STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295046	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boulder City Hospital Snf	901 Adams Blvd. Boulder City, NV 89005

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 46265 Based on interview, record review, and document review the facility failed to ensure Minimum Data Set (MDS) 3.0 assessments were transmitted timely for 5 of 5 residents reviewed for Resident Assessment (Residents 11, 28, 27, 3, and 9). The deficient practice had the potential to impact resident care by also delaying the resident care plan. Findings include: The facility policy titled Assessments Periodic for Minimum Data Set (revised 10/25/2021) documented periodic assessments were conducted by the MDS Coordinator. The results of the assessments were used to create resident care plans and calculate resource utilization grouping categories used by regulators, payers, and surveyors. The facility MDS data from the resident assessment indicated data was more than 120 days for Residents 11, 28, 27, 3, and 9. The State MDS Coordinator documented in June 2023, there was a 20% late submission for residents at the facility. On 06/07/2024 in the afternoon, the Minimum Data Set (MDS) Coordinator indicated working remotely and only coming to the facility when there was a technical issue with connecting from home. The MDS Coordinator verbalized if there was a technical issue which prevented transmitting the resident assessment data, it could be late due to having to make preparations to come to the facility. The MDS Coordinator indicated it was the responsibility of the MDS Coordinator to notify the interdisciplinary team of assessment timeframe and develop a calendar for assessment completion. The MDS Coordinator explained having 14 days to complete transmission of the MDS data once the resident assessment was completed. The MDS Coordinator confirmed all MDS data was sent in batches, indicating there could be some assessments transmitted late based on the specific admitted s. The MDS coordinator verified the process of completing the resident assessment and as there was no direct contact with the resident, notes would be reviewed and if needed the author of assessment notes would be contacted. The MDS coordinator acknowledged the practice could lead to inaccurate or outdated information by the time the resident assessment was completed. The MDS coordinator verbalized there was no designated back up in case the MDS coordinator was not able to work, or access needed information. (continued on next page)

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

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 06/07/2024 in the afternoon, the Director of Long Term Care confirmed there was no access to any other staff member including the Director of Long Term Care to transmit MDS data as required. The Director of Long Term Care verbalized having to contact the MDS Coordinator on several occasions to correct data which was inaccurate on the resident assessment. The MDS Coordinator job description documented the MDS Coordinator was responsible to assess and/or coordinate the assessment of all residents and to complete the Resident Assessment Instrument (RAI) and transmit data to the appropriate entities timely.

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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** 50289 Based on observation, interview, record review, and document review, the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) level two referral was completed for 1 of 15 sampled residents (Resident 35). The deficient practice had the potential to deprive the resident of concern and other residents of necessary behavioral health services. Findings include: Resident 35 (R35) R35 was admitted on [DATE], with a diagnosis of schizophrenia. On 06/04/2024 in the morning, R35 was up in a wheelchair and stated had been at the facility for about 3 months. A PASARR level one document dated 01/12/2024, indicated R35 did not have dementia, mental illness (MI), intellectual disability (ID), mental retardation (MR), or any related condition (RC) and was deemed appropriate for nursing facility placement. The admission diagnoses from an acute care facility dated 01/26/2024, documented R35 had no cognitive deficits or diagnoses. The acute care facility physician progress note dated 01/28/2024, documented after talking to R35 and the family of R35, the nurse practitioner added the schizophrenia diagnosis to the admitting diagnoses and referred for a psychiatric (psych) consult and resident was subsequently placed on antipsychotic medication. On 06/06/2024 at 1:34 PM, the Social Worker (SW) confirmed the PASSAR level one was completed prior to the resident being admitted to the acute care facility and receiving the schizophrenia diagnosis. The SW confirmed the purpose of the PASARR was to ensure residents were appropriately placed and the facility could meet the needs of the residents. The SW explained the SW was responsible for completing the online PASARR requests. The SW indicated it was believed the referral for a PASARR level two was not necessary because the resident was not receiving any psych services and was stable on antipsychotic medication. On 05/28/2024, an alert charting nurse progress note documented the patient was masturbating while staff was providing care. The unacceptable behavior was discussed with the resident and the resident agreed and was cooperative. The medical record lacked documented evidence R35 was referred for a PASARR level two. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Division of Health Care Financing and Policy- Medicaid Services Manual- for Nursing Facilities Policy dated 05/01/2015, documented when an individual has been identified with possible indicators of mental illness, intellectual disabilities, or related condition, a PASARR Level II screening must be completed to evaluate the individual and determine if nursing facility services and/or specialized services are needed and can be provided in the nursing facility. Examples include: a resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting a presence of a mental disorder (where dementia is not the primary diagnoses), or an intellectual disability or related condition was not previously identified and evaluated through PASARR. Social services would be responsible for keeping track of each resident's PASARR screening status and referring to appropriate authority.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46265 Based on observation, interviews, record review, and document review, the facility failed to follow or clarify physician order regarding a suprapubic catheter size prior to insertion. The deficient practice had the potential to result in discomfort or inadequate drainage of the bladder. Findings include: Resident 31(R31) R31 was admitted on [DATE] with diagnoses including obstructive uropathy and severe neurocognitive deficit. On 06/04/2024 at 9:15 AM, resident was sitting in bed awake and alert. Resident indicated staff recently changed catheter. On observation the resident had suprapubic catheter inserted on right side abdomen. Dressing was soiled with yellow tinged fluid. On 06/07/2024 at 10:00 AM, a Licensed Practical Nurse (LPN) indicated all wound and any care treatments such as catheter care would be documented in the treatment book at the nurse's station. The treatment book would contain the most recent order for resident care. The treatment administration record for R31 indicated an order to change suprapubic catheter with 18 french 30 milliliter(mL) balloon monthly. A physician order in the electronic medical record indicated to change with 18 french 5 mL balloon every two weeks. On 06/07/2024 at 10:15 AM, the charge nurse confirmed suprapubic catheter currently inserted in R31 was a 16 french with 10 mL balloon. On 06/07/24 at 10:20 AM, the charge nurse indicated all catheter supplies were stored in the clean utility for residents which were not on hospice, the charge nurse confirmed resident was not on hospice. The charge nurse indicated the nurse completing the catheter change would use the order from the treatment administration record as the correct order and if the catheter was not available, the nurse would be able to get the correct size from the hospital central supply. If the correct size catheter was not available, the nurse would need to contact the physician to clarify order. The charge nurse indicated the staff should always follow the physician order and complete appropriately or clarify order. The facility policy titled Physician orders Execution (revised 08/24/2009) documented at no time was staff to execute a physician order which was inconsistent with their Practice Act or facility policies and procedures. Staff was not to perform an intervention without the required physician order. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Catheter Care (revised 09/06/2011) documented the facility would provide consistent care of an indwelling catheter to reduce infection, promote adequate drainage and comfort. Change catheters monthly with a physician order.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 50289 Based on observation, document review and interview, the facility failed to ensure stored foods were labeled and dated and food items were discarded prior to the expiration date. This 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 8:15 AM, an open bag of chicken tenders was stored in the walk-in freezer without a label as to what is in the bag or a date as to when the bag was opened. The Dietary Manager explained the open bagged item should have been dated as to when the bag was opened and labeled before placing the opened bag back in the freezer. The Dietary Manager had the staff label and date the bag during the survey. The Dietary Manager was able to determine when the bag was opened by the menu details. On [DATE] at 8:17 AM, a container of cottage cheese was stored in the walk-in refrigerator with an expiration date of [DATE]. The Dietary Manager explained the item should have been discarded. The Dietary Manager explained the process for checking for expiration dates was for staff to check the dates when a new shipment was received. The Dietary Manager discarded the expired food item during the survey. An undated policy with the subject entitled food storage revealed that all foods and supplies are to be clearly labeled. On [DATE], the Dietary Manager stated did not have any specific policies on labeling and dating foods nor on expired foods.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 46265 Based on interview and document review the facility failed to ensure the quarterly payroll based journal (PBJ) data was submitted to Center for Medicare and Medicaid Services (CMS). The deficient practice prevented CMS from analyzing staffing patterns and populate the staffing component of the Nursing Home Compare website. A review of the facility Certification and Survey Provider Enhanced Reporting System (CASPER) report revealed the facility failed to submit staffing data for the first quarter of 2024. On 06/04/24 at 1:28 PM, the Minimum Data Set (MDS) Coordinator indicated being the person responsible for submitting the PBJ data and was aware the PBJ data was not submitted for the first quarter of the 2024 fiscal year. The MDS Coordinator explained being at facility once a week and was not in the facility when it was due. The MDS coordinator verbalized most of work was done remotely however, was unable to access information from remote workstation and was planning on completing the next day however became ill. The MDS coordinator revealed being the only one at the facility with access and ability to complete the report and indicated the Chief Nursing Officer was made aware the PBJ data was not submitted. 06/04/24 01:49 PM, the Director of Long-Term Care (Director) verbalized starting position in March of 2024 which was after the submission was due. The Director was aware the PBJ data was not submitted for the first quarter of 2024 and there was no system in place at the time for back up if the MDS Coordinator was not able to complete. The Director indicated the MDS Coordinator started working remote in December of 2023 and only came to the facility if required because of technical difficulties at remote workstation. The MDS Coordinator was the only staff member with access to reporting system to submit PBJ data.