Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tlc Care Center	1500 W Warm Springs Rd Henderson, NV 89014

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51395 Based on interview, record review and document review, the facility failed to ensure a grievance report was initiated and followed through for 1 of 37 sampled residents (Resident 1). The deficient practice had the potential to result in a resident having an unresolved grievance. Findings include: Resident 1 (R1) was admitted on [DATE] and discharged on [DATE], with diagnoses including acute post traumatic pain, left femoral fracture and right distal femur fracture. R1's Face Sheet (demographics) listed the resident had a significant other. R1's significant other alleged on 01/19/2024, R1's feet and legs were massaged by a janitor. On 12/05/2024 at 2:00 PM, the Administrator indicated recalling R1's significant other reported an incident regarding a housekeeper massaging R1's feet and legs. The Administrator confirmed the alleged incident was not included nor documented in the facility's Grievance log for 2024. On 12/05/2024 at 2:26 PM, a Certified Nursing Assistant (CNA) recalled the alleged incident when a housekeeper informed the CNA R1 needed assistance. Upon entering the resident's room, R1 reported a staff member rubbed my feet good. The CNA revealed R1's significant other was at bedside and became upset. The CNA reported the incident to the nurse and case manager. On 12/05/2024 at 2:42 PM, the Case Manager (CM) confirmed R1's significant other was upset and reported someone had massaged R1's legs. The CM explained checking R1's physician orders to verify if there was an order for massage and no such order was obtained. The CM acknowledged R1 reported a staff member massaged the resident's legs. The CM then reported the incident to the Director of Nursing (DON). The CM explained nonclinical staff were not to be performing massage on residents due to the potential of causing harm. On 12/05/2024 at 2:53 PM, the alleged staff member revealed holding the position of a housekeeper at the time of the incident. The staff member explained recalling the incident which involved R1. The staff member revealed responding to R1's call light where the resident requested for socks, and medicated ointment located on R1's table to be applied. The staff member confirmed the ointment had R1's name on the label and they applied the ointment and socks to the resident. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/06/2024 at 9:47AM, a Housekeeper explained housekeeping staff were not allowed to perform care tasks for residents such as massaging their feet and legs because of safety issues. On 12/06/2024 at 10:10 AM, the Housekeeping Supervisor indicated a housekeeper's job duties were to clean the facility and not to provide any direct care or physical touching of residents due to not being clinical or licensed staff. On 12/06/2024 at 10:50 AM, the Administrator explained any staff member, including the Administrator, could initiate and complete a grievance form. The Administrator acknowledged there was no grievance form filed and followed through when R1's significant other reported the alleged incident. The Administrator confirmed a grievance form should have been filed to investigate the incident and identify the corrective actions to resolve the grievance. The facility's policy titled Grievances/Complaints, Recording and Investigation (undated), documented all grievances and complaints filed with the facility would be investigated and corrective actions taken to resolve grievances. Documentation of the investigation and actions taken in response would be maintained at the facility. Complaint # NV00070364

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46265 Based on interview and record review, the facility failed to vancomycin medication was initiated upon admission for 1 of 37 sampled residents (Resident 20). The deficient practice had the potential prevent the continuation of a resident's medicine regimen for a serios infection. Findings include: Resident 20 (R20) was admitted on [DATE] with diagnoses including infection following procedure, enterocolitis due to clostridium difficile. The medical record revealed hospital discharge instructions for R20 included continuation of Vancomycin intravenous (IV) 750 milligrams (mg) once daily. A Physician Order dated 01/02/2024 documented Vancomycin HCl (hydrocholoride) Intravenous Solution. On 12/03/2024 at 11:40 AM, the Director of Admissions and Marketing verbalized the facility would use the discharge instructions from the hospital to order medications and treatments for the resident. Medications orders would be sent electronically to the pharmacy and staff would ensure room and equipment was ready for admission of new resident. The Director of Admissions indicated the Unit manager would complete the admission orders. On 12/04/2024 at 11:40 AM, the Unit Manager indicated the floor nurse would complete the admission assessment. The nurse would ensure orders from the discharge summary were transferred to the pharmacy electronically. Pharmacy would have the ability to make deliveries at 10 AM, 2 PM, 6 PM, 10 PM, 2 AM, 6 AM. The Unit Manager indicated it was important to not miss a dose of vancomycin, if possible, however a missed dose could be added to end of treatment to complete if missing only one or two days. It would not be appropriate to miss more than two days of doses. On 12/04/2024 at 11:55 AM, the Nurse Supervisor explained when a resident was admitted the nurse or unit manager would review the discharge summary and enter orders based on information given. Information would be verified during assessment and for resident receiving antibiotics the pharmacy would be given information to properly dose the medication. The facility would need to contact the Infectious Disease physician and verify the order to start treatment. The Unit Manager and Nurse Supervisor confirmed the process should take less than a day to complete and if given the approval could potentially use the emergency medications if in stock. The Unit Manager provided a list of emergency medications on hand which included Vancomycin. On 12/05/2024 at 8:30 AM, the Infectious Disease (ID) provider indicated it was important to continue antibiotic medications as ordered and not have missed doses of more than one or two days. The ID verbalized the point of an antibiotic was to ensure the blood levels were maintained with enough medication to destroy bacteria and missing doses would lower the level of the antibiotic in the blood possibly leading to ineffective treatment or antibiotic resistance if stopping and restarting antibiotics. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The medication administration record revealed R20 was given the first dose of IV Vancomycin on 01/02/2024. An admission nursing report documented R20 was to continue Vancomycin IV at facility. On 12/06/2024 at 1:58 PM, the consultant Pharmacist indicated IV antibiotics were either time dependent or dose dependent. Vancomycin was a dose dependent antibiotic meaning dosing levels must be monitored through laboratory values every third dose of medication. The Pharmacist acknowledged when a resident was already taking antibiotic medication the pharmacist would review the most pertinent labs however if the order was on the discharge instructions the resident would be able to receive the medication at the next required dose which would have been on 12/30/2023. Complaint #NV00072736

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51396 Based on interview, record review, and document review, the facility failed to provide documented evidence discharge planning was provided to 1 of 37 sampled residents (Resident 10). The deficient practice had a potential for inadequate post management and coordination of the continuation of care for a resident. Findings Include: Resident 10 (R10) was admitted on [DATE] for short term rehabilitation for open heart surgery. R10 was discharged on [DATE]. R10's medical record lacked documented evidence of a case manager's assessment for discharge needs during the resident's short-term stay. On 12/03/2024 at 1:19 PM, the Licensed Social Worker indicated case management oversaw discharge planning for short term skilled residents. On 12/03/2024 at 1:30 PM, the Case Manager (CM) verbalized a discharge assessment would be documented within twenty-hours of admission and the resident would continually be assessed throughout the stay for any discharge needs and coordination. The CM could not provide documentation of a discharge planning assessment for R10. On 12/05/2024 at 10:01 AM, the Director of Nursing (DON) indicated the DON oversaw the case management department. The role of the CM would be to coordinate with the resident to formulate a discharge plan. Any assessments performed by the CM should be charted in the resident's medical record. The DON confirmed the lack of documentation in R10's medical record regarding a discharge plan. The facility policy titled, Discharge Planning dated on 10/01/2021 revealed the discharge plan would be initiated as early as possible in the admission process and would be re-evaluated to identify any changes in the resident's condition. This information would be documented in the resident's medical record. Complaint NV00070559

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51395 Based on interview, record review, and document review, the facility failed to provide documented evidence assistance with activities of daily living (ADL) was provided for 1 of 37 sampled residents (Resident 3). The deficient practice had the potential for the resident's skin integrity to be compromised. Findings include: Resident 3 (R3) was admitted on [DATE] and discharged on [DATE], with diagnoses including abnormalities of gait and mobility, and osteomyelitis of vertebra, sacral and sacrococcygeal region. R3's Care Plan documented the following: - Resident had an ADL self-care performance deficit as evidenced by Parkinson's disease and acute respiratory failure. The interventions/tasks identified in the resident's care plan included assistance of staff for toileting. -Resident had bladder incontinence related to impaired mobility. The interventions/tasks identified in the resident's care plan included to clean the peri-area with each incontinent episode. The Admission Minimum Data Set (MDS) dated [DATE], documented R3 was dependent with toileting hygiene (The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement.) and always incontinent with bowel and bladder. On 12/06/2024 at 9:18 AM, R3's admission MDS and ADL Flowsheet for February 2024 and March 2024 were reviewed with the MDS Coordinator. The documentation for toileting hygiene during the day shift (from 6:00AM- 2:00PM) was recorded as Not Applicable (NA) on the following dates: - from 02/04/2024 through 02/14/2024 - 02/16/2024 - from 02/18/2024 through 02/21/2024 - from 02/23/2024 through 02/29/2024 - from 03/01/2024 through 03/07/2024 The MDS Coordinator confirmed the findings and indicated R3 was dependent with ADLs. The MDS Coordinator explained R3 needed help from staff with toileting hygiene which included changing the resident's adult briefs and there was no documented evidence the resident was provided with toileting hygiene during the day shift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/06/2024 at 9:51AM, a Certified Nursing Assistant (CNA) acknowledged the documentation in R3's ADL Flowsheet for toileting hygiene should have been a 4 for dependent and a 2 for one-person physical assist to prove the resident had been provided assistance with toileting such as perineal care and changing the adult briefs. On 12/06/2024 at 10:36AM, the DON revealed the CNAs were expected to document the ADL assistance provided to the residents in the ADL Flowsheet at least every shift. The facility's policy titled Activities of Daily Living (ADLs), (undated), documented the residents who were unable to carry out activities of daily living would receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Complaint # NV00070438

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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** 51395 Based on interview, record review and document review, the facility failed to ensure weekly wound evaluations were completed and weekly skin observations were documented accurately for 1 of 37 sampled residents (Resident 1) and failed to implement a physician order for a psychiatric consultatin for 1 of 37 sampled residents (Resident 32). The deficient practice had the potential to delay the assessment and treatment of residents' skin condition and management of a resident's mental health. Findings include: 1.) Resident 1 (R1) was admitted on [DATE] and discharged on [DATE], with diagnoses including acute post traumatic pain, left femoral fracture and right distal femur fracture. The Weekly Skin Observation for R1 dated 01/14/2024 documented the following skin conditions: - right lateral thigh stapled incision - left elbow abrasion - left knee abrasion - right thigh stapled incision - left lateral thigh stapled incision The Weekly Skin Observations for R1 dated 01/21/2024, 01/28/2024, and 02/04/2024 documented the resident had no bruises, open wounds, surgical incisions, skin tears, reddened areas or other skin conditions noted. The Weekly Wound Evaluation for R1 dated 01/14/2024 documented surgical wound of right thigh (back). There were no other surgical wounds documented in the evaluation. R1's medical record lacked documented evidence a Weekly Wound Evaluation was completed on 01/21/2024, 01/28/2024, and 02/04/2024. The Physician/Nurse Practitioner (NP) Progress note for Wound Care Consultation dated 01/22/2024, documented the patient (R1) was seen for surgical wounds on bilateral lower extremities (BLE) present upon admission. Wound examination documented the following: 1. Right knee surgical wound- three sites present on the knee, medial lateral and anterior with staples. 2. Right posterior thigh surgical wound - with staples. 3. Left hip with three areas with intact staples. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Right groin surgical wound with staples intact. On 12/03/2024 at 12:30 PM, the Wound Care Nurse, indicated an initial wound evaluation was completed for each resident upon admission. The floor nurse would complete the Weekly Skin Observations for their assigned residents. The wound care team (wound care nurses) would complete the Weekly Wound Evaluations for residents who had wounds and were being followed by the wound care team. On 12/06/2024 at 10:17AM, the Director of Nursing (DON) explained the wound care nurses were expected to complete the Weekly Wound Evaluations to monitor the resident's progress and ensure the wound was not worsening. The DON confirmed R1's medical record lacked Weekly Wound Evaluations for 01/21/2024, 01/28/2024, and 02/04/2024. The DON acknowledged R1 weekly skin observations did not reflect the residents' skin conditions accurately. The DON confirmed the charting should have been accurate. The facility's policy titled Pressure Injury/Skin Breakdown- Clinical Protocol, (undated), documented the following: - Nursing would complete a weekly wound evaluation form. - Licensed nurse would complete skin observations weekly to identify any other areas of skin impairment. The Weekly Wound Evaluation form documented the following areas to be completed: - Instructions: To be completed by a Licensed Nurse on each wound weekly. - Skin Issues: Skin Concern Number, Diagnosis/Comorbidities related to skin condition, Type of Skin Issue, Location, Whether a new skin concern for the week, Physician notification, Family notification for new wound, Length and Width of the wound and who obtained the measurements, Dressing saturation, Wound odor, Surgical wound edges, Signs and symptoms of infection, Overall impression, Current treatment plan, and Interventions in place. - Care Planning The Weekly Skin Observation form documented the following areas to be completed: - Skin color - Skin temperature to touch - Skin moisture - Skin turgor - Any bruises, open wounds, surgical incisions, skin tears, reddened areas or other skin conditions noted? (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Additional information 51396 2.) Resident 32 (R32) was admitted on [DATE], with a diagnosis of altered mental status due metabolic encephalopathy (a neurological disorder that cause brain dysfunction due to a chemical imbalance in the blood). R32's progress notes documented the following behaviors: On 10/10/2024 at 6:36 PM, a nurse documented the resident grabbed a nurse's arm and made an inappropriate remark to the staff member. The action was reported to the shift supervisor and the Assistant Director of Nursing (ADON). On 10/10/2024 at 7 PM, the social worker documented resident was making inappropriate remarks toward nursing staff. On 10/12/2024 at 5:18 PM, a nurse documented the resident attempted to swing and hit staff when providing care. On 10/23/2024, social services documented the resident was being sexually inappropriate and abusive to staff on 10/21/2024 and 10/22/2024. On 10/23/2024 at 5:18 PM, a nurse documented the resident was combative toward staff. R32's physician's orders documented the following orders: On 10/15/2024, psychiatric evaluation. On 10/17/2024, baseline psychiatric consult. R32's primary physician progress notes dated 10/16/2024 at 4:33 PM, documented will obtain psychiatric evaluation. On 12/06/2024 at 9:06 AM, the Unit Manager (UM), explained a resident would need a psychiatric evaluation if a resident was combative to staff members or showing any aggressive behaviors. Once the psychiatric consultation was ordered by the primary physician, the UM would coordinate for the psychiatric consultation. The UM verified there were two orders for a psychiatric consultation in R32's medical record and could not provide any documentation a psychiatric consultation was completed or documentation of nurse coordination to attain the prescribed consult. On 12/06/2024 at 10:09 AM the Director of Nursing (DON), acknowledged the psychiatric evaluation order should have been coordinated by the nursing staff to ensure the psychiatric provider consulted with the resident to address the behaviors and provide the necessary interventions. The DON reviewed R32's medical record and could not verify documentation of a psychiatric consultation.

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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** 51395 Based on interview, record review and document review, the facility failed to ensure weekly wound evaluations were completed and weekly skin observations were documented accurately for 1 of 37 sampled residents (Resident 2). The deficient practice had the potential to delay the assessment and treatment of residents' skin condition. Findings include: Resident 2 (R2) R2 was admitted on [DATE] and discharged on [DATE], with diagnoses including endocarditis, other abnormalities of gait and mobility, and Type 2 diabetes mellitus. The Physician/Nurse Practitioner Progress note for Wound Care Consultation dated 12/11/2023 documented the following skin conditions of R2 which were present on admission: 1. Right heel wound stage 1 pressure related 2. Right buttock pressure stage 3 3. Left iliac crest deep tissue injury (DTI) intact The following Weekly Skin Observations were documented in R2's medical record: -12/10/2023: No bruises, open wounds, surgical incisions, skin tears, reddened areas or other skin conditions noted and additional information: skin clean dry and intact. -12/16/2023: No bruises, open wounds, surgical incisions, skin tears, reddened areas or other skin conditions noted. -12/23/2023: Resident refused evaluation -12/31/2023: No bruises, open wounds, surgical incisions, skin tears, reddened areas or other skin conditions noted. R2's medical record lacked documented evidence a Weekly Wound Evaluations was completed from admission to discharge. On 12/03/2024 at 12:30 PM, the Wound Care Nurse, indicated an initial wound evaluation was completed for each resident upon admission. The floor nurse would complete the Weekly Skin Observations for their assigned residents. The wound care team (wound care nurses) would complete the Weekly Wound Evaluations for residents who had wounds and were being followed by the wound care team. On 12/03/2024 at 2:08 PM, the Assistant Director of Nursing (ADON) confirmed there were no Weekly Wound Evaluations completed for R2. The ADON acknowledged the wound care team should have completed the wound evaluation weekly. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/06/2024 at 10:17AM, the Director of Nursing (DON) explained the wound care nurses were expected to complete the Weekly Wound Evaluations to monitor the resident's progress and ensure the wound was not worsening. The DON confirmed R2's medical record contained no Weekly Wound Evaluations from admission to discharge. The DON acknowledged R2's weekly skin observations did not reflect the residents' skin conditions accurately. The DON confirmed the charting should have been accurate. The facility's policy titled Pressure Injury/Skin Breakdown- Clinical Protocol, (undated), documented the following: - Nursing would complete a weekly wound evaluation form. - Licensed nurse would complete skin observations weekly to identify any other areas of skin impairment. The Weekly Wound Evaluation form documented the following areas to be completed: - Instructions: To be completed by a Licensed Nurse on each wound weekly. - Skin Issues: Skin Concern Number, Diagnosis/Comorbidities related to skin condition, Type of Skin Issue, Location, Whether a new skin concern for the week, Physician notification, Family notification for new wound, Length and Width of the wound and who obtained the measurements, Dressing saturation, Wound odor, Surgical wound edges, Signs and symptoms of infection, Overall impression, Current treatment plan, and Interventions in place. - Care Planning The Weekly Skin Observation form documented the following areas to be completed: - Skin color - Skin temperature to touch - Skin moisture - Skin turgor - Any bruises, open wounds, surgical incisions, skin tears, reddened areas or other skin conditions noted? - Additional information

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 50513 Based on observation, interviews, and documentation review, the facility failed to provide a safe environment free from accident hazards by ensuring the sharps containers were replaced after it reached the manufacture fill line, used razors and syringes were disposed in an appropriate sharps container in a common shower room (Hall 600), residents were assessed for smoking, and the designated smoking area was under supervision. The deficient practice had the potential for increased risk of needle stick and compromised the resident's overall safety and well-being. Findings include: 1.) On 12/03/2024 at 9:41 AM, a sharps container on the medication cart for the 500 hall was full of sharp objects exceeding the three-quarters (3/4) of its capacity over the manufacture fill line. On 12/03/2024 at 9:42 AM, a Licensed Practical Nurse (LPN) (Employee 33 (E33) assigned to the medication cart, confirmed the sharps container was past the fill line, and indicated it was the nurse's responsibility to change the sharps container once it reached the manufacture three-quarters (3/4) fill line. On 12/03/2024 at 9:45 AM, a sharps container in the 500 common use shower room was full of sharp objects exceeding the three-quarters (3/4) of its capacity over the manufacture fill line. There were used razors sticking out of the lid of the sharps container. On 12/03/2024 at 10:20 AM, a sharps container wall mount in the 600 common use shower room did not have the sharps container receptacle. The sharps container wall mount was full of used razors and other objects with no locking mechanism to secure the sharps items. On 12/03/2024 at 10:33 AM, the 600 hall LPN Charge Nurse (E34) confirmed the sharps container was missing, and the wall mount was full of unsecured, used sharps objects. On 12/03/2024 at 11:20 AM, the Assistant Director of Nursing (ADON) advised the lid of the sharps container should have been locked when sharp objects reached the manufacture three-quarters (3/4) fill line, before being replaced with a new sharps container and disposed in the hazardous material room. On 12/03/2024 at 1:12 PM, the Central Supply Clerk (E35) advised there had been no shortage of sharps containers in the facility, with over 40 extra empty sharps bins in the central supply office. On 12/03/2024 at 3:08 PM, the Staff Development Director/Infection Prevention Manager (E3) verbalized sharps containers were changed out by the nurses and should not be filled past the three-quarters (3/4) fill line indicated by the manufacture on the containers. The facility policy titled Sharps Disposal documented sharps bin would be sealed and replaced when they are approximately 75% to 80% full to protect from punctures and/or needlesticks. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295071	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024
NAME OF PROVIDER OR SUPPLIER Tlc Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 W Warm Springs Rd Henderson, NV 89014	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	46265 2.) On 12/03/2024 at 12:20 PM, there were six residents in the courtyard smoking without staff supervision. There was a propane fueled gas grill in the area, no residents were currently near the grill. The gas was turned on and had a regulator along with ignitor button on front panel with the controls for gas burners in the grill. The controls for the gas burner were set to low position which would be required to start flame. There were empty dishes and cigarette butts sitting on the grill counter extension and in the drip tray below the main grill area. The Administrator was shown the concerns with the grill in an area where residents were smoking. The Administrator indicated the grill was normally kept in storage and brought out for barbeque events at the facility. The maintenance department was responsible for the grill, and it should have been removed from the courtyard after the barbeque event. Housekeeping would be responsible for cleaning the area to ensure no cigarette butts were left in the area. The Administrator acknowledged the lighting knobs for the grill were in the wrong position and should be turned to the off position. The Administrator verified the propane tank was empty. On 12/03/2024 at 3:00 PM, there were four residents in the designated smoking area smoking cigarettes without staff supervision. On 12/04/2024 at 9:10 AM, there were eight residents in the designated smoking area smoking cigarettes without staff supervision. On 12/05/2024 in the morning, Resident 38 (R38) indicated staff was rarely out in the designated smoking area. R38 verbalized the only time staff was generally out in the designated smoking area was if the staff was assisting resident to get chair through the doorway and then would go back inside. On 12/05/2024 at 9:18 AM, a Licensed Practical Nurse indicated most smoking residents would go to the courtyard on own without assistance from staff from the unit. On 12/05/2024 at 1:38 PM, a Nursing Supervisor explained there were designated smoking times however most residents were non-compliant with established times. The Nursing Supervisor indicated the courtyard by the front desk was the designated smoking area and it was expected for the residents to get smoking materials from the activities staff or from the front desk. The Nursing Supervisor confirmed all residents using the courtyard for smoking would have a quarterly assessment and even if the resident was independent and low risk staff would be required to supervise the smoking session. On 12/06/2024 at 10:00 AM, the Director of Nursing (DON) confirmed all smoking residents would receive a quarterly smoking assessment and acknowledged the current list of smokers had not been assessed on a quarterly basis with many of the residents last assessment at least one year ago. On 12/06/2024 in the afternoon, the Administrator indicated the facility was a smoking facility. The administrator indicated all clinical staff would be expected to carry out all required assessments including smoking assessments, and the residents would be supervised while smoking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Smoking Permitted (revised 10/20/2022) documented for safety purposes all smoking related materials must be stored in a safe place in the facility. Residents would be evaluated for ability to smoke independently, and evaluations would be reviewed by the interdisciplinary team at least monthly. The facility would identify safe smoking locations and times for providing supervised smoking. Complaint #: NV00072348

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 51395 Based on observation, interview, record review, and document review, the facility failed to ensure staff did not use personal blood pressure monitors to take vital signs for residents in transmission-based precautions when disposable blood pressure cuffs were available. The deficient practice had the potential to increase the risk of cross-contamination. Findings include: On 12/04/2024 at 8:42AM, a Certified Nursing Assistant (CNA) explained using personal electronic blood pressure monitor for obtaining the resident's vital signs. The CNA confirmed using the same equipment for residents on transmission-based precautions (TBP). The CNA showed an electronic blood pressure cuff with a gray cloth wrist band which was kept in the CNA's personal bag. The CNA revealed using the bleach wipes in cleaning the equipment. The CNA was not familiar with the amount of time the bleach wipe would need to stay visibly wet on a surface to effectively kill germs. The CNA explained the blood pressure cuff was wiped with a tissue to dry it after cleaning with a bleach wipe. The CNA provided the canister of the bleach wipes used for cleaning the equipment. The Unit Manager who was present during the interview, showed the CNA a facility disposable blood pressure cuff. The Unit Manager explained the disposable blood pressure cuff should have been used for residents on TBP. The CNA confirmed it was their first time seeing this equipment and was unaware the facility had the equipment for use. On 12/04/2024 at 8:57 AM, another CNA explained using a personal blood pressure monitor to obtain vitals for residents and the monitor was disinfected with bleach wipes after use. The CNA explained the equipment was left to air dry for five to ten minutes or wiped dry with a tissue. The CNA was aware the facility had disposable blood pressure cuffs explaining it had not been used in a long time. On 12/06/2024 at 10:28 AM, the Director of Nursing (DON) confirmed residents on TBP should have dedicated vital sign equipment (such as blood pressure cuffs) available inside each room. Staff were expected to disinfect equipment after use, between each patient, and were expected to follow the manufacturer's instructions of the disinfecting wipes. The DON acknowledged there was a risk of the equipment being contaminated if the manufacturer's instructions were not followed. The facility provided the manufacturer's instructions for the disinfecting wipes. The IFU documented the kill time of three minutes for Clostridium difficile spores, 30 seconds for certain viruses and bacteria, and one minute for Candida albicans and Trichophyton interdigitale. The facility policy titled Isolation-Categories of Transmission-Based Precautions (undated), documented when transmission-based precautions were in effect, non-critical resident-care equipment items such as a sphygmomanometer (a device used to measure blood pressure) would be dedicated to a single resident when possible. If re-use is necessary, then the items would be cleaned and disinfected according to current guidelines before use with another resident.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29141 Based on interview and document review the facility failed to ensure 1.) the Infection Preventionist had specialized training in infection control prior to appointment to the position; 2.) a COVID-19 outbreak was reported to the appropriate state agency; and 3.) N-95 respirator fit testing was completed, documented and staff training was provided per facility policy. The deficient practice had the potential for the facility's infection prevention program to be ineffective. Findings include: 1.) On 12/03/2024 at 3:08 PM, the RN Staff Development Coordinator/Infection Prevention RN (E3), explained had been appointed in their current position at the end of September 2024. E3 confirmed there was a COVID-19 outbreak accounting for 55 COVID-19 positive residents, many of them symptomatic, and 12 positive staff members. E3 did not know the COVID-19 cases should have been reported to the appropriate state agency. E3 indicated having health issues preventing them to be full time at the facility and not having a back-up person to oversee the infection control program. E3 confirmed they did not have specialized infection control training but was in the process of scheduling the session. Infection control training was provided to new staff members during orientation. Human Resources was responsible for ensuring all topics, including infection control, were covered during orientation. E3 had not demonstrated to staff members how to properly use PPE or ensuring proper use by staff demonstration. E3 provided a PowerPoint presentations of what was expected. On 12/05/2024, the Human Resources (HR) Director confirmed E3 personnel record did not have proof of specialized infection control training required for the IP position. On 12/06/2024 at 11:08 AM, the Facility Administrator explained E3 was scheduled to complete IP specialized training within 30 days, but this training had not been completed. The Administrator confirmed there was no alternate Infection Preventionist or designee to cover E3 during medical leave, despite another staff member having specialized infection control training but not serving in that capacity. 2.) On 12/03/2024 in the morning, the Administrator and the Infection Preventionist (IP) explained that on 11/18/2024 two residents tested positive for SARS-CoV-2 (COVID-19) after presenting with symptoms of COVID-19. The facility implemented COVID-19 testing and during the first 48-hour testing period no further cases were identified. The IP indicated another round of testing was performed 48 hours later where nine residents tested positive for COVID -19, and over a two-week period a total of 55 residents and 12 staff members had tested positive. The IP confirmed the facility did not report the COVID-19 positive cases to the appropriate state agency. On 12/06/2024 at 11:08 AM, the Administrator verbalized the facility had reported the COVID-19 outbreak to the National Healthcare Safety Network (NHSN), but E3 did not reported to the appropriate state agency. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3.) On 12/03/2024 at 7:49 AM, a Housekeeping Aide (E26) was observed wearing an N-95 respirator with only one strap with the second strap hanging loose. E26 verbalized not having been fit-tested for the N-95 respirator or receiving training for the use of PPE. On 12/03/2024 at 8:17 AM, a Certified Nursing Assistant (CNA) (E27) was observed entering room [ROOM NUMBER] with droplet precautions signage to deliver a meal tray without wearing a gown or N-95 respirator. The CNA verbalized the facility did not provide N-95 respirators and had to use a double face mask. On 12/04/2024 at 8:32 AM, a Licensed Practical Nurse (LPN) (E20) indicated the proper personal protective equipment for a COVID-19 isolation room was to wear a gown, N-95 respirator, and gloves. E20 confirmed had not been fit-tested for an N-95 respirator in the facility. On 12/04/2024 at 8:47 AM, CNA (E11) was observed wearing an N-95 respirator, specifying it was their personal mask and not knowing where to find N-95 respirators in the facility. On 12/04/2024 at 8:51 AM, Maintenance Assistant (E31) indicated they had not been fit-tested to wear a N-95 mask. On 12/04/2024 at 9:03 AM, an RN (E32) was at the medication cart in the 900-hall with an N-95 respirator placed over a tissue on top of the medication cart. E32 verbalized the N-95 respirator had been used when entering rooms on droplet TBP due to COVID-19. E32 indicated being fit-tested for the N-95 respirator about two or three years ago. On 12/03/2024 at 3:08 PM, the RN Staff Development Coordinator/Infection Prevention RN (E3) confirmed N-95 respirator fit testing for staff was not completed. The review of the job description for the Quality Assurance/Staff Development/Infection Preventionist RN, revealed that E3 signed the document on 09/07/2024. The job description outlined an extensive list of key responsibilities critical to maintaining infection control and ensuring quality assurance within the facility that included: - Identify infection control issues, conducting process and outcome monitoring, coordinating and monitoring monthly departmental infection control rounds, and disseminating infection data to nursing staff and healthcare practitioners. - Coordinate outbreak investigations with the director of nursing and the medical director. - Assist with covid-19 infection tracking and reporting. - Managed N-95 respirator fit testing for employees. - Conduct observation for clinical staff competencies and review infection prevention policies and programs with staff (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy titled Administrative Infection Control Processes, dated 2023, revealed the infection prevention and control program was coordinated and overseen by an infection prevention specialist, commonly referred to as an infection preventionist. The policy indicated the qualifications and essential skills required for this role were detailed in the Infection Preventionist job description. The policy documented a qualified candidate must obtain a Certification in Infection Control and Epidemiology (CIC preferred) prior to employment.