STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295037	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Henderson Health and Rehabilitation	1180 E. Lake Mead Parkway Henderson, NV 89015

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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** 51397 Based on observation, interview and record review the facility failed to develop a care plan for denture care needs for 1 of 35 sampled residents (Resident 15). The deficient practice had the potential to place residents at risk for inability to chew food, malnutrition and unintentional weight loss Findings include: Resident 15 (R15) R15 was admitted on [DATE], with diagnoses including lack of coordination and dysphagia. On 08/21/2024 at 8:28 AM, R15 was observed sitting up in a wheelchair eating breakfast in their room. R15 had two pieces of toast, scrambled eggs, one banana and a glass of juice. R15 did not have any teeth while eating the banana. R15 had dentures and required assistance to put on the dentures. R15 stated they frequently ate without the dentures because they did not get help putting the dentures on during meal service. R15 voiced frustration with not getting help putting on their dentures and stated it limited food and eating options. R15 indicated the dentures were in a yellow denture cup on the nightstand. Review of R15's care plan for personal care/oral hygiene revised on 06/12/2024, showed R15 required one staff member participation with personal hygiene and oral care. The care plan showed R15 was at risk for poor intake by mouth, had difficulty swallowing and was at risk for aspiration (choking). Interventions included: - Provide assistance with meals as needed. The care plan lacked documentation to show R15's need for denture assistance as well as goals with appropriate interventions. On 08/23/2024 at 10:37 AM, the Minimum Data Set (MDS) coordinator stated R15 did not have any issues with their dentures. The MDS Coordinator stated any oral/dental needs in the care plan would be listed under oral care and hygiene. The MDS Coordinator stated the nursing staff had the capability to individualize the care plan to include a care plan for dentures. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/23/2024 at 3:29 PM, the Director of Nursing (DON) reviewed the care plan and stated R15 should have been care planned for denture use so it could reflect on the point of care flowsheets the certified nursing assistants looked at.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51397 Based on interview and record review the facility failed to provide pressure ulcer (PU) preventative measures for 1 of 3 sample closed records reviewed (Resident 246). The deficient practice had the potential to place residents at risk for worsening pressure ulcers and diminished quality of life. Findings include: Resident 246 (R246) R246 was admitted on [DATE] with stage 3 pressure wounds to the right heel, right lower extremity and coccyx. Review of the Minimum Data Set showed R246 required substantial/maximal assistance, rolling from left to right. Review of the care plan showed R246 had impaired skin integrity and existing pressure ulcers. Goals included potential for complications would be minimized. Interventions included: -Provide assistance with turning and repositioning to prevent skin breakdown. Review of the turning and repositioning flowsheet from 02/20/2024 to 03/11/2024, showed R246 was not repositioned for 15 shifts during this period. 02/20/2024- Not repositioned on the AM and night shifts 02/21/2024- 02/23/2024- Not repositioned on night shifts 02/25/2024- 02/29/2024- Not repositioned on night shifts 03/05/2024- Not repositioned on night shift 03/07/2024- Not repositioned on day shift On 08/23/2024 at 10:58 AM, the Wound Care Nurse stated repositioning a resident was very important in preventing new pressure ulcers or preventing existing ulcers from getting worse. The Wound Care Nurse stated bed bound residents should be repositioned every two hours to achieve this. Review of the facility policy revised on 12/2023, indicated residents with pressure ulcers were to receive necessary treatment and services to promote healing, prevent infection and prevent new, avoidable pressure injuries from developing. The policy stated this could be achieved by multiple factors including repositioning the resident. On 08/23/2024 at 3:29 PM, the Director of Nursing (DON) stated the care staff should have repositioned R246 and the documentation should have reflected that. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Complaint #NV00070737

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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 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** 40142 Based on observation, interview, record review and document review, the facility failed to ensure a resident was provided 1:1 feeding assistance per physician order for 1 of 35 sampled residents (Residents 114). The deficient practice had the potential to prevent residents from consuming provided meals to maintain optimal weight. Findings include: Resident 114 (R114) R114 was admitted on [DATE] and readmitted on [DATE], with diagnoses including end stage renal disease and dysphagia oropharyngeal phase and Barrett's esophagus without dysplasia. On 08/22/2024 at 8:05 AM, R114 was observed sitting in wheelchair in the middle of the 2100-Hallway holding an empty blue bowl with right hand, white cereal contents were spilled on R114's clothes. The resident had difficulty mouthing words but managed to say yes when asked if the resident needed help. Several rooms away, a nurse was standing behind a medication cart, there were no other staff members observed in the unit. On 08/22/2024 at 8:07 AM, a breakfast tray placed on a rolling bedside table was observed approximately three feet away from R114. The tray contained a meal ticket which revealed R114 was on a renal dysphagia pureed diet and contents of the meal tray were identified as super cereal, omelet, and juice. The meal ticket did not include any assistance instructions. On 08/22/2024 at 8:15 AM, a Registered Nurse (RN) indicated not being familiar with R114 since the RN was a night shift nurse not steadily assigned to the resident. The RN indicated not being aware if R114 required supervision or assistance with meals. On 08/22/2024 at 8:20 AM, a Certified Nursing Assistant (CNA) came out from another resident's room in the 2100-hall. The CNA indicated not being familiar with R114 because the CNA was originally assigned to the 300-Hall but was reassigned to the 2100-Hall this morning due to a staff call-in. The CNA confirmed R114 was holding an empty bowl of cereal the contents of which appeared to have spilled on R114's clothes. The CNA observed R114's tray and described the plate as five percent consumed as there appeared to be a few bites from the scrambled egg with the rest of the food items left untouched. The CNA continued to observe R114 and verbalized R114 appeared to be appropriate for one-on-one (1:1) feeding assistance or at the very least supervision due to cognition issues. The CNA confirmed R114 had no supervision or assistance when the breakfast tray was served. The CNA explained being busy feeding another resident and the CNA was not familiar how many staff members were assigned to the unit. An Admission Minimum Data Set (MDS) dated [DATE], documented Resident 114 had a Brief Interview for Mental Status (BIMS) score of 03 (severely impaired cognition). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/22/2024 at 8:30 AM, the RN indicated being busy with medication administration and confirmed the RN was not providing any supervision or assistance to R114 during breakfast. The RN indicated not being aware R114 had spilled cereal on self because the RN was focused on medication pass. A Physician Order dated 03/01/2024, documented to provide R114 with 1:1 feeding assistance as resident required maximum cueing to safely consume meals. A Speech Therapy Encounter Note dated 03/05/2024, documented Speech Therapist (ST) provided caregiver education on new order of 1:1 feed, ST provided caregiver training on feeding techniques and cues to provide R114 safe swallow. A Physician Order dated 07/23/2024, documented to provide R114 with 1:1 feeding assistance as resident required maximum cueing to safely consume meals. R114's Nutrition Care Plan revealed R114 had an undesired significant weight loss identified in February 2024, May 2024, June 2024, and July 2024, and an intervention was added on 07/22/2024 which was to provide 1:1 feeding assistance to R114 with maximum cueing and encouragement. An Admission Nutrition Evaluation dated 12/21/2023, documented R114 was able to feed self and required tray set up. R114's weight was 150.0 pounds (lb.) and a body mass index (BMI) of 21.5 (reference range: BMI 23-30). A Quarterly Nutrition Evaluation dated 03/21/2024, documented R114 was able to feed self and required tray set up. R114's weight was 145.0 lb. which was considered an insignificant weight loss over three months. BMI 20.8 below ideal BMI for age. A Quarterly Nutrition Evaluation dated 06/20/2024, documented R114 required limited assistance with tray set up, provide 1:1 feeding assistance as needed. R114's weight was 134.0 lb. which was considered an unplanned/undesired significant weight loss over a three-month and six-month period. BMI 19.2. An Admission Nutrition Evaluation dated 07/28/2024, documented R114 required limited assistance with tray set up, provide 1:1 feeding assistance as needed. R114's weight was 130.0 lb. which was considered an unplanned/undesired significant weight loss over six months. BMI 18.7. The Follow-up Question Look Back report on Eating revealed the following feeding assistance was provided to R114 during the period covering 08/01/2024 through 08/22/2024: -Tray set up or clean up assistance was provided 35 times out of 61 meal opportunities. Tray set up and clean up assistance was defined as: helper sets up or cleans up while resident completed activity. Helper assists only prior to or following the activity. -Supervision or Touching assistance was provided 13 out of 61 meal opportunities. Supervision or touching assistance was defined as: helper provided verbal cues and/or touching, steadying or contact guard assist. Assistance may be provided throughout or intermittently. -Partial or moderate assistance was provided once out of 61 meal opportunities. Partial or moderate assistance was defined as: helper does less than half the effort. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Dependent assistance was provided once out of 61 meal opportunities. Dependent assistance was defined as: helper does all the effort to complete the activity. -R114 refused the eating activity six times out of 61 meal opportunities. The Quarterly MDS dated [DATE], revealed R114 had a weight loss of more than five percent (%) in the last month or loss of 10 % in the last six months which was not physician prescribed. On 08/22/2024 at 2:13 PM, the Registered Dietitian (RD) explained nutritional assessments were completed on admission, quarterly, annually and when there were significant changes. The RD reviewed R114's medical record and confirmed the RD documented R114 as able to feed self, requiring tray set up in the nutritional assessments dated 12/21/2023 and 03/21/2024 and documented R114 as requiring limited assistance, tray set up with 1:1 assistance as needed in the nutritional assessments dated 06/20/2024 and 07/28/2024. The RD confirmed R114 was currently at significant weight loss status with 7.6 % weight loss over a three-month period and 14.1 % over a six-month period. On 08/23/2024 at 8:35 AM, the RD clarified 1:1 feeding assistance as needed meant there were times R114 may need assistance with meals and there may be times the resident did not need assistance with meals. The RD read the physician's order dated 07/23/2024 which the RD interpreted as R114 requiring feeding assistance at all times with every meal. The RD indicated not being aware of the physician's order and acknowledged the RD's nutritional assessments on R114's functional status and assistance with meals did not align with the physician's order. The RD pulled up R114's Kardex which documented to provide the resident with 1:1 feeding assistance as R114 required maximum cueing to safely consume meals. The RD indicated there was a breakdown of communication among the inter-disciplinary team (IDT) members regarding R114's functional status and required assistance with eating. On 08/23/2024 at 8:35 AM, the Assistant Director of Nursing (ADON) indicated not being aware of the physician's order regarding providing R114 with 1:1 feeding assistance for all meals. The ADON indicated being under the impression R114 required tray set up and supervision with eating. The ADON indicated expecting CNAs to check each resident's Kardex especially when they were not familiar with the resident to ensure proper assistance was provided to each resident with meals. The ADON confirmed significant weight loss was identified for R114 since the June 2024 nutrition evaluation. The ADON indicated there was a breakdown of communication among the inter-disciplinary team (IDT) members regarding R114's functional status and required assistance with eating. On 08/23/2024 at 1:24 PM, the Director of Nursing (DON) indicated being familiar with the physician's order for R114's 1:1 feeding assistance. The DON explained the original order was signed by the physician on 03/01/2024 based on ST recommendations. The order was discontinued on 07/20/2024 when R114 was transferred to the hospital. Upon the resident's readmission on 07/23/2024, the physician's order for 1:1 feeding assistance was renewed where R114 was expected to have been provided 1:1 feeding assistance with all meals. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON indicated being made aware by staff of the meal observation by the surveyor on 08/22/2024 when there was no assistance nor supervision provided to R114 during the breakfast meal. The DON explained there were two CNAs and one LPN who called off work in R114's unit on 08/22/2024 and staff were reassigned to cover the 2100-Hall. The DON verbalized the meal observation reflected staff were not following the physician's order and the resident's nutrition care plan. The DON indicated being aware of R114's significant weight loss and indicated the resident would have benefitted from 1:1 feeding assistance to keep the resident engaged in the meal process. The DON agreed the RD's nutritional assessment which reflected R114 requiring tray set up with limited assistance and 1:1 feeding assistance as needed did not align with the physician's order which clearly stated 1:1 feeding assistance was to be provided for all meals and not on an as needed basis. The DON indicated the CNAs were expected to read each resident's Kardex which clearly documented R114 required 1:1 assistance with each meal.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40142 Based on interview, record review, and document review, the facility failed to ensure 1) dialysis (renal replacement therapy) appointments were not missed, or full treatment not completed for 2 of 7 sampled residents (Residents 114 and 220); and 2) dialysis communication records were completed for 3 of 7 sampled residents (Residents 176, 113, and 126). The deficient practice placed the residents at risk for complications of insufficient dialysis including but not limited to fluid overload, uremia (toxins in the blood) and electrolyte imbalance. Findings include: 1) Resident 114 (R114) R114 was admitted on [DATE] and readmitted on [DATE], with diagnoses including end stage renal disease and dependence on renal dialysis. A physician's order dated 07/23/2024, documented R114's received dialysis treatments on Tuesdays, Thursdays, and Saturdays at an outpatient dialysis provider. A nursing progress note dated 07/18/2024, revealed the assistant administrator instructed the nurse to ask the physician if it was okay for R114 to miss dialysis this Saturday (07/20/2024) due to facility not having transportation. Nurse awaiting physician response. The medical record lacked documented evidence the physician responded to the nurse regarding R114's upcoming scheduled dialysis on 07/20/2024. On 08/21/2024 at 10:17 AM, the charge nurse at the dialysis provider indicated R114 had been a patient since 02/04/2023 and staff were very familiar with R114. The charge nurse explained R114's dialysis prescription was three hours and 30 minutes, three times a week on Tuesdays, Thursdays and Saturdays. The charge nurse confirmed R114 was a no-show on 07/20/2024 and the dialysis clinic did not receive any phone calls from the skilled nursing facility (SNF) regarding R114's absence. The dialysis center staff made multiple attempts to contact the SNF on 07/20/2024 but was unsuccessful at getting someone on the phone. On 08/23/2024 at 2:29 PM, the Director of Transportation (DOT) confirmed R114 was not transported to the dialysis provider on 07/20/2024 due to the facility not having a driver since one driver was on vacation and another had called off work on 07/20/2024. A Dialysis Communication Record dated 08/17/2024, documented R114 arrived late at the dialysis provider and prescribed treatment time was not completed. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/22/2024 at 9:51 AM, R114's primary nurse at the dialysis provider indicated being familiar with R114 who had been assigned to the nurse since R114's transfer from another dialysis clinic in February 2023. The nurse explained the dialysis staff did their best to complete each patient's dialysis prescription time even on days when patients arrived late because every minute counted with dialysis. The dialysis nurse indicated there had been a few times R114 arrived late, but the nurse still completed R114's treatment, however, on 08/17/2024 the nurse was unable to complete 114's treatment because the transportation driver at the SNF had arrived at usual time and was unable to wait for completion of treatment. A Dialysis Progress Note dated 08/17/2024, documented unable to complete prescribed time due to R114's transportation arriving late. The nurse reminded transportation driver to bring R114 on time next treatment. On 08/23/2024 at 2:29 PM, the Director of Transportation indicated not being the driver assigned to transport R114 on 08/17/2024 and verbalized not being able to speak on behalf of the driver who transported R114 on 08/17/2024. The Dialysis agreement dated 08/24/2023, documented the SNF was responsible in ensuring each resident was prepared to spend an extended length of time in the dialysis facility for the administration of the prescribed treatment. The SNF was responsible for arranging transportation of residents to and from the dialysis facility. 33980 Resident 220 (R220) R220 was admitted on [DATE], with diagnoses including end stage renal disease and dependence on renal dialysis. The Physician Order dated 06/04/2024, documented hemodialysis every Tuesday, Thursday, and Saturday. The Nursing Progress Notes dated 07/20/2024 at 6:50 PM, documented a report was received from day shift nurse R220 missed hemodialysis today due to no transportation. On 08/22/2024 at 10:27 AM, the Medical Records Director confirmed R220 had no dialysis communication record for 07/20/2024 (Saturday) because the resident missed dialysis due to no transportation. On 08/22/2024 at 3:30 PM, the Director of Transportation revealed the nurses would inform them of the dialysis schedule of the residents. The facility would have provided transportation to all residents with their dialysis appointment. The Director of Transportation explained the need to verify the Transportation Log for 07/20/2024. On 08/22/2024 at 3:54 PM, the Director of Transportation indicated the facility had contracted two companies to transport residents to their appointment as needed or when the facility drivers called-in sick. The Director of Transportation explained the driver scheduled to transport residents to dialysis on 07/20/2024 called-in and the other driver was on vacation. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Transportation confirmed R220 missed the dialysis appointment on 07/20/2024 because of transportation issue. The contracted transport company was only able to transport three of five residents scheduled for dialysis on 07/20/2024. A copy of the Transportation Log for 07/20/2024 was provided which documented R114 and R220 were not transported to their dialysis appointment on the same day. On 08/23/2024 at 8:31 AM, the Administrator explained if one driver was on vacation, other drivers should have been asked if they could have covered (worked for the driver on vacation) or called the contracted transport companies to find coverage. On 08/23/2024 at 1:48 PM, the Director of Transportation indicated the driver assigned to work on 07/20/2024 was scheduled from 8:00 AM to 6:30 PM. The driver called-in at 5:00 AM on 07/20/2024. The Director of Transportation confirmed the contracted transport company could only accommodate three of five residents because their schedule was tight since the request was made on the same day. The Director of Transportation explained the request for transport with the contracted transport company should have been done at least three days ahead so the request could have been accommodated. 2) Resident 176 (R176) R176 was admitted on [DATE], with diagnoses including stage three chronic kidney disease and dependence on renal dialysis. A Physician Order dated 05/09/2024, documented hemodialysis every Monday, Wednesday, and Friday. R176's medical record lacked documented evidence a Dialysis Communication Record was completed for 07/19/2024 (Friday). Resident 113 (R113) R113 was admitted on [DATE] and discharged on [DATE], with diagnoses including end stage renal disease and dependence on renal dialysis. A Physician Order dated 06/05/2024, documented dialysis every Monday, Wednesday, and Friday. R113's medical record lacked documented evidence a Dialysis Communication Record was completed for 08/16/2024 (Friday) and 08/19/2024 (Monday). Resident 126 (R126) R113 was admitted on [DATE] with diagnoses including end stage renal disease and dependence on renal dialysis. A Physician Order dated 02/26/2024, documented hemodialysis every Monday, Wednesday, and Friday. R126's medical record lacked documented evidence a Dialysis Communication Record was completed for 07/22/2024 (Monday). (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/22/2024 at 10:20 AM, a Licensed Practical Nurse (LPN) indicated when a resident went to dialysis, the nurse assigned to the resident would have completed the pre-dialysis portion of the Dialysis Communication Record (form) and would have given the form to the resident or transporter to be given to the dialysis center. The dialysis nurse would have completed the post-dialysis portion of the Dialysis Communication Record and returned the form to the resident. The nurse assigned to the resident would make sure the resident had the completed Dialysis Communication Record when they returned to the facility. If none, the assigned nurse would have called the dialysis center to follow-up the form. The LPN explained the Dialysis Communication Record should have been completed to ensure the resident's condition, vital signs, medications received, pre-weight, post-weight, treatment received, and dialysis recommendation/follow-up were communicated between the facility and dialysis center. On 08/22/2024 at 10:27 AM, the Medical Records Director confirmed the following: - R176 had no Dialysis Communication Record for 07/19/2024. - R113 had no Dialysis Communication Record for 08/16/2024 and 08/19/2024. - R126 had no Dialysis Communication Record for 07/22/2024. The Medical Records Director explained when a resident returned from dialysis, the nurse would have placed the Dialysis Communication Record in a folder for Medical Records located in each nurse's station. The Medical Records Staff would have collected the Dialysis Communication Record daily then uploaded the form in the electronic health record (EHR) of the resident. The Medical Records Staff was responsible in auditing the EHR to ensure the Dialysis Communication Record was completed and filed in the resident's EHR. On 08/23/2024 at 7:39 AM, the Director of Nursing (DON) indicated the assigned nurse was expected to complete the top two sections of the Dialysis Communication Record prior to dialysis and would have given the form to the resident to be brought to the dialysis center. The top sections of the form which should have been filled out by the nurse were the General Information To Be Completed by the Facility and Resident Specific Pre-Dialysis Information. The DON explained when the resident returned from dialysis, the assigned nurse was expected to review the Dialysis Communication Record for any recommendations documented by the dialysis nurse. If there was no Dialysis Communication Record, the assigned nurse was expected to call the dialysis to follow-up and request for the completed Dialysis Communication Record. The facility's policy titled Dialysis (Renal), Pre- and Post-Care dated December 2023, documented the facility would participate in ongoing communication and collaboration with the dialysis center regarding dialysis care and services. The care of the resident receiving dialysis services would reflect ongoing communication, coordination and collaboration between the facility and dialysis staff. Documentation related to pre- and post-dialysis care would be placed in the clinical record and should have included communication between facility and dialysis staff or medical provider. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295037	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Henderson Health and Rehabilitation	1180 E. Lake Mead Parkway Henderson, NV 89015

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled Dialysis, Transportation Arrangements for dated December 2023, documented it had been the policy of the facility to assist residents in arranging transportation to and from an offsite dialysis facility. Requests for transportation should be made as far in advance as possible. Complaint #NV00071740

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33980 Based on interview and record review, the facility failed to ensure the Abnormal Involuntary Movement Scale was completed (AIMS - a rating scale designed to measure involuntary movements known as tardive dyskinesia which could develop as a side effect of an antipsychotic medication) for 1 of 35 sampled residents (Resident 15). The deficient practice had the potential to result in adverse consequences for resident's health and well-being. Findings include: Resident 15 (R15) R15 was admitted on [DATE], with diagnoses including bipolar disorder, anxiety disorder, and major depressive disorder. The physician's order dated 06/14/2024, documented Aripiprazole (Abilify - an antipsychotic medication) oral Tablet 5 milligram (mg) Give 1.5 tablet by mouth two times a day for mood changes. R15's Medication Administration Record (MAR) for August 2024, documented the resident had been receiving Aripiprazole as ordered. R15's medical record lacked documented evidence an AIMS assessment was completed upon initiation of the antipsychotic medication. On 08/22/2024 at 2:00 PM, the Medical Records Director confirmed there was no AIMS assessment filed in the resident's electronic health record. On 08/23/2024 at 2:41 PM, the Director of Staff Development (DSD) indicated a resident who was receiving an antipsychotic medication should have an AIMS assessment completed to determine if the resident was manifesting extrapyramidal symptoms (EPS -- drug-induced movement disorders) such as tardive dyskinesia. On 08/23/2024 at 3:30 PM, the Director of Nursing (DON) explained the nurses were expected to complete the AIMS assessment for a resident when an antipsychotic medication was initially ordered then every six months. On 08/23/2024 at 3:33 PM, the DSD acknowledged an AIMS assessment should have been completed for R15 on 06/14/2024. On 08/23/2024 at 3:44 PM, the Assistant Director of Nursing (ADON) indicated being responsible for making sure an AIMS assessment was completed for a resident upon admission if antipsychotic medication was ordered, when the antipsychotic medication was initially ordered, then every six months.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46265 Based on observation, interview, and document review the facility failed to ensure the walk-in freezer was maintained in safe operating condition, food items stored inside the reach-in refrigerator and freezer were labeled, dated, and not expired, the kitchen was maintained in sanitary condition and a hand washing sink was provided for the steam table set up in the main dining room for meal service. The deficient practice posed a potential risk to safety and health standards which could lead to contamination, inadequate storage, and place residents at risk of foodborne illness. Findings include: On [DATE] at 7:49 AM, an initial tour of the kitchen with the Dietary Supervisor was completed with the following findings: - significant dust build up on vents and light fixtures over the food preparation and tray line area. - in the dry storage room there were damaged cans of beans and mushrooms stored with the active food items to be used. - in the walk-in freezer there were three fans for cooling at back of freezer and one did not have a blade cover. - in the walk-in refrigerator there was a bowl with lettuce, cheese, and tomato mixed together and was not labeled or dated. In the reach in refrigerator: - no date on container containing boiled eggs. - container with chopped type of meat had no label or date. - container of blue cheese expired on [DATE]. - sliced cheese in plastic wrap was not labeled or dated. - a container of potato with egg salad expired on [DATE]. - two bowls of pre-made salad was not dated. In the storage room containing cleaning equipment there was a squirt bottle containing cleaning chemical which was not labeled. On [DATE] at 7:55 AM, in the main dining area, there was a satellite set up for warming and keeping food at temperature to serve residents during meals. There was no hand washing area in the room. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Dietary Supervisor indicated the set up was used to hold foods at proper temperature to use to prepare plates for residents eating in the main dining area. The Dietary Supervisor was advised by an Environmental Health Specialist Surveyor (inspector who inspects the facility kitchen to issue a permit to operate the kitchen) the area would need to be shut down until there was a sink in the room for observing hand hygiene practices. The Dietary Supervisor acknowledged information given. On [DATE] at 8:30 AM, the Dietary Supervisor acknowledged the concerns noted during the initial tour and verbalized the process when receiving items was to ensure they were not damaged. The Dietary Supervisor indicated when receiving items the staff was expected to ensure all items put in the refrigerators and freezers had a received date, open date, and expiration date along with label to identify item. The Dietary Supervisor confirmed the freezer had a fan blade which did not have a protective cover and it was unacceptable. The Dietary Supervisor explained it may have been knocked off when stacking items nearby, however it should have been immediately replaced. On [DATE] at 12:15 PM, the facility staff was in the dining room using the satellite steam table set up in the main dining room. There was no sink available in the dining room. On [DATE] at 12:20 PM, the facility staff was in the dining room using the satellite steam table set up in the main dining room. There was no sink available in the dining room. On [DATE] at 12:15 PM, a surveyor observed staff using satellite steam table in main dining area and using it to warm returned trays until they were used. A staff member served a tray and removed the top for resident and the resident refused tray. Cover was placed back on steam table for holding temp and then given to another resident. On [DATE] in the afternoon, the Dietary Supervisor explained not being aware food service had to immediately stop, indicated thinking the facility could notify the residents and would have a few days to stop serving from the satellite area. The Dietary Supervisor revealed when a tray had been served to a resident it could not be returned to the line and given to another resident. On [DATE] at 9:28 AM, the Infection Preventionist (IP) explained the IP was involved in the general training for kitchen staff for proper hand washing etiquette and the Dietary Supervisor followed up with additional training for proper food safety training. The IP verbalized it was not acceptable to re-use a tray which was opened for one resident and given to another resident. On [DATE] at 1:10 PM, the Administrator was advised the satellite area in main dining was still being used for warming and preparing meal trays for residents. There was no sink in the area for staff to wash hands, perform general hand hygiene and adhere to infection control practices. The administrator indicated the area was not supposed to be used until a sink was available in the room. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy titled Food Storage (undated) documented sufficient storage were provided to keep foods safe, wholesome and appetizing. Food was stored, prepared, and transported at appropriate temperatures and by methods to prevent contamination or cross contamination. All foods should be covered, labeled and dated. All foods would be checked to ensure foods would be consumed by the safe use date, or frozen, or discarded.