STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295055	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
College Park Rehabilitation Center	2856 E. Cheyenne Ave. North Las Vegas, NV 89030

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50289 Based on interview, record review, and document review, the facility failed to ensure medications were administered timely to 1 of 4 sampled residents (Resident #1). The deficient practice had a potential for the intended use of the medication to be insufficient or ineffective with a possible cause of harm to the resident. Findings include: Resident #1 (R1) R1 was admitted to the facility on [DATE] with diagnoses of degenerative diseases of nervous system, pain, vitamin deficiency, and major depressive disorder. A physician order dated 11/18/2024 for Methocarbamol 1000 milligram (mg) tablet was ordered for pain and was to be given at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM. The medication administration record (MAR) revealed the resident missed the 1:00 PM and 5:00 PM doses on 11/18/2024, and the first dose of the medication was administered at 9:00 PM. The MAR documented the medication was not administered because the medication was not available. A physician order dated 11/14/2024 for Thiamine HCl (Vitamin B1) 100 mg tablet was ordered for vitamin deficiency and was to be given at 8:00 AM. The medication administration record (MAR) revealed the resident missed the 8:00 AM dose on 11/18/2024. The MAR documented the medication was not administered because the medication was not available. On 03/13/2025 at 11:20 AM, the Assistant Director of Nursing (ADON), confirmed the Omnicell (an automated medication dispensing system which stores and tracks medications) did contain Methocarbamol 500mg tablets and the tablets were available in the Omnicell at the facility which could have been used for the resident. On 03/13/2025 at 11:45 AM, the Director of Nursing (DON), confirmed it is the policy of the facility to use the Omnicell machine for unavailable medications. The DON stated there is someone in the facility at all times which has access to the Omnicell machine. The DON also verified the Thiamine HCl (Vitamin B1) was a house stocked item and if staff were truly out of the medication, the facility could have sent someone to the pharmacy to get the medication over the counter. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Medication Management Program: Administering the Medication Pass with a complete revision on 05/05/2023 and an email revision on 01/15/2025, documented if a medication was unavailable, contact the pharmacy and document accordingly. Notify the physician for possible alternatives available in e-kits (emergency kits) at time of discovery. Complaint #NV00072898

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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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50289 Based on interview, record review and documentation review, the facility failed to ensure 1 of 4 sampled residents (Resident #1) received a physical therapy evaluation in accordance with a physician's orders. This deficient practice could lead to the resident's continued decline in function and/or mobility. Findings include: Resident #1 (R1) R1 was admitted to the facility on [DATE] with diagnoses of degenerative diseases of nervous system, pain, muscle weakness, lack of coordination, and major depressive disorder. A Physician's Order dated 11/13/2024 documented, PT (Physical Therapy) Evaluation and Treatment. R1's medical record lacked documented evidence a PT evaluation had been completed. On 03/13/2025 at 11:30 AM, the Director of Rehabilitation (DOR) and physical therapist acknowledged R1's medical record lacked documented evidence R1 had been evaluated for physical therapy. The DOR stated was told the resident had refused the evaluation, but there was no documentation of the refusal. The DOR indicated the physical therapist should have attempted the evaluation and documented in the evaluation R1 refused the evaluation, or the physical therapist could have discharged the PT order and let nursing, and the physician know. The DOR explained this physician order for a PT Evaluation was a standing order for all newly admitted residents. Nursing informs therapy the resident was admitted , and therapy conducts the evaluations as ordered. The DOR also indicated the physical therapist had access to the physician's orders. The DOR verified an evaluation had not been completed for R1 in accordance with the physician's order from 11/13/2024. A facility policy entitled Physician Orders- Telephone and Verbal under Rehabilitation Services Policies and Procedures with a complete revision on 03/01/2019, and an email revision on 04/15/2021 documented, a qualified medical personnel will take and implement telephone and verbal orders according to Facility Practice Guidelines. Complaint #NV00072898

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50289 Based on interview and document review, the facility failed to maintain a safe and functional environment for 1 of 4 residents sampled (Resident #1). This deficient practice led to unusable devices and could have caused harm to the resident. Findings include: Resident #1 (R1) R1 was admitted to the facility on [DATE] with diagnoses of degenerative diseases of nervous system, pain, vitamin deficiency, muscle weakness, lack of coordination, and major depressive disorder. On 11/13/2024, the Maintenance Request Log documented work orders were put in for room [ROOM NUMBER]A which included: -need an overbed table and a TV that works for the new Admit -need a wall phone -the bed foot board is loose The work order for an overbed table and a TV that works for R1 upon admission, was documented as having been completed by staff on 11/13/2024. The other two work orders were not marked as having been completed. On 11/15/2024, the Maintenance Request Log documented another work order was put in for room [ROOM NUMBER]A for a wall phone. This request was marked completed on 11/15/2024. On 11/16/2024, the Maintenance Request Log documented another work order was put in for room [ROOM NUMBER]A for a loose bed foot board. This request was marked completed on 11/16/2024. On 03/13/2025 at 8:45 AM, the Maintenance Assistant confirmed the work orders for the phone and foot board were not marked as having been completed. The Maintenance Assistant explained had thought the work orders had been completed by the other maintenance worker, but just not marked as having been completed. However, the Maintenance Assistant was not sure why there would have been duplicate work orders put in two and three days later for the same items if they had been fixed previously. The Maintenance Assistant verified there was no documented evidence the work orders for the phone and foot board had been completed the first time they were put in. The facility policy titled Routine Maintenance under Maintenance/Housekeeping Policies and Procedures dated 03/2006, indicated the facility would perform routine maintenance on floors, walls, fixtures, and equipment. Complaint #NV00072898