STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295036	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Las Vegas Care Center	3215 E. Cheyenne Ave. North Las Vegas, NV 89030

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 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** 50289 Based on observation, interview, record review, and document review, the facility failed to ensure a medication was administered timely to 1 of 3 sampled residents (Resident #2). The deficient practice had a potential for the intended use of the medication to be insufficient or ineffective with a possible cause of harm to the resident. Findings include: Resident #2 (R2) R2 was originally admitted to the facility on [DATE] with diagnoses of Parkinson's Disease without dyskinesia, chest pain, personal history of transient ischemic attack, and cerebral infarction without residual deficits. A physician order dated 06/07/2024 for Doxycycline Hyclate 100 milligram (mg) tablet was ordered for cellulitis and was to be given at 9:00 AM and 9:00 PM. The medication administration record (MAR) revealed the resident missed the 9:00 PM dose on 06/07/2024, both doses on 06/08/2024, and the first dose of the medication was administered on 06/09/2024 at 9:00 AM. The MAR documented the facility was awaiting delivery of the medication from the Pharmacy. A physician order dated 06/07/2024 for Amoxicillin- Pot Clavulate 875-125 mg tablet was ordered for cellulitis and was to be given at 9:00 AM and 9:00 PM. The medication administration record (MAR) revealed the resident missed the 9:00 PM dose on 06/07/2024, both doses on 06/08/2024, and the first dose of the medication was administered on 06/09/2024 at 9:00 AM. The MAR documented the facility was awaiting delivery of the medication from the pharmacy. An Omnicell (an automated medication dispensing system which stores and tracks medications) medication availability log, revealed the Doxycycline Hyclate 100mg tablet and the Amoxicillin- Pot Clavulate 875-125 mg tablet were both available in the Omnicell at the facility to be used for the resident. On 01/30/2025 at 12:45 PM, a Licensed Practical Nurse (LPN) Unit Manager, confirmed the Omnicell medication availability log did contain the Doxycycline Hyclate 100mg tablet and the Amoxicillin- Pot Clavulate 875-125 mg tablet and both were available in the Omnicell at the facility to be used for the resident. (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/30/2025 at 02:16 PM, the Director of Nursing (DON), confirmed it is the policy of the facility to use the Omnicell machine for unavailable medications. The DON stated there is someone in the facility at all times which has access to the Omnicell machine. The DON also verified the physician had not been notified of the late start date of either of the medications. A facility policy titled Medication Procurement: Emergency Boxes and On-Site Stores revised 04/17/2024, documented on-site stores of medications were to be utilized in the care of new admissions, new orders unable to be received before the next scheduled pharmacy delivery, or when immediate medication administration were required.

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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 0697 Level of Harm - Minimal harm or potential for 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** 50513 Based on observation, record review and interview, the facility failed to provide pain medication as requested, assess, and document resident pain level accurately according to physician's order for 1 of 1 unsampled residents (Resident 4). The deficient practice placed the resident at risk for ineffective and inadequate pain control. Findings include: Resident 4 (R4) was admitted on [DATE] with diagnoses including angina pectoris, muscle wasting and atrophy, chest pain, absences of right and left leg below the knee, and pain. On 01/30/2025 at 10:23 AM, a Licensed Practical Nurse (LPN3) verbalized if medication is not available for a resident, a nurse should check the Omnicell (onsite medication dispensing machine) for the medication before waiting for the pharmacy to deliver the medication. On 01/30/2025 at 10:35 AM, the Registered Nurse Unit Manager (RN3) indicated the nurses use the Omnicell often to ensure resident do not go without medication. On 01/30/2025 at 10:42 AM, R4 was lying in bed, alert and oriented. R4 verbalized Norco (narcotic pain medication) not being given upon request during morning medication pass because the facility had run out of medication, and the resident would have to wait until the facility received the medication. R4 indicated only being given Tylenol but was still in pain. On 01/30/2025 at 10:48 AM, another LPN (LPN2) indicated if a resident does not have medication, the nurse can retrieve it from the Omnicell. On 01/30/2025 at 10:57 AM, LPN3 verbalized R4 had run out of Norco, but the pharmacy had indicated the medication would arrive around 11:30 AM. LPN3 indicated the resident had orders for Tylenol, and LPN3 had administered Tylenol while waiting for the Norco to arrive. LPN3 asked R4 if the resident was still in pain, and R4 confirmed the Tylenol was not effective and would like additional pain medication. LPN3 asked the resident if R4 would like additional Tylenol or Norco that can be pulled from the Omnicell. R4 verbalized wanting the Norco instead. The Omnicell inventory list indicated Hydrocodone-acetaminophen (Norco) - 5/325 mg was included in the inventory. R4's Comprehensive Care Plan dated 09/19/2024 documented the resident has pain and discomfort, and staff must assess and monitor for signs and symptoms of increased pain or discomfort. R4's medical record revealed Physician orders for: - Check resident for level of pain (8AM - 4PM - 8PM). Dated 08/31/2022 - Acetaminophen (Tylenol), over the counter - 325 milligrams (mg), administer 2 tablets (650 mg) as needed every 6 hours for moderate pain from 3-5. Dated 06/01/2023 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Hydrocodone-acetaminophen (Norco) - 5/325 mg, administer 1 tablet as needed every 4 hours for pain scale from 6-10. Dated 11/27/2023 R4's Medication Administration Review (MAR) for Acetaminophen lacked documented evidence of being administered on 01/30/2025. The MAR for Hydrocodone-acetaminophen documented being administered on 01/30/2025 at 11:16 AM. On 01/30/2025 at 11:49 AM, R4 indicated being at a pain level of 9 in the morning when the Tylenol was given, but the resident was feeling much better after receiving the Norco. On 01/30/2025 at 11:53 AM, LPN3 indicated not administering Tylenol and confirmed not administering any pain medication to the resident. LPN3 verbalized not asking the resident about the level of pain during the morning medication pass and incorrectly marking a pain level of 0 in the MAR. LPN3 conveyed if the resident's pain level had been properly monitored, the resident would have received pain medication sooner and not have been in pain. On 01/30/2025 at 11:30 AM, the Director of Nursing (DON) advised the pharmacy monitors and keeps the Omnicell stocked monthly. The DON verbalized the expectation for the nursing staff is to take medication from the Omnicell instead of waiting for the pharmacy to send it. The DON emphasized if a resident indicated a pain level of 8 to 10, the nursing staff should pull medication from the Omnicell, if the medication is available. The DON indicated LPN3 should have taken the Norco from the Omnicell instead of administering Tylenol. On 01/30/2025 at 2:27 PM, the DON verbalized if the resident's level of pain is not checked, it can delay the treatment and cause the pain to not be addressed. The DON indicated a pain level of 0 should not be given pain medication. The Medication Procurement policy revised 04/17/2024, documented the facility would utilize the onsite medication dispensing system when immediate medication administration is required. The Pain Management policy revised 05/05/2023, documented ongoing evaluation of resident's pain level will be used as the basis for revision of the comprehensive care plan. If the resident's pain is not adequately controlled, the resident's care plan may need to be revised.