STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295070	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Plaza Regency Post Acute Rehab	6021 W. Cheyenne Ave. Las Vegas, NV 89108

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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** 34524 Based on clinical record review, interview, and document review, the facility failed to ensure Comprehensive Care Plans included a care plan related to 1) the care and treatment for constipation (Resident #24), 2) the care and treatment of insomnia and constipation (Resident #134), 3) the care and treatment of edema (Resident # 134), and 4) the care and treatment of post-traumatic stress disorder (PTSD) (Resident #28) to include goals, preferences, needs, and interventions, for 4 of 29 sampled residents. The deficient practices had the potential to deprive residents of necessary care and treatments. Findings include: Resident #24 (R24) R24 was admitted to the facility 09/09/2024, with diagnoses including pain in left hip, presence of left artificial hip, and acquired absence of right leg below knee. On 09/18/2024 at 9:45 AM, R24 verbalized had been constipated and needed more than the stool softeners prescribed. The resident explained had received a suppository on 09/17/2024, and the suppository gave some relief. On 09/19/2024 at 8:32 AM, a Certified Nursing Assistant verbalized R24 had complaints of constipation. On 09/19/2024 at 2:23 PM, a Registered Nurse (RN) verbalized R24 took pain medication for chronic pain and the pain medications could cause constipation. The RN explained the resident received a scheduled stool softener twice a day for constipation and had as needed medications for bowel care as well. The resident received Miralax on 09/16/2024, and a Dulcolax suppository on 09/17/2024, which yielded a bowel movement. A physician's order dated 09/09/2024, documented Colace oral capsule 100 milligram (mg). Give one capsule by mouth two times a day for constipation. A physician's order dated 09/09/2024, documented Senna tablet 8.6 mg. Give two tablets by mouth as needed for bowel care/no bowel movement. (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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 09/09/2024, documented Miralax Powder (Polyethylene Glycol 3350). Give 17 grams by mouth as needed for bowel care. Give in 4-8oz water/fluid as needed if no bowel movement. A physician's order dated 09/09/2024, documented Dulcolax suppository 10 mg. Insert one suppository rectally as needed for bowel care/no bowel movement, if Miralax or Senna not effective within 24 hours. R24's Comprehensive Care Plan lacked a care plan for constipation. On 09/20/2024 at 2:44 PM, the Director of Nursing (DON) verbalized R24 received pain medications and medications to prevent constipation as a result of the pain medications. The DON confirmed R24 did not have a care plan for constipation and should have. Resident #134 (R134) R134 was admitted to the facility on [DATE], with diagnoses including nondisplaced intertrochanteric fracture of left femur, subsequent encounter for fracture with routine healing and nontraumatic hematoma of soft tissue. On 09/19/2024 at 2:23 PM, an RN verbalized R134 received Melatonin for insomnia and Lasix for edema. The RN explained the staff looked for pitting and swelling and would expect to find a care plan for edema and insomnia on the resident's care plan. A physician's order dated 09/05/2024, documented Melatonin 5 mg tablet. Give one tablet by mouth one time a day for insomnia. A physician's order dated 09/11/2024, documented Lasix 40 mg tablet. Give one tablet by mouth two times a day for edema in the lower extremities. R134's Comprehensive Care Plan lacked a care plan for insomnia and edema. On 09/20/2024 at 2:35 PM, the DON verbalized the expectation was a care plan would be created for a resident with insomnia and edema. The DON confirmed R134 took medications for insomnia and edema and should have had a corresponding care plan. 43311 Resident #28 Resident #28 was admitted to the facility on [DATE], with diagnoses including post-traumatic stress disorder, chronic, and metabolic syndrome. The Minimum Data Set 3.0 (MDS) Report, Section I, I6100:Post Traumatic Stress Disorder, documented Resident #28 had a diagnosis of PTSD. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #28's physician order dated 02/01/2024, documented Prazosin HCL oral capsule 2 milligrams, give one capsule by mouth as needed for history related to PTSD, chronic. A behavior note dated 09/12/2024, documented Resident #28 became upset when the facility transport did not show up to transport the resident to an eye doctor appointment. Resident #28 became angry and drove down the sidewalk and away from the facility with staff following. Resident #28 was redirected back to the facility with staff and was informed the eye appointment had been rescheduled to another day. Resident #28's clinical record lacked documented evidence the care plan included care for the resident's diagnosis of PTSD. On 09/19/2024 at 4:13 PM, a Resident Care Manager (RCM) explained a care plan was created for PTSD to include behaviors specific to the resident like aggressiveness or depression, and would include what alleviated those behaviors. On 09/19/2024 at 4:38 PM, the RCM confirmed Resident #28 did not have a care plan created or implemented to address the resident's chronic PTSD. On 09/20/2024 at 11:22 AM, the Assistant Director of Nursing (ADON) explained a resident with a history of PTSD, behaviors, and taking medication for PTSD should be care planned. The ADON confirmed Resident #28 was not care planned for the focus, goals, and interventions of PTSD. The facility policy titled Care Planning-Interdisciplinary Team, dated 11/2017, documented the care plan was recognized as an interdisciplinary dynamic process that included at a minimum: nursing, social services, activities, and dietary. The care planning process began on the day of the admission by nursing and the Interdisciplinary Team was responsible for the development of an individualized comprehensive care plan for each resident on an ongoing basis. The facility policy titled Goals and Objectives, Care Plans, dated 11/2017, documented care plans would incorporate Person-Centered goals and objectives that lead to the resident's desired outcome. The facility policy titled Care Plans-Person Centered Comprehensive, dated 08/2017, documented an individualized Person-Centered comprehensive care plan included objectives and goals to meet the resident's medical, nursing, mental, and psychological needs and was developed for each resident based on the resident strengths, needs, and preferences.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40377 Based on clinical record review, document review, and interview, the facility failed to complete a discharge summary by the primary care provider to include the recapitulation of the resident's stay and the treatment and services obtained at the facility for 1 of 2 sampled closed records (Resident #142). The deficient practice has the potential to impact the resident not receiving the appropriate post discharge care, medications or treatments. Findings include: Resident #142 (R142) R142 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, essential (primary) hypertension, type 2 diabetes mellitus with diabetic neuropathy, and fibromyalgia. The resident was discharged on ,d+[DATE]. R142's Discharge Summary lacked evidence of a physician's signature, diagnoses, recapitulation of the admission to include the course of treatment and services provided by the facility. A Nursing Note dated 02/19/2024 at 11:12 AM, documented the physician was notified R142 would like to be discharged from the facility 02/19/2024. R142's daughter was able to get the resident an apartment. The resident had a private physician and pharmacy in the community. Nursing gave diabetes mellitus insulin education and would leave with all of the resident's medications on hand at the facility. The facility received a physician's order for the resident to be discharged from facility on 02/19/2024. A Discharge Note dated 02/19/2024 at 1:32 PM, documented R142 for discharge home on 02/19/2024. Refresher training for insulin check and insulin administration was done with the resident doing the procedure. The resident verbalized the resident knew how to do it and had done it before. Medications on hand were given to the resident. R142 left the facility at 1:25 PM ambulatory with front wheeled walker accompanied by family member in stable condition. On 09/20/2024 at 2:25 PM, the Social Services Director verbalized the facility lacked documented evidence of a complete Discharge Summary. On 09/20/2024 at 3:05 PM, the Medical Records Clerk confirmed Resident #142's clinical record lacked documented evidence of a complete Discharge Summary. On 09/20/2024 at 3:05 PM, the Medical Records Director confirmed Resident #142's clinical record lacked documented evidence of a complete Discharge Summary by the primary care provider to include the recapitulation of the resident's stay and the treatment and services obtained at the facility. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/20/2024 at 3:54 PM, the Administrator verbalized the wrong template was used for R142's discharge, the facility did not have a Discharge Summary, and the resident was not provided a recap of the resident's admission or an explanation of the course of treatments and services provided at the time of discharge. The Administrator confirmed the family or resident's representative was also not given the documentation regarding the resident's admission.

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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** 43310 Based on observation, clinical record review, interview, and document review the facility failed to ensure a wound care nurse followed physician orders for 1 of 29 sampled residents (Resident #61). The deficient practice had the potential to place the resident at risk for delayed healing of a wound. Resident #61 Resident #61 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing. A Skin Wound Assessment form dated 09/18/2024, documented Resident #61 had a facility acquired unstageable pressure injury (PI) to the front of the resident's right knee. The wound measured 0.9 cm area, 1. 2 cm length x 1.1 cm width. The PI was documented as healing slowly or stalled but stable. A physician's order dated 05/21/2024, documented to cleanse the unstageable wound to Resident #61's right knee with normal saline, pat dry, apply barrier cream and then cover with foam dressing, three times per week and as needed for soiling and/or accidental removal. On 09/19/2024 at 9:46 AM, during a wound care observation, the Wound Care Nurse gathered supplies to perform wound to a wound on Resident #61's right knee. The supplies included silver alginate. On 09/19/2024 at 9:50 AM, during the provision of wound care for Resident #61, the Wound Care Nurse applied Tri-Ad cream to a silver alginate pad and placed the dressing over the wound on Resident #61's right knee, and dressed with island gauze. The Wound Care Nurse confirmed an order for silver alginate should have been obtained prior to use. On 09/19/2024 at 9:58 AM, the Wound Care Nurse verbalized had been using silver alginate on Resident #61's right knee wound for approximately one week. The Wound Care Nurse confirmed Resident #61's clinical record lacked an order for the use of silver alginate and an order for silver alginate should have been obtained and entered into the resident's clinical record prior to use. On 09/19/2024 at 10:58 AM, the Director of Nursing Services (DNS) confirmed a physician's order was required for wound care. The DNS explained wounds were assessed weekly to determine the effectiveness of the treatment being provided, and if after two weeks the wound was not improving, a new order was requested. On 09/19/2024 at 11:04 AM, the DNS confirmed a wound care assessment dated [DATE], documented the physician was notified Resident #61's PI wound was not improving. The DNS confirmed Resident #61's clinical record lacked documented evidence of a physician's order for the use of silver alginate when providing wound care to the PI on Resident #61's right knee. The DNS confirmed a physician's order was required prior to the use of silver alginate. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Wound Care -Level II, revised 03/2017, documented the first step when preparing to provide wound care was to verify there was a physician's order in place. A facility policy titled Physician Medication Orders, documented medication and treatments were administered only upon the order of a person duly licensed to prescribe such medications. Physician orders for medications and treatments were to be documented in the clinical record as provided per order.

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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** 40377 Based on clinical record review, document review, and interview, the facility failed to ensure licensed staff did not jeopardize a resident's hemodialysis catheter for 1 of 29 sampled residents (Resident #57). This deficient practice may have placed the patient at risk for delays in dialysis treatments, unnecessary discomfort and medical/surgical interventions. Findings include: Resident #57 (R57) R57 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including chronic kidney disease, stage 5, end stage renal disease, dependence on renal dialysis, and hyperkalemia. R57's Care Plan initiated on 06/18/2024, documented no intravenous therapy, blood draws, or blood pressure to left arm. A physician's order dated 06/17/2024, documented no blood pressure on left arm, every shift. A review of R57's vitals documented blood pressures were taken on the left arm on the following dates and times: - 08/28/2024 at 10:54 AM, 139/73 mmHg, sitting left arm - 08/27/2024 at 8:27 PM, 142/78 mmHg, sitting left arm - 08/27/2024 at 9:32 AM, 154/74 mmHg, sitting left arm - 08/26/2024 at 7:33 PM, 122/64 mmHg, lying left arm - 08/25/2024 at 7:54 PM, 126/64 mmHg, lying left arm - 08/25/2024 at 10:43 AM, 124/62 mmHg, sitting left arm - 08/22/2024 at 8:47 PM, 135/70 mmHg, sitting left arm - 08/22/2024 at 10:24 AM, 124/50 mmHg, sitting left arm - 08/21/2024 at 7:51 PM, 153/80 mmHg, sitting left arm - 08/21/2024 at 10:32 AM, 138/64 mmHg, sitting left arm - 08/19/2024 at 8:12 PM, 110/60 mmHg, lying left arm - 08/18/2024 at 9:01 PM, 118/70 mmHg, sitting left arm (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 08/17/2024 at 7:03 PM, 128/64 mmHg. lying left arm - 08/17/2024 at 11:41 AM, 124/60 mmHg, lying left arm - 08/15/2024 at 9:48 PM, 128/60 mmHg, sitting left arm - 08/14/2024 at 9:11 PM, 103/60 mmHg, sitting left arm - 08/12/2024 at 7:29 PM, 122/64 mmHg, lying left arm - 08/12/2024 at 4:00 PM, 118/62 mmHg, lying left arm - 08/08/2024 at 8:32 PM, 130/65 mmHg, sitting left arm - 08/08/2024 at 10:09 AM, 118/64 mmHg, sitting left arm - 08/07/2024 at 8:02 PM, 105/60 mmHg, sitting left arm - 08/07/2024 at 10:46 AM, 146/74 mmHg, sitting left arm - 08/05/2024 at 8:44 PM, 100/49 mmHg, sitting left arm - 08/04/2024 at 9:34 AM, 130/70 mmHg, lying left arm - 08/01/2024 at 8:48 PM, 135/60 mmHg, sitting left arm - 08/01/2024 at 8:48 AM, 118/65 mmHg, sitting left arm An Outpatient Dialysis Record dated 09/09/2024, documented R57's left upper arm graft was clotted and dialysis was not performed. R57 was referred to a surgery center. A Surgery Center Note dated 09/10/2024, documented R57 had a fistulagram due to a 50% stenosis in the arterial graft segment and a 50% in-stent stenosis in the venous graft segment. The stenosis was treated with angioplasty and hemostasis was achieved. A Surgery Center Note dated 09/19/2024, documented R57 had a fistulagram which demonstrated a 70% stenosis in the venous graft and an 80% stenosis in the axillary vein. The stenosis was treated with angioplasty and hemostasis was achieved. On 09/20/2024 at 8:55 AM, a Licensed Practical Nurse (LPN1), verbalized the resident was getting hemodialysis and had a left upper arm fistula. LPN1 verbalized R57 had a procedure done yesterday due to a previous thrombosis. LPN1 verbalized there was an order to not take blood pressures on the resident's left arm, the arm of the fistula. LPN1 confirmed the resident's clinical record included documented evidence of previous blood pressures taken on the resident's left arm. LPN1 verbalized taking blood pressures on arm with the fistula can ruin the fistula, dislodge it, put resident in to stress. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/20/2024 at 9:44 AM, a Licensed Practical Nurse (LPN2), confirmed the resident's clinical record included documented evidence of previous blood pressures taken on the resident's left arm. LPN2 confirmed R57 had a left upper arm fistula. LPN2 confirmed R57 had a physician's order dated 06/17/2024, documented to not take blood pressure on the left arm. LPN2 verbalized taking a blood pressure on the resident's left upper arm could burst out the fistula and damage the port. On 09/20/2024 at 9:51 AM, the Director of Nursing (DON), confirmed R57 had a fistula on the left upper arm. The DON verbalized standard of practice was to not take a blood pressure on the arm with a fistula. The DON verbalized it would put pressure on fistula could cause bleeding and the port to clot. The DON confirmed the physician's order, dated 06/17/2024, to not take left arm blood pressures. The DON confirmed R57's clinical record documented multiple blood pressures taken on the resident's left arm. The DON confirmed R57 had a thrombosis in fistula on 09/09/2024, and dialysis was not done as scheduled on 09/09/2024. The DON verbalized a surgical procedure was done 09/10/2024 to remove the thrombosis. The DON verbalized a sign was at the head of the resident's bed indicating no blood pressures to the left arm. On 09/20/24 at 10:03 AM, a sign was observed at the head of the resident's bed documenting no IV, blood draws or blood pressure to left arm. On 09/20/24 at 10:45 AM, a Registered Nurse (RN) from the resident's Dialysis Center verbalized staff should never take a blood pressure on the arm of a resident's fistula. The RN verbalized it can collapse the fistula access and produce a clot. The facility policy titled End-Stage Renal Disease, Care of Resident with Dialysis, revised 08/2017, documented residents with end stage renal disease will be cared for according to currently recognized standards of care. Education and training of staff included the care of shunts and fistulas.

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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** 43311 Based on observation, interview, clinical record review, and document review the facility failed to ensure medication was administered with an error rate less than 5 percent (%). There were 27 opportunities and 7 medication errors. The medication error rate was 25.93%. Findings include: Resident #82 (R82) R82 was admitted to the facility on [DATE], with diagnoses including cerebrovascular disease, unspecified, essential hypertension, and hyperlipidemia. An Order Summary for R82 documented the following: -Aspirin EC tablet Delayed Release 81 milligrams (mg), give one tablet by mouth one time a day related to essential hypertension. -Lisinopril tablet 40 mg, give one tablet by mouth one time a day related to essential hypertension. -Protein Gel/Liquid, one time a day, give 30 milliliters (ml) protein liquid in 120 ml juice. -Cholecalciferol tablet 1000 unit, give 2000 units by mouth one time a day for supplement. -Plavix 75 mg (Clopidogrel Bisulfate), give one tablet by mouth one time a day related to cerebrovascular disease, unspecified. -PreserVision AREDS 2+ Multivitamin oral capsule, give two capsules by mouth one time a day for supplement. -Vitamin C tablet 500 mg (Ascorbic Acid), give one tablet by mouth in the morning for supplement. On 09/19/2024 at 9:13 AM, a Licensed Practical Nurse (LPN) administered the following medications to R82: -Aspirin EC tablet Delayed Release 81mg, one tablet by mouth -Lisinopril 40 mg, one tablet by mouth -Protein Gel/Liquid 30 ml, 30 ml by mouth in 120 ml juice -Cholecalciferol 1000 units, two capsules by mouth -Plavix 75 mg, one tablet by mouth (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-PreserVision AREDS 2+ Multivitamin oral capsule, two capsules by mouth -Vitamin C 500 mg, one capsule by mouth On 09/19/2024 at 9:17 AM, the LPN explained a daily medication was to be administered at 8:00 AM, and could be administered one hour before or one hour after 8:00 AM. The LPN confirmed R82 was administered seven medications late and not according to policy. On 09/20 2024 at 2:28 PM, the Director of Nursing (DON) explained the expectation of licensed nursing staff was to administer all medications using the five rights of administering medications: right patient, right time, right dose, right medication, and right route. The DON confirmed medication administration occurring after 9:00 AM was considered a late medication administration and did not follow policy. The facility policy titled Administering Medications, revised 08/2017, documented medications would be administered in accordance with the orders, including any required timeframe. After verifying the right resident, the individual administering the medication must check the label three times to verify the right medication, the right dosage, the right time, and the right method of administration before giving the medication. Medications would be administered in a safe and timely manner, and as prescribed.

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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 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** 43310 Based on interview, clinical record review, and document review, the facility failed to ensure 1 of 5 residents reviewed for vaccinations, including pneumococcal vaccines (Residents #66) was screened for eligibility to receive a pneumococcal vaccine, education regarding the vaccine was provided to the resident and/or the resident representative, and the indicated pneumococcal vaccine was offered and either administered or declined. The deficient practice may have placed the resident at risk for not being protected against serious illness. Findings include: Resident #66 Resident #66 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including iron deficiency anemia, shortness of breath, chronic obstructive pulmonary disease, and unspecified asthma. Resident #66's clinical record lacked documented evidence the resident was screened for eligibility to receive a pneumococcal vaccine, and education regarding the vaccine was provided to the resident and/or the resident representative, and the indicated pneumococcal vaccine was offered and either administered or declined. On 09/20/2024 at 2:00 PM, the Infection Preventionist confirmed the facility lacked documented evidence Resident #66 was screened for eligibility to receive a pneumococcal vaccine, education regarding the vaccine was provided to the resident and/or the resident representative, and the indicated pneumococcal vaccine was offered and either administered or declined. The facility policy titled Pneumococcal Vaccine, dated 10/20/2020, documented all residents were offered pneumococcal vaccines to aid in the prevention of pneumococcal infections. Prior to or upon admission residents were assessed for eligibility to receive a pneumococcal vaccine, and when indicate the vaccine was offered within 30 days of admission. A review of prior vaccination status was conducted within five working days of the resident's admission. The resident or legal representative received information and education regarding the risk and benefits of receiving the vaccine. Residents or the resident's legal representative had the right to refuse vaccination. The date of vaccination, lot number expiration date, name of the person administering the vaccine, and the site of the vaccination were documented in the resident's clinical record. Administration of the pneumococcal vaccine was made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination.