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	09/11/2024

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

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39418 Based on observation, interview, record review, and document review, the facility failed to complete a Preadmission Screening and Resident Review (PASARR) Level 2 evaluation for newly found changes or diagnosis for 4 of 32 sampled residents (Resident 115, 81, 139 and 119). The deficient practice had the potential to place residents at risk of not being evaluated for appropriate determination of necessary behavioral health services. Findings include: Resident 115 (R115) R115 was admitted on [DATE], with an admitting diagnoses including chronic pancreatitis and blindness. On 08/09/2024 at 9:00 AM, the resident was observed lying in bed. During the introduction, R115 stated not wanting to talk to anyone and sternly ordered to leave the room. On 08/10/2024 and 08/11/2024 in the morning, R115 was observed wheeling self along the hallways while constantly talking to self. R115 was observed stopping at other resident room doorways and continuously talking even with no one inside the room. R115's Admission History and Physical dated 03/29/2024, lacked documented evidence under History of Present Illness (HPI) of any psychological symptoms suggesting a behavioral diagnosis. R115's listed Past Medical History: Blindness and history of polysubstance abuse. The facility provided R115 Admission PASRR dated 04/10/2023, documented Determination: No mental illness (MI), intellectual disability (IDD), and/or conditions related to intellectual disability (RC) or Dementia. Psychiatric Evaluation dated 03/30/2024 at 2:18 PM, documented Assessment: Patient had reported issues with anxiety over conditions, depression due to conditions, ongoing problems with pain and insomnia, suggest sleeping medications at bedtime, will discuss power of attorney (POA) with family, no capacity to leave against medical advice (AMA) and suggest discharge planning with social worker. (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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Psychiatric Progress Notes dated 05/19/2024 at 3:43 PM, documented Assessment: Patient had reported issues with anxiety over conditions, depression due to conditions, ongoing problems with pain and insomnia, will adjust medications. Psychiatric Progress Notes dated 08/11/2024, documented Psychiatric Review of Systems: positive for anxiety and insomnia/sleep changes. Assessment: Patient had reported issues with anxiety over conditions, refused all options, stopped taking antidepressant, discussed options, declined different anti-depressant despite reports of previously taking the medication. The patient declines to take this medication and will not order additional medications. All psychiatry consults visits had documented the diagnoses of: Anxiety and major depressive disorder (MDD), recurrent - severe with psychotic symptoms. Review of R115's nursing progress notes from 08/01/2024 to current revealed the following behavioral incidences: - The resident requires frequent redirection, - The resident has outburst and makes repetitive delusional statements, - The resident is argumentative with staff and is disruptive to other residents due to yelling and going in their rooms. - The resident refuses psychotropic medications and sleep aides. - The resident continues to wheel self up and down the hallway, talking to self, shouting to others walking by, and lifting shirt up. - The resident has been confrontational with staff, being very loud, stating wanting to leave. - The resident has been hard to redirect. - The resident is insistent on leaving facility, packed bags and roaming through halls. A progress note entry dated 09/11/2024 at 1:33 PM, documented R115 was yelling at medical transport as the resident refuses to be taken to North Vista Hospital and the resident wants to go to University Medical Center (UMC). Informed medical transport know this was a L2k hold (Legal 2000 - a term used in Nevada for a mental health crisis hold) from resident's psychiatrist but medical transporters stated the resident can go where pleases as long as vital signs are stable and is alert and oriented. The nurse informed both primary and psychiatrist know regarding what medical transport had stated. Resident took all belongings and stated, I'm never coming back here. Transport documents, L2K forms, and physicians' orders. Social services and DON made aware; Unit Manager called Emergency Department at UMC to give report on resident at 1:30 PM. Resident 81 (R81) R81 was admitted on [DATE], with an admitting diagnoses including significant for diabetes and neurocognitive disorder. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/09/2024 at 9:40 AM, the resident was observed verbally abusive to plumbers fixing the resident's sink. R81 was constantly yelling in Spanish to the contractors and at times to no one. On 08/10/2024 and 08/11/2024 in the morning, R81 was observed pacing inside the room, talking to self. R81's re-admission History and Physical dated 04/24/2024, documented the patient was found wandering and having suicidal ideation. The patient was evaluated in the emergency department, medically cleared and admitted to hospital psychiatric unit for further evaluation and treatment. Once the patient's psychotropic intervention was optimized and patient's mental health stabilized, patient was discharged to skilled nursing facility for ongoing care and treatment. The facility provided R81's Admission PASRR dated 10/12/2023, documented Determination: Dementia Alzheimer OBS. Psychiatric Evaluation dated 12/24/2023, documented Assessment: History of schizoaffective disorder, recent hospitalization , refusing medications, ongoing issues with compliance, discontinued oral medications due to refusals and no criteria for forced medications. The patient was requesting to leave against medical advice (AMA), but no capacity and coordinate with family. Psychiatric Evaluation dated 08/16/2024, documented Assessment: The patient has a reported history of neurocognitive disorders (NCDs) with delirium and psychosis, refusing oral medications, no criteria for legal hold at this time, no criteria for forced medications at this time, the patient was still yelling out. All psychiatry consult visit had a documented the diagnoses of: NCD with behavior and anxiety, schizoaffective disorder bipolar type. Review of R81's nursing progress notes from 09/01/2024 to current, revealed the following behavioral incidences: - The resident continues to refuse medication and blood sugar check. The patient was yelling and screaming while in room. Very difficult to redirect, denies pain or discomfort. - The resident yelling loudly, hitting bathroom door, upset plumber and our maintenance director was in bathroom fixing the sink, staff and this writer tried to explain to resident but was unsuccessful resident continued to yell, hit the bathroom door threatening staff. - The resident continues to refuse all meds, and blood sugar this shift, can be heard yelling to self and staff in Spanish, maintenance in bathroom in resident room attempting to unclog toilet, maintenance swapped out toilet due to toilet and drains being clogged with multiple brown paper towels, staff member at room to translate for maintenance, resident states I have been throwing those paper towels in the toilet since I got here, staff member educated resident in Spanish on risk of clogging toilet, and encouraged resident to not do so, will continue to monitor. - The resident was heard yelling loudly. Upon entering room noted aide picking up soiled brief with stool off floor and wet paper towels from resident throwing onto the floor, resident very loud yelling and waving hands in the air pointing in this writer face then threw wet paper towel hitting me on the leg. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident continues to refuse all medications and blood sugar checks. The resident had an episode of yelling and screaming. The resident was peeking out of doorway cursing at staff members. Very difficult to redirect. Denies any pain or discomfort. Will continue to monitor. Resident 139 (R139) R139 was admitted on [DATE], with an admitting diagnoses including cerebral infarction due to thrombosis and Dementia. On 08/09/2024 at 9:55 AM, the resident was observed lying in bed. During the introduction R139 just looked and said nothing. On 08/11/2024 in the afternoon, an aide was sitting next to R139 for close monitoring due to residents' aggressive behavior. R139's admission History and Physical dated 06/02/2024, the patient had a history of dementia who recently developed cerebral venous thrombosis with subarachnoid hemorrhage. This is causing refractory strokes, started on antiepileptic and was eventually controlled. The patient was eventually controlled and transferred to this facility. The facility provided R139's Admission PASRR dated 11/29/2023, documented Determination: Dementia Alzheimer OBS. Psychiatric Evaluation dated 06/02/2024, documented Assessment: issues with anxiety and sleep, suggest monitoring, no suicidal ideation (SI) or homicidal ideation (HI), ongoing restlessness and anxiety, problems with mood and psychosis. Psychiatric Evaluation dated 09/01/2024, documented Assessment: Noted negative signs of psychosis (avoidance, agitation, withdrawn behavior). Ongoing combative behavior, kicking and spitting at staff members, problems with refusals, aggression noted, will continue to titrate medications to target, ongoing intermittent fatigue. All psychiatry consults visits had documented the diagnoses of: Major depressive disorder, single episode, severe with psychotic features. Review of R139's nursing progress notes from 09/01/2024 to current revealed the following behavioral incidences: - The resident was up most of the night pacing the hallways and wandering into other resident's room. Very difficult to redirect. The resident became physically aggressive at the staff. Assisted back to bed and 1:1 close observation provided. - The resident continues to pace quickly in the hallways running fast. Assisted patient to TV room for resting period. - The resident was monitored 1:1 supervision alternating staff due to aggressive behavior and to keep distance from other residents and aggressive behaviors for safety. - The resident pulled down brief and pants in dayroom and pooped onto the floor and urinated. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/10/24 at 3:03 AM, the Director of social services (SS) indicated PASRR 2 had to be completed for residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition. The Director acknowledged indications of behaviors and or diagnoses would place a resident into the criteria for a level 2 PASRR. The Director indicated SS is responsible in referring residents for level 2 in conjunction with the DON. The Director confirmed there were no residents currently being considered for a level 2 evaluation. On 09/11/2024 10:53 AM, the Director of Nursing (DON) confirmed the mentioned residents had the exhibited behaviors and diagnoses. The DON was not aware the residents did not have a PASRR level 2 completed. The DON reviewed the original PASRR and acknowledged the lack of the MI identified on the level 1 PASRR. The DON acknowledged the residents should have had a Level 2 completed to ensure the residents were appropriate for the facility and any recommendations were followed through. The DON indicated staff should have informed SS or DON so the application could have been submitted. 41903 Resident 119 (R119) R119 was admitted on [DATE] and readmitted on [DATE], with diagnosis including heart failure unspecified, urinary tract infection, and essential primary hypertension. On 09/09/2024 at 12:49 PM, R119 was observed in bed while watching television. R119 was pleasant, calm, and did not display concerning or withdrawn behaviors when interviewed. A Nevada PASRR Level I Identification Determination dated 11/04/2021, revealed R119 did not have dementia, mental illness (MI), mental retardation (MR) or any related condition (RC), and was deemed appropriate for nursing facility placement. R119's medical record revealed new diagnosis of anxiety disorder due to known physiological condition on 06/27/2023, anxiety disorder unspecified on 07/02/2023, panic disorder (episodic paroxysmal anxiety) on 07/03/2023, post-traumatic stress disorder unspecified on 07/03/2023, and major depressive disorder, recurrent severe without psychotic features on 08/02/2023. A Psychiatric Progress Note dated 08/16/2024, documented R119's affect was flat, withdrawn and had been isolating in the room. R119 was depressed and anxious at times. Assessment included R119 had occasional panic. R119's medical record lacked documented evidence a referral was made for PASRR level 2 evaluation after the newly found diagnoses listed above. On 09/11/2024 at 1:17 PM, the Director of Nursing confirmed R119 had new diagnosis of anxiety disorder due to known physiological condition, anxiety disorder unspecified, panic disorder (episodic paroxysmal anxiety), post-traumatic stress disorder unspecified, and major depressive disorder, recurrent severe without psychotic features. The DON acknowledged R119 should have been referred for PASRR level 2 evaluation based on the newfound diagnoses and behaviors displayed. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Social Services Policies and Procedures, PASARR Documentation Policy revised 06/09/2023, documented any resident with newly evident or possible serious mental disorder, intellectual disability (ID) or a related condition must be referred, by the facility to the appropriate state-designated mental health intellectual disability authority for review.

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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** 40142 Based on observation, interview, record review and document review, the facility failed to ensure 1) the physician was notified of a high Vancomycin trough level (laboratory monitoring of Vancomycin to maintain therapeutic blood levels and prevent serious side effects) prior to administration of next dose and, 2) there was a physician order to hold Vancomycin when the nurse decided to not administer the medication during subsequent shift for a resident who was being treated for bacterial pneumonia for 1 of 32 sampled residents (Resident 143). The deficient practice placed the resident at risk for ineffective antibiotic therapy and serious side effects. Findings include: Resident 143 (R143) R143 was admitted on [DATE] and readmitted on [DATE], with diagnoses including intracranial injury with loss of consciousness and bacterial pneumonia. A physician's order dated 09/08/2024, documented to give Vancomycin reconstituted solution 1,000 milligrams (mg) 1.25 grams, intravenously (IV) every eight hours at 8:00 AM, 4:00 PM and 12:00 AM for bacterial pneumonia. On 09/09/2024 at 9:02 AM, R143's eyes were opened, but the resident was non-verbal. An IV pole was observed on the right side of R143's bed and a bag of IV Vancomycin 1,000 mg was infusing at 167 milliliters (ml) per hour through R143's right upper arm midline (IV access). On 09/10/2024 at 8:05 AM, R143 laid in bed with eyes opened. R143's enteral feeding was infusing but the IV pump was not in use. On 09/10/2024 at 8:07 AM, the Licensed Practical Nurse (LPN) indicated R143's IV Vancomycin scheduled for 8:00 AM would be held due to the night nurse's verbal report from the night nurse. The LPN explained the night nurse verbalized being responsible for entering laboratory orders for a Vancomycin trough level and would take care of coordinating with the laboratory vendor but according to the LPN, the laboratory technician had not arrived. The medical record lacked documented evidence the night nurse communicated the pharmacy request for a Vancomycin trough level with the physician, obtained and entered orders for a Vancomycin trough level to be drawn and coordinated with the laboratory vendor regarding the pharmacy request. The Laboratory book dated 09/09/2024 documented the resident's Vancomycin trough level had already been drawn on 09/09/2024 at 3:30 PM, specifically, the specimen was obtained at 3:19 PM, received by laboratory at 4:47 PM, verified by lab at 4:57 PM and results received by the facility at 11:26 PM. The laboratory report dated 09/09/2024, revealed R143's Vancomycin trough level was 21.8 microgram per milliliter (ug/ml). Reference range: 10.0 to 20.0 ug/ml. Interpretation: High. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The medication administration history report revealed the night nurse administered R143's Vancomycin's 12:00 AM dose on 09/10/2024. The medical record lacked documented evidence the nurse notified the physician regarding R143's high Vancomycin trough level which was made available to the facility at 11:26 PM on 09/09/2024. On 09/10/2024 at 9:10 AM, a Registered Nurse (RN) explained R143's Vancomycin trough had been drawn on 09/09/2024 at 3:30 PM and results were provided to the facility at 11:26 PM, more than 30 minutes prior to the next scheduled dose of 12:00 AM. The RN indicated the night nurse was an agency nurse who may not have been familiar with the laboratory book nor knew how to look up results in the electronic health record (EHR). On 09/10/2024 at 9:18 AM, the RN indicated the night nurse should have been aware of R143's high trough levels and communicated the abnormal result with the physician to enable the physician to provide guidance on whether to hold, delay or still administer the medication. On 09/10/2024 at 9:38 AM, the LPN acknowledged not personally verifying in the EHR on whether the night nurse had obtained orders for the resident's Vancomycin trough or whether a Vancomycin trough result was available in the EHR. The LPN confirmed there was no documentation nor information relayed by the night nurse that the physician was contacted for guidance and direction. The LPN acknowledged R143's scheduled 8:00 AM dose was held based solely on the verbal report from the agency night nurse. The LPN indicated the LPN should have verified Vancomycin trough levels in the EHR and contacted the physician before deciding to hold this morning's dose. On 09/10/2024 at 9:29 AM, the Unit Manager indicated the nurse who entered R143's Vancomycin orders on 09/08/2024 should have obtained and entered orders for laboratory monitoring for safety reasons since the medication was associated with certain toxicities. The Unit Manager confirmed R143's trough levels had been drawn and made available to the facility on [DATE] which the night nurse was expected to check prior to administering the midnight dose. In addition, the Unit Manager indicated the LPN should not have held R143's Vancomycin scheduled 8:00 AM dose without a physician's order. On 09/10/2024 at 1:36 PM, the Director of Nursing (DON) indicated Vancomycin was an antibiotic which had a narrow therapeutic index and came with blood monitoring requirements to attain therapeutic levels. According to the DON, when Vancomycin levels were low the drug would be ineffective and may cause toxicities when high. The DON indicated it was important for nursing to coordinate closely with pharmacy who was responsible for proper dosing and the physician who alone can order the drug to be held, delayed or given. The DON confirmed and emphasized the following: -the agency night nurse did not but should have known how to look up R143's Vancomycin trough levels which were made available to the facility on [DATE]. -the agency night nurse should have communicated R143's high trough levels with the physician prior to administering the medication on 09/10/2024 at 12:00 AM. - the LPN should not have held R143's 8:00 AM Vancomycin without a physician's order. The LPN did not administer the medication based solely on the verbal report from the night nurse, without verifying results were available in the EHR and without documentation the physician had not yet been notified. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- the nurse who entered the Vancomycin orders should have sought clarification, obtained and entered orders for blood monitoring such as Vancomycin trough levels and frequency thereof. The Pharmacy vendor's Vancomycin guidelines (2024), documented to 1) ensure initial Vancomycin orders included laboratory monitoring of Vancomycin levels and serum creatinine, 2) administer doses on time to achieve sustained serum concentrations, prevent resistance and progression of infection and mortality, 3) dose changes would be based on laboratory results if ordered by the prescriber and 4) do not hold dose unless there was a prescriber order to hold and 5) report laboratory results promptly for review. The IV Vancomycin education document (undated) which was provided by the DON, documented Vancomycin was an effective antibiotic used to treat a wide variety of bacterial infections. Vancomycin had a narrow therapeutic index (easy to underdose and overdose). Blood work was recommended to ensure proper dosing and to prevent kidney and ear damage.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46265 Based on observation, interviews, record review, and document review the facility failed to ensure care orders were entered and carried out for a colostomy (a surgical opening in the abdomen which provides a means for the collection of waste from the colon) in accordance with the resident care plan and facility policy for 1 of 32 sampled residents (Resident 69). The deficient practice had the potential for introducing infection and negative outcome of residents with a colostomy. Findings include: Resident 69 (R69) R69 was admitted on [DATE] and readmitted on [DATE]. On 09/09/2024 at 11:30 AM, R69 verbalized receiving care from the Certified Nursing Assistant (CNA) regarding colostomy however was not sure when the last time the barrier wafer was last changed on the colostomy. The medical record lacked documented evidence of any physician orders for the care and management of colostomy. On 09/10/2024 at 9:45 AM a CNA indicated the CNA would provide basic cleaning care for residents with a colostomy. The CNA would clean the area around the colostomy, ensure it was draining appropriately and change collection bag if needed. If the CNA noticed any concerns such as leaking or loose appliance, the nurse would be notified. Colostomy care would be documented in the electronic health record. The medical record revealed progress notes regarding colostomy were limited to identifying the colostomy was intact. The medical record did not indicate measures taken to monitor the colostomy or provide cleaning and care or changing the skin barrier wafer (appliance). On 09/10/2024 at 9:49 AM, a Licensed Practical Nurse indicated the CNA was responsible for cleaning around colostomy site, if the appliance on the colostomy needed to be changed the nurse would generally complete, however the CNA was trained to change appliance and bag. When a resident had colostomy there would be a physician order to identify the device used and frequency of cleaning and changes of appliance. The LPN indicated there were no orders for the resident of concern. On 09/10/2024 at 9:52 AM, the Unit Manager indicated there were no care and management orders for colostomy for resident of concern and there should be. When a resident had a colostomy, it would be identified during assessment and care and management orders should be entered. If there were no orders, there was a potential the needed care would be missed for the resident. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/11/2024 at 8:04 AM the Director of Nursing (DON) indicated when resident was admitted with colostomy a physician order should be obtained to clarify the type of care needed, how often and frequency of changing the colostomy appliance. The DON verbalized it was not appropriate to only document colostomy care in the care plan or physician orders. The facility policy titled Ostomy Care (revised 06/01/2015), documented ostomy appliances (wafers) usually stay on for five to seven days. If the resident experiences leakage, burning or pain underneath the appliance/wafer, it should be changed immediately and the peristomal skin evaluated.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40142 Based on observation, interview, record review and document review, the facility failed to ensure gastrostomy (G-tube) care orders were entered and carried out in accordance with facility protocol for 1 of 32 sampled residents (Resident 79). The deficient practice placed the resident at risk for G-tube complications including but not limited to infection, malposition and discomfort. Findings include: Resident 79 (R79) R79 was admitted on [DATE] and readmitted on [DATE], with diagnoses including metabolic encephalopathy, gastroparesis and gastrostomy malfunction. On 09/09/2024 at 1:34 PM, R79 was awake and able to communicate. A bottle of Glucerna 1.5 and a water bag was hanging on a tube feeding (TF) pump with feeding tube looped around the machine. The Unit Manager indicated R79's enteral feeding schedule was to be started at 7:00 PM and terminated at 7:00 AM. A physician's order dated 05/24/2024, documented to give Glucerna 1.5 at 80 cubic centimeters (cc) per hour for 12 hours via percutaneous endoscopic gastrostomy (PEG) tube, start at 7:00 PM, end at 7:00 AM. Flush PEG with water at 60 cc per hour for 12 hours, start at 7:00 PM, end at 7:00 AM. On 09/11/2024 at 9:18 AM, R79 laid in bed with TF pump off but tubing was still attached to the resident's G-tube site. R79 pulled gown up which revealed a reddish-brown stain on the inner part of the gown and on the edges of the gauze dressing which covered the G-tube site labeled 09/11. On 09/11/2024 at 9:19 AM, the Licensed Practical Nurse (LPN) indicated terminating R79's enteral feeding earlier in the morning. The LPN indicated the tubing was not disconnected from R79 because R79 was holding on to the clamp and refused to be disconnected. On 09/11/2024 at 9:20 AM, R79 verbalized not refusing to be disconnected from the tubing. On 09/11/2024 at 9:20 AM, the LPN did not correct R79 when the resident denied refusing to be disconnected. The LPN confirmed there was a reddish-brown stain which appeared to be dried blood on the resident's gown and on the edges of the G-tube gauze dressing. The LPN indicated the night nurse reported there was drainage around R79's G-tube site but did not expound on the drainage. The LPN acknowledged not assessing R79's G-tube site during the termination of feed because the LPN trusted the night nurse's report there were no complications to the site. On 09/11/2024 at 9:22 AM, the LPN removed the gauze dressing which revealed bright red tissue around the stoma (surgical opening). Scant amount of bleeding was observed more pronounced when the LPN pressed around the stoma. R79 interrupted, I have pulled my G-tube before. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/11/2024 at 9:32 AM, the Wound Registered Nurse (RN) assessed R79's G-tube site and described the fresh tissue as hyper granulation which was caused by tissue growth from the inside which was not unusual for G-tube sites, however, the bleeding was not normal and should be reported to the wound nurse who would make recommendations and obtain orders from the wound physician. The wound nurse indicated if R79's G-tube condition was not identified and addressed now, it would have placed R79 at a higher risk for G-tube complications such as infection. On 09/11/2024 at 9:50 AM, the Director of Nursing (DON) entered R79's room, donned gloves and assessed R79's G-tube site. The DON described the tissue growth as fresh and beefy red which appeared to be hyper granulation. The DON indicated the agency LPN was expected to assess the site during termination of the enteral feeding and report the skin condition and bleeding to the wound nurse. The DON indicated nurses must do their own assessments rather than just rely on other nurse's report. On 09/11/2024 at 9:52 AM, the DON and wound nurse indicated R79 had a history of tugging on G-tube but refused an abdominal binder. The DON indicated assessing the site was more important for R79 due to other risks such as malposition and dislodgement. If the G-tube was mispositioned and feeding was initiated without proper assessment, the resident may be placed at risk for aspiration, bloating, discomfort and unnecessary hospitalization . On 09/11/2024 at 1:02 PM, the DON indicated having had the chance to review R79's medical record and confirmed no care orders were in place for R79's G-tube site care which should have included assessment and monitoring every shift, identifying and reporting abnormalities and cleansing and dressing changes. The DON indicated the resident was admitted with a G-tube on 02/18/2024 and there had been no care orders for the G-tube site ever since. According to the DON, any nurse who identified care orders were lacking and not in place could have obtained and transcribed care orders from a physician. The DON indicated the facility followed the [NAME] standards of practice for tube feeding. The Lippincott Nursing Procedures (9th edition), revealed G-tube site care included inspecting the tube for migration, signs of infection, pain and presence of drainage. If skin problems develop, consult the wound nurse.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40142 Based on observation, interview, record review and document review, the facility failed to ensure it was free of a medication error rate of five percent (%) or greater for one unsampled resident (Resident 58) and 1 of 32 sampled residents (Resident 61). The deficient practice placed other residents at risk for medication errors. Findings include: On 09/10/2024 in the morning, a Medication Administration Pass observation was performed with 32 opportunities observed and revealed three errors. The medication error rate was 9.38%. Resident 58 (R58) R58 was admitted on [DATE] and readmitted on [DATE], with diagnoses including type two diabetes mellitus. On 09/10/2024 at 8:21 AM, the Licensed Practical Nurse (LPN) prepared and administered the following medications to R58: - Metformin hydrochloride (HCl) 500 milligrams (mg), one tablet - Aspirin 81mg chewable, one tablet - Vitamin B12 500 micrograms (mcg), two tablets - Docusate sodium 100 mg, one tablet - Sennosides with docusate sodium 8.6 mg, two tablets - Thiamine 100 mg, one tablet - Vitamin D 25 mcg 1,000 units, two tablets A physician's order dated 07/23/2024, documented to give Metformin 500 mg, one tablet by mouth twice a day at 7:00 AM and 7:00 PM, give with meals. On 09/10/2024 at 8:25 AM, there was no breakfast tray in R58's room. R58 indicated finishing breakfast about an hour ago. Resident 61 (R61) R61 was admitted on [DATE], with diagnoses including type two diabetes mellitus and schizoaffective disorder. On 09/10/2024 at 8:37 AM, the LPN prepared and administered the following medications to R61: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Metformin HCL 500 mg, two tablets - Aspirin 81 mg enteric coated, one tablet - Clopidogrel 75mg, one table - Cymbalta Duloxetine 30 mg delayed released, one tablet - Enoxaparin syringe 40 mg/0.4 milliliter (ml) injection - Famotidine acid reducer 20 mg, one tablet - Magnesium oxide 400 mg, one tablet - Pregabalin 75 mg, two tablets - Vitamin D3 25 mcg 1,000 units, four tablets A physician's order dated 07/23/2024, documented to give Metformin 500 mg two tablets by mouth twice a day at 7:00 am and 7:00 PM, give with meals. On 09/10/2024 at 8:40 AM, there was no breakfast tray in R61's room. R61 indicated finishing being done with breakfast more than an hour ago. Late medications/Not given with meals On 09/10/2024 at 8:42 AM, the LPN explained breakfast trays were delivered to the unit at 7:00 AM. The LPN indicated Metformin (anti-diabetic drug) was ordered to be given with meals for R58 and R61 because the medication decreased intestinal absorption of glucose. The LPN acknowledged administering R58's Metformin at 8:21 AM and R61's Metformin at 8:37 AM which was more than one hour after breakfast was served. The LPN explained being assigned 25 residents and the LPN acknowledged routinely administering 7:00 AM medications together with routine medications scheduled for 8:00 AM as a time-saving measure so the LPN would not need to enter a resident's room twice. On 09/10/2024 at 9:55 AM, the Unit Manager indicated Metformin was a diabetic medication typically ordered to be administered with meals to help control the resident's blood sugar by reducing the amount of glucose absorbed by the body. The Unit Manager indicated if it was not possible for the medication to be given during the actual mealtime, the LPN should at least try to administer the medication 30 minutes before or after a meal for efficacy. According to the Unit Manager the Metformin for R58 and R61 was not administered in accordance with physician's order when the medication was administered more than one hour after breakfast, and it was also considered a late administration since the facility expected medications to be given within one hour from scheduled time. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/10/2024 at 12:47 PM, the Director of Nursing (DON) indicated Metformin was typically ordered prior to or during meals because the drug bonded with food to decrease glucose levels in the body plus doing so reduced bowel side effects. The DON confirmed the Metformin for R58 and R61 were not given in accordance with the physician's order to give with food and in addition the medication was considered as late administrations since the medication which was scheduled for 7:00 AM were given to R58 at 8:21 AM and to R61 at 8:37 AM. The Mosby's Nursing Drug Reference handbook 2024 (37th edition) which was provided by the DON, revealed Metformin was an antidiabetic drug which inhibited hepatic glucose production and increased sensitivity of peripheral tissue to Insulin. Administer oral route with meals to decrease gastrointestinal upset and provide best absorption. The Medication Management Program policy revised 05/05/2023, documented nurses must understand indications or reason for use of therapy, effectiveness for achieving therapeutic goal, drug actions and the rights of medication administration which included right time. Medications were administered no more than one hour before to one hour after the designated medication pass times. Omitted/Missed dose On 09/10/2024 at 8:37 AM, the LPN administered nine routine medications to R61 except for Risperdal. A physician's order dated 09/02/2024, documented to give Risperdal 2 mg one tablet by mouth twice a day at 8:00 AM and 8:00 PM. On 09/10/2024 at 8:45 AM, the LPN indicated R61's Risperdal could not be administered due to the drug being unavailable. The LPN explained it was the LPN's first shift for the week and indicated expecting the previous nurses assigned to R61 to have replaced the resident's Risperdal to prevent a missed dose. The LPN indicated being trained to reorder medications which were running low, specifically when there were at least three days' worth of the medication remaining. The LPN indicated nurses could place orders electronically, by facsimile or by phone. On 09/10/2024 at 10:03 AM, the Unit Manager indicated nurses were expected to reorder medications when supply was running low to prevent missed doses. The Unit Manager indicated nurses may order electronically by clicking on the reorder button, by facsimile or placing a phone call to pharmacy. The Unit Manager pointed to the medication dispensing system in the medication storage room and indicated Risperdal was available in the form of 0.25 mg tablets. The Unit Manager indicated the LPN should have reached out to the physician for guidance on whether to administer eight Risperdal 0.25 mg tablets or to just wait for pharmacy delivery. The Unit Manager reviewed R61's medical record and confirmed the LPN had not reached out to the physician rendering R61's Risperdal as a missed dose which was not handled properly. On 09/10/2024 in the morning, the LPN acknowledged not reaching out to the physician regarding R61's missed Risperdal dose. The LPN indicated not having access to the medication dispensing system due to being newly employed in June 2024. The LPN indicated not being aware Risperdal was available in the medication dispensing system. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/10/2024 at 12:41 PM, a pharmacy representative arrived in the 200-Hall nurse's station to drop off medications. The pharmacy staff member indicated they made three deliveries a day and some emergency deliveries when needed. According to the pharmacy staff member, medications could be delivered within the day or the following day depending on what time the order was placed. On 09/10/24 at 2:17 PM, the Director of Nursing (DON) reviewed R61's medical record and confirmed the LPN had not notified the physician about the missed Risperdal dose this morning. The DON indicated nurses were trained to reorder medications when there was at least three days of medications left to avoid missed doses. According to the DON, Risperdal was an anti-psychotic medication which may affect the resident's mood and behavior and affect therapeutic levels when missed. The DON indicated missed doses were expected to be reported to the physician. The Medication shortages/Unavailable medications policy revised 08/01/2024, documented upon discovery of an inadequate supply of a medication, facility staff should initiate action to obtain the medication from pharmacy. If a medication was found to be unavailable, the nurse should obtain the supply from the medication dispensing system. If the medication could not be obtained through the emergency supply, the nurse should contact the physician to obtain new orders or directions for alternate administration.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39418 Based on interviews, record review, and document review, the facility failed to provide documented evidence influenza and pneumococcal vaccine was provided for 2 of 5 sampled residents (Resident 115 and 81). The deficient practice had a potential to prevent ensuring residents have had the necessary vaccines in fighting off diseases. Findings include: Resident 115 (R115) R115 was admitted on [DATE], with diagnoses including chronic pancreatitis and blindness. R115 Electronic Healthcare Records (EHR) under Preventive Health Care; Vaccinations, Tests & Results documented: No data available. Resident 81 (R81) R81 was admitted on [DATE], with diagnoses including significant for diabetes and neurocognitive disorder. R81 EHR under Preventive Health Care; Vaccinations, Tests & Results documented: No data available. On 09/11/2024 at 12:41 PM, reviewed the EHR with the Infection Preventionist (IP) and confirmed the vaccine records section of the residents were blank. The IP checked the physician's orders and the medication administration record (MAR) for the missing vaccines with no results. The IP indicated all vaccines either given, historical or offered but refused were to be documented on the residents EHR. The facility policy titled Standing Orders for Immunizations dated 05/15/2023, documented the facility evaluates residents' vaccination status upon admission and annually. The facility will provide pneumococcal and influenza vaccinations, unless medically contraindicated or refused by the resident or representative. Document the date, time and injection site or the declination in the medical record.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39418 Based on interviews, record review, and document review, the facility failed to provide documented evidence Corona Virus 19 (COVID 19) vaccine was provided for 2 of 5 sampled residents (Resident 115 and 81). The deficient practice had a potential to prevent ensuring residents have had the necessary vaccine in fighting off the specific viral disease. Findings include: Resident 115 (R115) R115 was admitted on [DATE], with diagnoses including chronic pancreatitis and blindness. R115 Electronic Healthcare Records (EHR) under Preventive Health Care; Vaccinations, Tests & Results documented: No data available. Resident 81 (R81) R81 was admitted on [DATE], with diagnoses including significant for diabetes and neurocognitive disorder. R81 EHR under Preventive Health Care; Vaccinations, Tests & Results documented: No data available. On 09/11/2024 at 12:41 PM, reviewed the EHR with the Infection Preventionist (IP) and confirmed the vaccine records section of the residents were blank. The IP checked the physician's orders and the medication administration record (MAR) for the missing COVID 19 vaccine with no results. The IP indicated all vaccines either given, historical or offered but refused were to be documented on the residents EHR. The IP indicated the historical COVID 19 could be looked up at the Web-IZ (Nevada's Immunization Information System (IIS), which contains immunization records for all ages) and then recorded at the EHR of the resident. The IP confirmed COVID 19 vaccine was part of the immunization standing orders from the physicians. The facility policy titled Standing Orders for Immunizations dated 05/15/2023, documented the facility evaluates residents' vaccination status upon admission and annually. The facility will provide pneumococcal and influenza vaccinations, unless medically contraindicated or refused by the resident or representative. Document the date, time and injection site or the declination in the medical record.