24 weight: 72 pounds (lb.), 02/06/24 weight: 75 lb. (-4.0% x one month), 12/06/23 weight: 74.4 (-3.2% x three months), and 09/07/23 weight: 80 lb. (-10.0% x six months) Continue plan of care (POC). A Nutrition/Dietary Note dated 04/09/24, revealed High risk RD note: weight change patient does not like many things, refuses supplements. Discussed TF, appetite stimulant with Director of Nursing (DON)/Medical Doctor (MD), declined Significant weight loss times one year .04/08/24 weight: 72.6 lb.04/03/23 weight: 90.8 lb. (-20% x one year) .Continue POC. A Physician Note dated 04/11/24, revealed Clinically stable .Patient was discussed during table rounds today for MDS; most recent change was decreasing Topamax from 200 mg to 150 mg on 04/03/24 secondary to weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R13's Nursing Notes dated 04/01/23-present, revealed no evidence of TF and/or appetite discussed and denied. Review of R13's Physician Notes dated 04/01/23-present, revealed no evidence of TF and/or appetite discussed and denied. On 04/18/24 at 8:02 AM, R13 was sitting at a table in the main dining room with a breakfast tray in front of the resident. R13's tray had French toast casserole, bite sized sausage, yogurt, and eggs with eight-ounce glasses of orange juice (OJ), milk, apple juice, and water. At 8:13 AM, R13 was observed to eat 50% of the breakfast meal. R13 drank all of the OJ, 75% of the milk, and 95% of the apple juice. R13 refused the water and yogurt. R13 ate 50% of the food on the tray. R13 was able to feed self after staff placed food on the fork. When R13 was done with breakfast, R13 gently pushed the staff's hand away and removed the clothing protector. When R13 was done, staff removed the resident from the dining room and went back to the resident's room. Review of facility provided R13's Dietary Slip, dated 04/18/24, revealed Nutrition enhanced meal (NEM), soft bite (SB6), Finger foods (FGRFD). Preferences: French toast, hashbrown potatoes, pancakes, sausage, and toast. Beverages/Equipment: apple juice eight ounce, OJ eight-ounce, strawberry yogurt, water eight-ounce, whole milk eight ounce, and scoop plate. Allergies/Dislikes: bacon, cereal, ham and waffles. On 04/18/24 at 8:17 AM, the Medical Director indicated in the last two to three weeks had started tapering down R13's Topamax dosage. The Medical Director stated R13 picked and chose what the resident wanted to eat. The Medical Director verbalized back in September 2023, had recommended a [NAME] diet due to this diet prevented seizures but was unsure if R13 was receiving this diet. The Medical Director indicated must look at balancing the resident's seizures and weight loss; however, the last seizure was over a year ago. The Medical Director stated would expect the nursing staff to notify the guardian of R13's weight loss. The Medical Director verbalized there had been no discussion about an appetite stimulant for R13. The Medical Director stated that anything new introduced to R13 was very hard due to te resident's behavioral issues and felt that a tube feeding would be way too invasive for R13. The Medical Director indicated R13 tended to fight staff, attempted to bite, and slapped staff. On 04/18/24 at 9:26 AM, the DM indicated there has been no talk about an appetite stimulate; however, did indicate that the RD recommended an appetite stimulate due to R13's continued weight loss. The DM indicated R13 was very hard to feed, and seemed as if R13 liked kids food. The DM stated had tried hot pockets, chicken nuggets, ice cream, hot dogs, hamburgers, pizzas, burritos. Also, indicated R13 has been trialed on different supplements such as magic cup, boost, and protein shakes, which R13 had refused to drink. The DM stated R13 currently was into mashed potatoes and hashbrowns. The DM explained the mashed potatoes had powered milk inside of them for increased protein, and extra butter for increased calories. The DM indicated R13 had never been on a keto diet. On 04/18/24 at 9:55 AM, Certified Nursing Assistant (CNA4) weighed R13 in the resident's wheelchair. CNA4 indicated R13's wheelchair weighed 35 pounds and total together the observed weight was 105.2 pounds. When the wheelchair weight was substantiated, R13's actual weight was 70.2 pounds. This end weight was confirmed by CNA4, indicating a 2.4-pound loss in 17 days. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/18/24 at 11:55 AM, R13's lunch tray was placed in R13's bedroom on the overbed table, while R13 was lying in the bed asleep. At 11:56 AM, surveyor went into R13's bedroom, to see R13's lunch tray. The tray had eight-ounce glasses of milk, water, and apple juice. On R13's plate, was a piece of cake, piece of bread, medium portion of mash potatoes with brown gravy, small amount of fresh fruit, and large portion of ground beef topped with spaghetti sauce. The resident's tray was untouched and covered. On 04/18/24 at 12:00 PM, staff entered R13's bedroom, turned around and left. At 12:06 PM, staff entered R13's bedroom again, picked up some of R13's clothing and left the room. At 12:26 PM, R13's lunch tray remained on the over bed table, untouched and covered. At 12:44 PM, staff obtained R13's lunch tray from the resident's room and placed it on an open metal cart. At 1:07 PM, R13's lunch tray was observed and was untouched. Review of facility provided R13's Dietary Slip, dated 04/18/24, revealed NEM, SB6, FGRFD. Preferences: mashed potatoes/gravy. Beverages/Equipment: apple juice eight-ounce, water eight-ounce, whole milk eight ounce, and scoop plate. Allergies/Dislikes: bacon, ham, rice and side vegetables. On 04/18/24 at 1:10 PM, the Social Service Designee (SSD) indicated weight loss had been an on-going concern for R13. The SSD indicated one day R13 would eat and the next day, R13 would throw the food. The SSD was unaware when the guardian had been notified of the beginning of R13's weight loss. On 04/18/24 at 1:21 PM, the Director of Nursing (DON) stated was aware of R13's weight loss, but unaware of discussing an appetite stimulant and/or tube feeding. The DON confirmed staff should have attempted to feed R13 the lunch tray and not just leave the tray in the resident's room. On 04/18/24 at 2:00 PM, the RD stated the first time that an appetite stimulant and/or tube feed was discussed with the DON was on 11/08/23. However, in a follow up on 12/06/23, was told that both have been tried and did not work, so the recommendation was denied. The RD was unaware of the type of TF and/or appetite stimulant that was used prior. The RD indicated had asked no further questions. The RD explained there was no nutritional committee, and the RD did not communicate with the physician. The RD verbalized the facility had done special meals, the previous DON had brought in outside food for R13, had tried supplements which R13 has refused, and there had been trials of different foods to see what R13 would eat. The RD's understanding was R13 was a 1:1 assistant for feeding. The RD indicated not feeding and/or not offering R13's lunch today was unacceptable and would have expected staff to offer R13 snacks and/or an alternative since R13 did not eat. On 04/19/24 at 9:28 AM, the DM indicated the only enhanced foods R13 got this week was mashed potatoes with extra butter and powdered milk and macaroni and cheese. On 04/19/24 at 9:30 AM, R13 was in bed sleeping, a breakfast tray was sitting on the overbed table. R13 had drank 100% of the eight-ounce glasses of milk, orange juice, and apple juice. R13's plate still had one small hash brown, one piece of toast cut in half, and bite size sausage. The hash brown and toast had not been touched and it appeared that the bite sized sausage had approximately two percent eaten. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/19/24 at 10:00 AM, Licensed Practical Nurse (LPN 1) indicated was unaware of R13 not eating lunch on 04/18/24, and would have expected the staff to make the LPN aware of. LPN 1 indicated R13's food intake and weight has been going down ever since R13 had teeth extracted. LPN 1was unsure of the timeframe but thought it was sometime summer 2023. LPN 1 indicated dietary had been trying different foods over and over, and R13 was getting tired of those foods. LPN 1 verbalized sometimes would bring in outside food for R13 because some food was better than nothing at all. LPN 1 confirmed R13 was forgotten about sometimes, not on purpose, but R13 did not get the attention the resident needed and deserved. To the LPN's knowledge a by mouth (PO) appetite stimulate had never been considered for R13. LPN 1 expected staff would always offer R13meals and was aware of the 2.4-pound weight loss in 17 days. On 04/19/24 at 12:01 PM, R13's lunch tray was sitting on the overbed table with eight-ounce glasses of milk, apple juice, and water. R13's lunch plate had mashed potatoes with white gravy and bite sized country fried steak with white gravy. There was one roll, and a small cup of ice cream. The lunch tray was not touched and still covered. At 1:15 PM, R13's lunch tray remained on the overbed table with the eight-ounce glass of milk 75% drank, and 95% apple juice drank. However, the plate still had the mashed potatoes and bite sized country fried steak untouched. The ice cream and roll had been untouched. On 04/19/24 at 12:05 PM, LPN2 indicated R13 had never had a tube feeding and/or had one been discussed. Resident 16 (R16) R16's significant change MDS with an ARD of 02/15/24, revealed R16 had a readmitted [DATE]. R16 had a BIMS score of 10 out of 15, indicating R16 had moderately impaired cognition and diagnoses of end stage renal disease, diabetes mellitus, congestive heart failure, malnutrition, and received dialysis. R16's Diet Profile, dated 03/29/23, revealed no food preferences. R16's Care Plan revised 12/13/23, revealed R16 is at risk for unplanned/unexpected weight loss r/t [related to] poor food intake. The goal included R16 will consume 75% of two of three meals/day. Interventions included: Give R16 supplements as ordered. Alert nurse/dietitian if not consuming on a routine basis and weigh per center protocol. R16's clinical record revealed orders for Renal diet, 7 Regular texture, Regular consistency, CCHO [controlled carbohydrates]; 1.5L [liter] fluid restriction, dated 12/09/23, and may have between meal and HS [bedtime] snack within dietary parameters dated 03/30/23. No supplements were ordered. Review of R16's Nutrition- Amount Eaten form dated 03/19/24 to 04/17/24, revealed R16 consistently consumed 76-100% of meals. No documentation was found for snack consumption. An RD [Registered Dietitian] Nutritional Assessment, dated 04/09/24, revealed a 12% increase weight change from 204 pounds (Lbs.) and Comments: HD [hemodialysis] MWF [Monday Wednesday Friday]. No sig [significant] changes, sig wt [weight] loss x 1-month, likely r/t [related to] fluid shifts dt [due to] ESRD [end-stage renal disease] on HD. Weekly wts. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Pine Care Center	1500 Avenue G Ely, NV 89301

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R16's weight history, revealed R16 had lost 6% of the resident's body weight in three months and 13% in 10 days. This included: On 04/18/24 at 10:09 AM R16's weight was observed at 177.2 Lbs. while standing On 04/08/24 at 204.0 Lbs. while in a wheelchair On 03/07/24 at 181.0 Lbs. while in a wheelchair On 02/27/24 at 181.2 Lbs. while in a wheelchair On 02/13/24 at 182.6 Lbs. while in a wheelchair On 02/07/24 at 173.6 Lbs. while in a wheelchair On 02/06/24 at 173.6 Lbs. while in a wheelchair On 01/25/24 at 187.0 Lbs. while standing On 01/17/24 at 190.0 Lbs. while in a wheelchair On 01/09/24 at 187.8 Lbs. while in a Wheelchair On 01/05/24 at 190.0 Lbs. while standing Review of R16's dialysis communications revealed R16's post weight was 80.8 [177.8 Lbs.]) on 04/08/24 and 80.2 [176.4 Lbs.] on 04/17/24. These weights were a difference of 26.2 Lbs. and 27.6 Lbs., respectively, from the facility's weight for R16 dated 04/08/24. On 04/16/24 at 11:56 AM, R16 was served lunch which included lettuce, quesadillas, refried beans, fruit, a glass of water, and tea. R16 consumed the meal well. On 04/18/24 at 7:58 AM, R16 was served breakfast that included milk, coffee, french toast casserole, and a sausage patty. Cereal was not included as per the menu. R16 was asked why hadn't receive cereal, and stated didn't know, but liked cereal. R16 consumed the meal well. Review of the CCHO/renal menu for breakfast on 04/18/24, provided by the facility, revealed cereal, sausage patty, and french toast casserole. On 04/18/24 at 12:10 PM, R16 was served lunch which included tea, coffee, pasta with meat balls, a [NAME] salad, grapes, and garlic bread. R16 ate well. On 04/18/24 at 8:28 AM, the Medical Director (MD) was asked if was aware R16 had lost weight and there were discrepancies between the facility weights and the dialysis weights. MD confirmed R16 was on dialysis, but relied on the facility's weights, not the dialysis weights. MD gave no further explanation. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/18/24 at 10:02 AM, CNA4 confirmed was the person who weighed the residents. CNA4 was asked about how R16 was weighed. CNA4 stated sometimes weighed R16 standing and other times in a wheelchair. CNA4 stated didn't rely on the dialysis weights and didn't review them. On 04/18/24 at 10:23 AM, LPN1 was asked about the facility's method in obtaining R16's weight. LPN1 stated the facility weighed R16 but weren't consistent with obtaining weights as sometimes R16 was weighed in a wheelchair and other times standing. LPN1 stated was aware the dialysis also weighed R16, but did not use their weights, but the MD used the dialysis weights. During a telephone interview on 04/18/24 at 2:28 PM, the RD was asked if was aware of R16's weight loss and the RD stated yes. The RD stated R16 was on dialysis and the resident's weight fluctuated due to fluid shifts. The RD was asked if was aware R16 ate well but was weighed today, 04/18/24, at 177.2 Lbs., which was down from 204 Lbs. on 04/08/24, a difference of 26 Lbs. The RD indicated was not aware. The RD was asked about R16's post weight at the dialysis center of 80.8 [177.8 Lbs.] that was taken on 04/08/24 same day the facility weighed R16 at 204 Lbs. The RD stated residents should be reweighed if the dialysis weights were different from the facility weights. The RD asked if any interventions were in place for R16, and the RD indicated would have to check. On 04/19/24 at 9:22 AM, the DM and Dietary Supervisor (DS) were asked why R16 didn't receive cereal at breakfast 04/18/24. DS reviewed R16's meal ticket and menu and confirmed there was no reason why R16 shouldn't have received cereal. DS stated it was the DS's mistake and confirmed R16 had not been receiving cereal at breakfast since the resident's readmission. DM indicated thought R16 had requested no cereal, but there was no documentation of this. DM confirmed this was a missed opportunity for additional calories. DM confirmed R16 only received bedtimes snacks and additional snacks would only be upon request. On 04/19/24 at 12:32 PM, DON asked for the R16 weight record from 04/19/24. DON stated was aware of the 26 Lbs. difference from 04/08/24 to 04/18/24. DON stated would be implementing a better system to ensure more accuracy. 36190

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on interview, record review, and review of facility policy, the facility failed to provide appropriate person-centered and individualized treatment and services for one of two residents (Resident (R) 19) reviewed for behavioral healthcare needs of 17 sampled residents. This failure placed the resident at risk for increased distress and a diminished quality of life. Findings include: A facility policy titled, Behavior Management, dated 03/03/24, revealed, .If a resident exhibits a new behavior symptom, staff implements the Behavior Monitor Flowsheet and notified the Social Services Director (SSD) and the IDT [interdisciplinary team] via the 24-Hour report .If the resident has an order for psychotropic medications or medications used for psychiatric diagnosis, the side effects are monitored and documented as indicated. The resident's record is reviewed for evidence of signs or symptoms of side effects related to psychotropic medication as part of the IDT review process . A facility policy titled, Suicide Threats, dated 03/03/24, revealed, .All nursing personnel and other staff involved in caring for the resident shall be informed of the suicide threat and instructed to report changes in the resident's behavior immediately . Resident 19 (R19) R19's Admission Record provided by the Director of Nursing (DON) revealed R19 was admitted to the facility on [DATE] with diagnoses which included depression and urinary tract infection. An MD Visit note, dated 03/13/24, revealed Patient did state during emergency evaluation 3/10/24 resident does not want to be here anymore and want (sic) to overdose on pain medication .Chronic pain .recently decreased on hydrocodone 10/325 from 3 pills a day to 2 pills a day by the resident's PCP [primary care physician] on 3/6/2024, likely secondary to suicidal ideation on pain medication . Review of the Admission Social Services assessment, dated 03/14/24 and provided by the Social Services Designee (SSD) revealed that R19 was agitated with placement, had a diagnosis of depression and was on an antidepressant medication. The assessment further revealed that R19 had no behavioral concerns and had no history of behavioral symptoms or interventions. R19's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/19/24, revealed R19 had a Brief Interview of Mental Status (BIMS) score of 13 out of 15, which indicated the resident had intact cognition and had no behaviors. The MDS further revealed R19 was asked if had little interest in doing things or if the resident felt down, depressed, or hopeless R19 was coded as No. The question of if the resident had thoughts of being better off dead or if was going to hurt herself in some way were not asked during the interview process. R19's Care Plan, dated 03/18/24 revealed, R19 uses antidepressant medication r/t [related to] Depression. Approaches included: (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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Administer Antidepressant medications as ordered by physician. Dated 03/19/24. -Monitor/document side effects and effectiveness q [every] shift. Dated 03/19/24. -Monitor/document/report PRN [as needed] adverse reactions to Antidepressant therapy. Dated 03/19/24. A Behavior Note, dated 04/04/24 at 10:37 AM revealed .Upon entering the room [R19] was found to be speaking to housekeeping. [R19] was stating was upset and was speaking very loudly to the housekeeper about not being able to poop, then got medicine to poop and now has diarrhea .While trying to get information from [R19] the resident yelled, What the hell do I have to do, die around here for someone to do something . A Communication with Family form dated 04/04/24 at 12:00 PM documented, .Talked to (resident representative) regarding what had occurred this morning .(she) Informed me that [R19] has an extensive Mental Health Background which had resulted in [R19] being placed in Mental Facilities for extended periods of time . A Behavior Note dated 04/09/24, revealed .Resident became hostile saying nothing helps with the pain. Resident stated, I may as well die if I can't get help for the pain .Resident started screaming at me and I redirected resident to calm down . The Behavior Monitoring Sheet dated April 2024, revealed and updated behavior which included staff were to monitor R19 for crying. R19's Care Plan was not updated with this new behavior nor were new approaches developed. On 04/17/24 at 8:56 AM, R19 stated, I began to experience significant pelvic pain and it wasn't getting any better, so I went to the hospital. I finally got one answer which was I had a blockage in my upper colon. R19 further stated, I had been on narcotics at the time. R19 was asked if was taking more narcotics than should. R19stated, No, not at all. I really didn't take them very much. R19 was asked if was taking an antidepressant medication for depression, resident stated, Yes, I have been on it a long time. It does help. I was hospitalized in California a long time ago for depression. R19 was asked if the resident could tell me more about that hospitalization , R19 stated, Well, I was pretty depressed, my husband left, and the kids grew up and left home. R19 was asked if had been offered counseling services since admission to the facility, R19 stated, no. R19 was asked if thought was wanting to hurt self or if would be better off being dead, since resident came to the facility, R19 replied, no, I haven't, and I don't have a plan. I am [AGE] years old and tired. On 04/17/24 at 9:33 AM, the SSD provided a paper copy of the admission social service assessment. The SSD was asked if was responsible for developing the Behavior Care Plan. The SSD stated, I do the social services part of the MDS and the Care Plan. The SSD further stated, R19 did not tell me was depressed, had no sad affect and when I did the resident's depression scale, it was zero. The SSD was asked if was aware of any potential suicide threats as voiced by R19 since admission and how does the SSD become aware of these if they occur. The SSD stated, I will go through the 24-hour sheet and look for what was said between nursing. The SSD further stated, I knew R19 wanted to be home with family, when I asked R19 about it, the resident had said no. The SSD was asked if the facility has a contract with a behavioral health care professional, the SSD stated, Yes. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/17/24 at 9:52 AM, the DON was asked if was aware of the statements of R19 wanting to die, as documented in the Progress Notes. The DON stated, to my knowledge, I was not aware of the statements. The DON further stated was recently hired to be the DON about 16 days ago and became aware that the psychotropic meds, behaviors, and care plans needed to correlate. The DON stated, I do read the 24-hour report, but I am trying to get the nurses to follow through when they document a behavior, specifically if there were statements of wanting to die, including the physician. On 04/18/24 at 8:16 AM, the Medical Director (MD) was asked how became aware of R19 wanting to use pain medication as a means of suicide, as documented in the MD's admission note. The MD stated, R19 was seen in the ER [emergency room] due to Norco (Hydrocodone-a pain medication). The resident was shown in the previous few weeks to have mentioned this to an outside PCP and the PCP had cut back on the amount of Norco prescribed. When R19 came in to the ER, was having increased pain, constipation, and UTI [urinary tract infection]. R19 had stated to the ER physician was taking more than should. The MD further stated had carried over the documentation from the hospital (when the MD wrote the MD Visit note.) The MD was asked if was aware of the other statements, as voiced by R19, of wanting to die. The MD stated, No, I was not aware of this. The MD further indicated had recently had behavioral health services start back and it would be great if they would see the resident.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on interview and record review, the facility failed to ensure the licensed consultant pharmacist performed a monthly medication regimen review for December 2023, for two of five residents (Residents (R) 16 and R18) reviewed for unnecessary medications of 17 sampled residents. This failure placed the residents at risk of the physician and nursing staff not being aware of irregularities. Findings include: Resident 18 (R18) An Admission Record, provided by the Director of Nursing (DON), revealed R18 was admitted to the facility on [DATE] with diagnoses including alcohol induced dementia with violent behaviors and diabetes. R18's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/10/23, revealed R18 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated R18 was severely impaired in cognition and was administered antipsychotic and antidepressant medications daily during the observation period. Review of the Medication Regimen Review book, provided by the DON, revealed no December 2023 medication reviews. Review of R18's Progress Notes did not reveal pharmacy documentation. On 04/17/24 at 12:50 PM, the DON confirmed the December 2023 Medication Regimen Reviews were not available. The DON further stated, had called the pharmacist, and was told the pharmacist did not have the reviews. 36190 Resident 16 (R16) R16's admission MDS with an ARD of 11/28/23, revealed R16 had a readmitted [DATE]. R16 had a BIMS score of 8 out of 15, indicating R16 had moderate cognitive impairment. Diagnoses included chronic kidney disease, congestive heart failure, hypertension, end stage renal disease, diabetes mellitus, depression, and malnutrition, receives dialysis, and medications that included insulin, antidepressant, and anticoagulant. Review of R16's orders revealed: -Zoloft [antidepressant] Oral Tablet 100 MG [milligrams] -Sertraline HCl [hydrochloric acid]) Give 100 mg, start Date 11/23/23 -Atorvastatin Calcium [cholesterol lowering medication] Oral Tablet 20 MG (Atorvastatin Calcium), start date 11/22/23 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Gabapentin [seizure medication] Oral Capsule 300 MG (Gabapentin), start date 11/22/23 -Lasix [diuretic] Oral Tablet 40 MG (Furosemide), start date 11/23/23 -Carvedilol [heart medication] Oral Tablet 6.25 MG (Carvedilol), start date 11/22/23. R16's care plan, dated 11/22/23, revealed R16 has depression r/t [related to] placement outside of family's home and an intervention that included: Pharmacy review monthly or per protocol. Review of the pharmacist's monthly medication records and EMR for December 2023 revealed no evidence R16's medications were reviewed.

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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** 36461 Based on interview, record review and review of the facility policy, the facility failed to ensure that indications and signs and symptoms for use of antibiotic medications were documented for 1 of 17 sampled residents (Resident (R) 2) resulting in the potential for adverse side effects from unnecessary medications. Findings include: Facility's policy titled, Urinary Tract Infection/Bacterial Protocol, dated 03/03/24, documented, .Empirical treatment should be based on a documented description of an individual's symptom and on consideration of relevant test results, co-existing illnesses and conditions, and pertinent risk factors .Bacteriuria alone (an asymptomatic UTI) should not be treated routinely . and .decisions should be made primarily on the basis of clinical signs and symptoms . Resident 2 (R2) R2's undated Admission Record revealed R2 was admitted to the facility on [DATE] with diagnoses which included neuromuscular dysfunction of the bladder, chronic respiratory failure, and hypertension. R2's quarterly Minimum Data Set (MDS) revealed R2 had a Brief Interview for Mental Status (BIMS) of 15 of 15 which indicated the resident was cognitively intact. R2's Progress Notes revealed no documentation prior to 02/26/24 which indicated R2 was showing signs and symptoms of a urinary tract infection (UTI). -Urinalysis (UA) results on 02/26/24, revealed .Nitrites positive, Leukocytes large and Bacteria 2+ . -The culture and sensitivity (C&S) final results on 02/29/24 revealed .Greater than 2 organisms recovered, none predominant. Please submit another sample if clinically indicated . No documentation was noted in R2's Progress Notes to indicate whether another urine specimen was collected, or clinically indicated. R2's Progress Notes revealed R2 was treated with Cefdinir (an antibiotic) 300 mg (milligrams) orally twice a day for five days. Review of R2's February 2024 Medication Administration Record (MAR) revealed R2 received the antibiotic from 02/27/24 through 03/03/24. R2's Progress Notes revealed R2 was sent to the Emergency Department (ED) on 02/28/24 for Acute Kidney Failure, based on elevated labs ordered on 02/27/24 by R2's attending physician. While at the ED, R2 was diagnosed with a UTI, an indwelling urinary catheter was inserted, and R2 was started on Keflex (an antibiotic) 500 milligrams (mg) orally (po) three times a day for seven days. When R2 returned to the facility the nursing staff failed to notify R2's attending physician of the new order for the antibiotic. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R2's March 2024 MAR revealed R2 continued with the Keflex (oral antibiotic) 500 mg po three times a day for five days from 03/03/24 through 03/08/24. Review of R2's EMR revealed a UA was ordered on 03/23/24 for .change in urine color/strong odor . R2's Progress Notes dated 03/23/24, revealed no documentation which indicated R2's urine had a change in color or strong odor. No further documentation was noted which indicated the facility attempted any non-pharmacological interventions, such as increasing fluids, for R2. R2's EMR lab results revealed UA results for 03/23/24, revealed - .Nitrites positive, Leukocytes - trace and Bacteria 4+ . -UA C&S [culture and sensitivity] final culture report dated, 04/01/24, revealed .Gram negative rods, Morgenella morganii 25,000 - 50,000 . -Cultures showing bacterial growth less than 100,000 are not clinical indicators of a UTI. No documentation was noted in R2's Progress Notes indicating R2 was showing any signs and symptoms of a UTI. Review of R2's March 2024 MAR revealed R2 was treated with Bactrim DS (antibiotic) orally one tab twice a day for seven days from 03/25/24 through 03/31/24. On 04/19/24 at 11:45 AM, Licensed Practical Nurse (LPN 1) verbalized was unable to recall R2 showing any clinical indicators for a UTI and indicated there was no documentation in R2's Progress Notes which indicated R2 had a UTI. On 04/19/24 at 1:30 PM, Director of Nursing (DON) confirmed R2's Progress Notes did not have documentation that clearly indicated R2 was showing signs and symptoms related to a UTI. The DON also stated the expectation was nursing staff clearly document indications of a possible UTI, the rationale for obtaining a urine specimen and starting an antibiotic.

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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 32513

Based on interview and record review, the facility failed to ensure the medical record was completed and accurate which included full completion of the care conference notes and accurately documenting the date, time, and attendees of the care conference for two residents (Resident (R) 18 and R13) and failed to obtain a physician order for an indwelling urinary catheter for one resident (R2) of 17 sampled residents. This failure placed residents at risk for inaccurate and incomplete medical information and potential unmet care needs.

Findings include:

Resident 18 (R18)

R18's Admission Record, provided by the Director of Nursing (DON), revealed R18 was admitted to the facility on [DATE] with diagnosis of alcohol induced dementia and diabetes.

R18's quarterly Minimum Data Set (MDS) revealed R18 had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R18 was moderately impaired in cognition.

Review of the Multidisciplinary Care Conference form, dated 05/23/23 revealed Section A, which included the date and time of the meeting, as well as Section B, attendance at the meeting was left blank. In addition, the Care Conference form was still in progress, and had not been closed out and locked.

Review of the Multidisciplinary Care Conference form, dated 02/05/24 revealed Section A, which included the date and time of the meeting, as well as Section B, attendance at the meeting was left blank. In addition, the Care Conference form was still in progress, and had not been closed out and locked.

On 04/16/24 at 11:41 AM, R18 was asked if had been invited or attended the resident's Care Conferences. R18 stated, I have not been invited and do not attend.

On 04/17/24 at 1:25 PM, the Social Service Designee (SSD) stated, it is my responsibility to complete the care planning notes when we hold the Care Conferences and did not fully document them, and they should have been closed out and not say in progress. The SSD further stated, If I get busy and can't finish them at the time of the meeting, it's a good chance they don't often get done.

On 04/18/24 at 9:08 AM, the DON was asked what the expectations were regarding ensuring all documentation at the Care Conferences was completed and locked. The DON stated, It is my expectation that all documentation is completed at the time of the meeting.

25232

Resident 13 (R13)

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2024
NAME OF PROVIDER OR SUPPLIER White Pine Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 Avenue G Ely, NV 89301	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R13's Face Sheet indicated R13 was admitted on [DATE] with diagnoses of cerebral palsy (CP), autistic disorder, and severe intellectual disabilities. R13's Multidisciplinary Care Conference dated 04/11/23 revealed, Unsigned, and in progress. There was no evidence that the social worker summary, physician summary, pharmacy summary and/or restorative care/physical therapy (PT)/occupational therapy (OT) summary were completed. R13's Multidisciplinary Care Conference dated 07/17/23, revealed Unsigned, and in progress. There was no evidence that the dietary, social worker summary, physician summary, pharmacy summary and/or restorative care/PT/OT summary were completed. In addition, there was no evidence that there was a meeting date and/or time along with no staff in attendance. R13's Multidisciplinary Care Conference dated 10/09/23, revealed Unsigned, and in progress. There was no evidence that the dietary, social worker summary, physician summary, pharmacy summary and/or restorative care/PT/OT summary were completed. On 04/18/23 at 1:10 PM, the Social Service Director (SSD) indicated responsibility for conducting the care conferences, and each department was responsible for filling out their information on the multidisciplinary care conference assessment before the SSD signed them. The SSD confirmed the multidisciplinary care conference assessments, dated 04/11/23, 07/17/23, and 10/09/23, were incomplete and indicated these should have been completed. 36461 Resident 2 (R2) R2's Admission Record revealed R2 was admitted to the facility on [DATE] with diagnoses which included neuromuscular dysfunction of the bladder, chronic respiratory failure, and hypertension. R2's quarterly MDS revealed R2 had a BIMS score of 15 out of 15 which indicated R2 was cognitively intact. A Progress Note dated 02/28/24, revealed R2 went to the Emergency Department (ED) on 02/28/24 for acute kidney failure, based on elevated blood work. Upon return to the facility R2 had an indwelling urinary catheter and had been diagnosed with a urinary tract infection (UTI), and started on an antibiotic. R2's EMR revealed no order for the urinary catheter. On 04/16/24 at 3:00 PM, R2 stated had the catheter for a while, but was unable to state when it was put in. On 04/18/24 at 1:30 PM, the DON stated was unable to find a physician's order for the urinary catheter and the DON was unable to state when the urinary catheter was inserted, or rationale for it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/18/24 at 3:00 PM, the DON acknowledged the facility had no documentation for R2's ED visit on 02/28/24. The DON stated would reach out to the hospital for additional information. The DON presented this surveyor documentation for R2's ED visit at 4:00 PM. The ED did not provide documentation related to UA results, only that R2 had been diagnosed with a UTI, an antibiotic started, and the urinary catheter inserted. On 04/19/24 at 11:45 AM, Licensed Practical Nurse (LPN 1) stated when residents returned from ED visits with any medication changes or urinary catheters inserted, the process was for nurses to notify the facility attending physician for approval. On 04/19/24 at 1:30 PM, the DON stated the expectation was nursing staff would notify the attending physician with any new or changed orders for residents after an ED visit and information would be documented in the resident's EMR.

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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 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** 32513 Based on observation, interview, record review, and review of facility policy, the facility failed to ensure hand hygiene and glove changes were performed for one of one resident (Resident (R) 3) reviewed for pressure ulcers of 17 sampled residents. This failure placed the resident at risk of infection. Findings include: Facility policy titled, Handwashing, Hand Hygiene, dated 03/03/24, revealed .Use an alcohol-based hand rub containing at least 62% alcohol; or alternately, soap (antimicrobial or non-antimicrobial) and water for the following situations .Before donning sterile gloves .Before handling clean or soiled dressings, gauze pads, etc.After handling used dressings, contaminated equipment . Resident 3 (R3)'s R3's Admission Record, provided by the Director of Nursing (DON), revealed R3 was admitted to the facility on [DATE] with diagnoses which included a stroke, peripheral vascular disease, and chronic kidney disease. R3's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/04/24, revealed R3 had a Brief Interview for Mental Status (BIMS) score of 2 out of 15 which indicted R3 was severely impaired in cognition and had two stage three (full thickness tissue loss) facility acquired pressure ulcers. During a wound care observation on 04/17/24 at 1:29 PM, Licensed Practical Nurse (LPN 1) donned gloves from the hallway PPE [personal protective equipment] cart outside R3's door. LPN 1 did not perform hand hygiene prior to glove usage. Certified Nurse Aide (CNA 4) also donned gloves without performing hand hygiene prior to entering the resident's room. After R3 was situated in bed for wound care, CNA4 was observed to remove the soiled dressing and throw the dressing away in the trash container. CNA4 did not remove the gloves or perform hand hygiene before continuing to assist with the resident during wound care observation. LPN1 applied the ointments and dressings as ordered. After wound care was completed and with the same soiled gloves, LPN1 reached into the LPN's pocket to retrieve a marker to date/time and initial the dressing. LPN1 then returned the marker to the pocket before removing the soiled gloves and performing hand hygiene. CNA4, with the same gloves on, assisted R3 with the resident's brief and pants before removing the CNA's gloves and washing hands. On 04/17/24 at 1:45 PM, LPN1 was asked when the last in-service on infection control was conducted which included glove changes and hand hygiene. LPN1 stated, It's been a minute. LPN1 further stated was aware did not perform hand hygiene prior to glove use and should have changed gloves before reaching into her pocket with soiled gloves on. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/17/24 at 1:52 PM, CNA4 was asked why did the CNA not perform hand hygiene or change gloves after removing the soiled dressing. CNA4 stated, Yes, I realized I did not use hand sanitizer before putting on my gloves, as soon as I did it. CNA4 further stated, I should have changed gloves after removing the soiled dressing.

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on interviews and record review, the facility failed to ensure 12-hour annual in-service training, as required for five of five Certified Nurse Aides (CNAs) (CNA4, CNA6, CNA5, CNA3, and CNA2) reviewed for training requirements. This failure placed the residents at risk of lacking the required knowledge and competency to perform their duties. Findings include: All five employee files were provided by Human Resources on 04/18/24. 1. Review of CNA4's employee file revealed a hire date of 05/24/22. The file contained no documentation regarding the required 12 hours of in-service training having been completed in the last year. 2. Review of CNA6's employee file revealed a hire date of 11/20/20. The file contained no documentation regarding the required 12 hours of in-service training having been completed in the last year. 3. Review of CNA5's employee file revealed a hire date of 12/21/22. The file contained no documentation regarding the required 12 hours of in-service training having been completed in the last year. 4. Review of CNA3's employee file revealed a hire date of 01/21/22. The file contained no documentation regarding the required 12 hours of in-service training having been completed in the last year. 5. Review of CNA2's employee file revealed a hire date of 12/30/22. The file contained no documentation regarding the required 12 hours of in-service training having been completed in the last year. On 04/18/24 at 11:55 AM, the Director of Nursing (DON) was asked if had documentation of the 12 hours of in-service training to include abuse/neglect and dementia care. The DON stated that had just been hired at the facility in the last 16 days and was not aware of what in-service training had been provided. On 04/18/24 at 1:43 PM, the DON provided the following in-service training to the survey team: -06/08/23, Abuse/neglect. -[DATE]: infection control. - 03/19/24 (30 min): on the facility elopement process, cultural competency (no date/time) - COVID-19 on 11/25/23. There was no dementia care/behavior training in the last 12 months. The DON was asked if these in-services were 12 hours, as required in the last year. The DON stated, no, this is all I could find.