

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  03/28/2025
NAME OF PROVIDER OR SUPPLIER  Tlc Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33980</b></p> <p>Based on observation, interview, record review and document review, the facility failed to ensure a physician's order was obtained, an assessment was completed, and care plan was developed for the self-administration of medication for one unsampled resident (Resident 38). The deficient practice had the potential for the resident's unsafe administration of medication or adverse reactions to medication.</p> <p>Findings include:</p> <p>Resident 38 (R38)</p> <p>R38 was admitted on [DATE], with diagnoses including peripheral vascular disease and age-related physical debility.</p> <p>The physician's order dated 10/18/2023, documented Ketotifen Fumarate Ophthalmic Solution 0.035% (eye drops), instill two drops in both eyes two times a day for itching.</p> <p>R38's Medication Administration Record (MAR) for March 2025, documented the medication was scheduled to be given at 8:00 AM and 8:00 PM.</p> <p>On 03/28/2025 at 8:44 AM, during the medication administration pass observation, a Licensed Practical Nurse (LPN) prepared R38's oral medications scheduled for 8:00 AM. The LPN indicated R38 kept and self-administered the eye drops.</p> <p>On 03/28/2025 at 8:56 AM, the LPN administered R38's medications except for the eye drops.</p> <p>On 03/28/2025 at 8:58 AM, R38 confirmed self-administering the eye drops as needed and kept the eye drops on bedside.</p> <p>R38 took the eye drops from a purse kept at the resident's bedside and showed the medication to the LPN. R38 refused to have the eye drops administered. The label of the eye drops documented Eye Itch Relief 0.035%.</p> <p>(continued on next page)</p>

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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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/28/2025 at 8:59 AM, the LPN revealed a physician's order for the resident's self-administration of medication and keeping the medication on bedside should have been obtained, an assessment should have been completed to determine if the resident could self-administer the medication, and care plan for self-administration of medication should have been developed.</p> <p>The LPN confirmed there was no physician's order obtained for R38's self-administration of the eye drops and for the resident to keep the eye drops on bedside, no assessment was completed and no care plan developed for the resident's self-administration of the medication (eye drops). The LPN acknowledged the medication should have been kept in a secured and locked storage and not in the resident's purse.</p> <p>On 03/28/2025 at 12:29 PM, the Regional Director of Clinical Services confirmed there were no physician's orders for R38's self-administration of the eye drops and keeping the eye drops at bedside, no assessment had been completed and no care plan developed for R38's self-administration of the medication.</p> <p>On 03/28/2025 at 2:01 PM, the Assistant Director of Nursing (ADON) indicated a physician's order should have been obtained for a resident's self-administration of medication and allowing the resident to keep the medication on bedside. The ADON revealed an assessment for self-administration of medication should have been completed and care plan should have been developed. The ADON explained the medication should have been kept in a secured and locked storage and not in the resident's purse.</p> <p>The facility's policy titled Self-Administration of Medications and Treatments (undated), documented the residents had the right to self-administer medications/treatments if the interdisciplinary team had determined it was clinically appropriate and safe for the resident to do so. As part of their overall evaluation, the staff and practitioner would assess each resident's mental and physical abilities and choice to determine whether self-administering medications and/or treatments was clinically appropriate for the resident.</p> <p>In addition to general evaluation of decision-making capacity, the staff and practitioner would perform a more specific skill assessment, which might include (but not limited to) the resident's:</p> <ul style="list-style-type: none"> <li>- Ability to read and understand medication labels/treatment instructions</li> <li>- Comprehension of the purpose and proper administration of the medications/treatments</li> <li>- Ability to remove medications and/or treatment supplies from a container</li> <li>- Ability to recognize risks and major adverse consequences of the medications/treatments</li> </ul> <p>Self-administered medications and/or treatment supplies would be stored in a safe and secure place. If safe storage was not possible in the resident's room, the medications of residents permitted to self-administer would be stored on a central medication cart or in the medication room.</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>50289</p> <p>Based on observation, interview, and document review, the facility failed to ensure residents have a right to make choices about aspects of their life in the facility which are significant to the resident for 1 of 35 sampled residents (Resident 102). The failure to accommodate the residents' preferences and choices had the potential risk to cause psychosocial distress to the residents.</p> <p>Findings include:</p> <p>Resident 102 (R102) was admitted to the facility with diagnoses of nontraumatic intracerebral hemorrhage and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.</p> <p>R102 had a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition.</p> <p>On 03/26/2025 in the morning, R102 stated do not get enough showers and two showers a week was not enough. R102 stated would like more showers because if the resident missed a shower for any reason, then the resident won't get another shower until the next week. R102 stated having to wait this long is too much. R102 complained about sweating in bed, hair becoming greasy, and body odor occurs when resident don't get enough showers.</p> <p>On 03/28/2025 at 3:41 PM the Administrator-In-Training (AIT) stated R102's shower days were Tuesday and Thursday, and the facility had added on Sunday for R102. However, on Tuesday, 03/25/2025, the facility did not have a Hoyer (mechanical resident lift) sling available to complete the shower transfer to get the resident from the bed to the shower chair/gurney. The AIT stated each resident should have their own sling for the Hoyer, but R102 did not have a sling at this time. The AIT also reported there was no documentation a shower had been given on 03/27/2025.</p> <p>On 03/28/2025 in the afternoon, the Assistant Director of Nursing (ADON) verified R102's shower days were Tuesday and Thursday, and the facility had added on Sunday for this resident. The ADON also verified on Tuesday, 03/25/2025, the facility did not have a Hoyer sling available to complete the shower transfer to get the resident from the bed to the shower chair/gurney and there was a lack of documentation whether a shower had been given on 03/27/2025.</p> <p>Facility policy titled Shower/Tub Baths (undated), documented the baths would promote resident cleanliness and provide comfort to the resident and the resident would, at a minimum, be offered at least two full baths per week and resident preferences for type and frequency of baths would be honored.</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37718</b></p> <p>Based on interview and document review, the facility failed to document a written response including rationale to address complaints brought forth in the resident council. The deficient practice had the potential to cause resident concerns to remain unresolved.</p> <p>Findings include:</p> <p>Resident council meeting minutes dated 02/19/2025 revealed residents complained of call lights were not answered in a timely manner, and staff were on their phones more than paying attention to residents.</p> <p>Resident council meeting minutes dated 03/19/2025 revealed a resident complained nurses were slow to answer their call light, resulting in waiting up to 45 minutes for assistance. A different resident complained had not had a shower in three months.</p> <p>Resident 57 (R57)</p> <p>R57 was admitted on [DATE]. The 02/04/2025 Quarterly Minimum Data Set (MDS) assessment indicated R57 had normal memory function.</p> <p>On 03/27/25 at 1:34 PM, R57 reported serving as the Resident Council President for greater than the prior four months. R57 reported resident council meetings were conducted on the third Wednesday of each month and eight or nine residents typically attended each meeting. R57 reported a staff member recorded the meeting minutes.</p> <p>R57 reported sometimes the facility did not make a response to concerns raised in the resident council. R57 verbalized residents in several recent council meetings had verbalized a complaint about delay in assistance from staff after putting on the call bell. R57 verbalized as of yet, no facility response to this concern had been received. R57 verbalized feeling frustrated by the lack of response to the ongoing issue. R57 verbalized other residents had also expressed frustration regarding the issue.</p> <p>On 03/27/25 at 1:34 PM, a group interview was conducted with R57 and seven other alert residents. Five of the residents verbalized their call lights could be on for 45 minutes before staff responded. The five residents stated the call light issue had been ongoing for several months. One resident reported staff were constantly on their phones.</p> <p>The facility was unable to provide any written documentation of corrective actions taken in response to the complaints from the meetings.</p> <p>On 03/28/25 at 2:18 PM, the Activities Assistant verbalized council notes were taken by activities staff and were furnished to department heads for response, but these were not consistently returned to the activities department for reply to the residents. Call light response time was an ongoing issue, and the complaints had been furnished to nursing, but no response had been returned to the Activity Assistant regarding what was being done.</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/28/25 at 8:43 AM, the Administrator (ADM) reviewed the resident council meeting minutes from the 02/19/2025 and 03/19/2025 meetings. The ADM verbalized there should have been written responses to the complaints regarding call light delay, staff using personal phones, and lack of shower provided. The ADM verbalized having checked, but written responses to the concerns could not be located. The ADM verbalized not being sure of the reason. The ADM verbalized having commenced employment at the facility on 03/23/2025, and the former ADM had left employment with no briefing provided on the status of complaints.</p> <p>On 03/28/25 at 1:01 PM, the Regional Director of Clinical Services verbalized concerns from the resident council should be forwarded to the appropriate department and an investigation/response should have been documented.</p> <p>The policy and procedure titled Resident/Family Council, undated, indicated resident council meetings were scheduled monthly or as requested by residents. The policy indicated the purpose was to provide a forum for concerns or suggestions for improvement. The policy indicated documentation of the resident council meeting would be utilized to track issues and their resolution. The facility department related to any issues would be responsible for addressing the item(s) of concern.</p> <p>The policy and procedure titled Grievances/Complaints, dated 01/2018, indicated all grievances, complaints, or recommendations stemming from resident or family groups would be considered. Actions on such issues would be responded to in writing, including a rationale for the response.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>50289</p> <p>Based on interview, record review and document review, the facility failed to ensure a resident was kept safe from physical abuse for 1 of 35 sampled residents (Resident #43). The deficient practice had the potential for the resident to experience emotional and physical harm.</p> <p>Findings include:</p> <p>Resident #43 (R43)</p> <p>Resident #43 (R43) was admitted to the facility 01/02/2025 with diagnoses including encephalopathy, urinary tract infection, hypothyroidism, and hypertension.</p> <p>The facility reported incident (FRI) dated 02/27/2025 documented the following:</p> <p>-On 02/25/2025, R43 was in a wheelchair in the 700 hall and was arguing with Employee 20 (E20). R43 was trying to wheel the wheelchair back to the room R43 had just been transferred from. E20 got in front of R43 and blocked the ability of R43 to move forward in the wheelchair. R43 became agitated and started yelling at E20 to get their hands off R43.</p> <p>- Employee 14 (E14) stepped outside their office and witnessed E20 holding R43's arms down against the wheelchair. R43 began to kick at E20. E20 then told R43 if R43 kicks E20, E20 would kick R43 back. Throughout 02/25/2025 and the following day E14 witnessed E20 leading R43 past the office of E14 holding R43's hands down against the wheelchair and R43 yelling to be let go of.</p> <p>-Conclusion: The allegation of physical abuse by E20 against R43 was substantiated. Subsequently E20 was suspended pending investigation and then terminated. The nursing board was notified on 03/25/2025 of the incident. R20 had been previously trained on abuse on 03/25/2024.</p> <p>A behavior note dated 02/25/2025 written by E20 documented R43 was kicking at staff and becoming more verbally and physically aggressive when not allowed to enter other resident rooms. R43 was yelling and using profanity.</p> <p>R43's medical record lacked documented evidence of social services involvement with this situation other than a Social Services note for a referral to psych services for agitation dated 02/26/2025.</p> <p>An email from the Director of Social Services (DSS) to the Administrator-in-Training on 02/27/2025 at 11:36 AM documented the incident between E20 and R43 had been brought to attention on this day and the DSS had the nurses write statements. The AIT acknowledged receipt of the email's information on 02/27/2025 at 11:48 AM.</p> <p>R43's care plans lacked evidence of an update or revision related to the incident involving the altercation with the staff member.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/26/2025 in the afternoon, R43 stated the current staff was very nice. R43 said there was a staff member which tried to kidnap the resident, but R43 has not seen this person since the other staff members stopped this person from kidnapping. R43 also stated the facility is run very well, and would not change a thing.</p> <p>During the onsite investigation on 03/26/2025, the facility's correction of the past non-compliance related to the incident occurred as evidenced by:</p> <ul style="list-style-type: none"> <li>-Observation of staff and resident interactions were professional and courteous.</li> <li>-Interviews with residents revealed they were happy with staff and were treated in a polite manner.</li> <li>- CNA's and Licensed Nurses indicated the facility provided continuing education regarding Abuse and Neglect.</li> <li>-Review of the facility's employee file for E20 revealed reference and background checks were completed.</li> <li>-Review of the facility's training records corroborated the staff interviews regarding training.</li> </ul> <p>Facility Reported Incident #NV00073562</p> <p>Complaint #NV00073745</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50513</p> <p>Based on observations, record reviews, staff interviews, and facility policy reviews, the facility failed to ensure 1 of 35 sampled residents (Resident 168) remained free from restraints not needed to treat a medical symptom, identify the use of lower bed rails as a restraint, and follow policies and procedures in assessing the use of a physical restraint or alternatives considered prior to implementing a physical restraint. The deficient practice could have resulted in a decline in activities of daily living, loss of dignity, and physical and psychosocial harm to the resident.</p> <p>Findings include:</p> <p>Resident 168 (R168)</p> <p>R168 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including muscle weakness, lack of coordination, major depressive disorder, anxiety disorder, chronic post-traumatic stress disorder, and a fracture of the base of the neck of the right femur.</p> <p>On 03/27/25 at 10:03 AM, R168 was observed sleeping in bed. The bed was in the lowest position with bilateral floor mats and full rails (two upper and two lower rails) raised.</p> <p>On 03/27/25 at 10:06 AM, a Certified Nursing Assistant (CNA) explained floor mats, bed rails, and lowering the bed were used for the safety of fall-risk residents.</p> <p>On 03/27/25 at 10:09 AM, a Licensed Practical Nurse (LPN) explained floor mats were placed beside beds to relieve pressure on staff's lower backs during care provision. The LPN also explained lower bed rails could be used for safety only if physician orders the rails and bed rail assessments were conducted but stated lower bed rails were typically considered restraints. The LPN confirmed R168 had both upper and lower rails raised and acknowledged the lower rails were physical restraints. The LPN was unable to recall how long the lower rails had been in place.</p> <p>R168's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/13/25 documented a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. Under Section P0100, Physical Restraints Used in Bed was documented as Not used. Section GG0115, Functional Limitation in Range of Motion, documented no impairment of the upper extremities and impairment on both sides of the lower extremities.</p> <p>The Physician's Orders lacked documented evidence of orders for bilateral floor mats, upper side rails, lower side rails, or full side rails.</p> <p>The Comprehensive Care Plan, initiated on 11/23/24, documented R168 was at risk for falls due to cognitive impairment, functional impairments, muscle weakness, and unsteady gait. The interventions lacked documented evidence of the use of bilateral floor mats, upper bed rails, lower bed rails, or full bed rails.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R168's medical record revealed The Side Rail and Entrapment Risk Assessment, completed on 05/04/2024, documented the resident was not dependent in bed mobility but had altered safety awareness due to cognitive decline and poor decision-making. The assessment identified periods of confusion and unsafe behaviors placing the resident at risk. The recommendations section lacked documented evidence of alternatives considered or trialed before implementing side rails. The use of both upper half-rails was recommended for independent bed mobility. The interventions section documented full/half rails up per physician's order for safety during care provision, to assist with bed mobility, and to observe for injury or entrapment related to side rail use.</p> <p>The clinical record lacked documented evidence of another Side Rail and Entrapment Risk Assessment completed after the resident's readmission on 11/23/24 to a different room.</p> <p>R168's medical record revealed a document titled Siderail Consent, which documented Full Rails on both sides to assist the resident in turning and positioning while in bed, transferring to and from bed, stabilizing while sitting on the side of the bed, and promoting safety while receiving care in bed. However, the document lacked the resident's name, signature, or the signature of a resident representative. A facility representative had signed and dated the document on 01/31/25.</p> <p>On 03/27/25 at 10:38 AM, an Assistant Director of Nursing (ADON) explained the facility did not have beds with full side rails. The ADON confirmed side rails used as enablers required a side rail assessment and bilateral fall mats and upper rails required a physician's order. The ADON verified R168's bed had bilateral fall mats and both full upper and full lower rails raised. The ADON acknowledged the lower rails were considered a restraint. The ADON was unaware of when the full rails had been installed.</p> <p>On 03/27/25 at 11:01 AM, the Regional Director of Clinical Services verified R168 had both upper and lower rails raised. The consultant explained whether lower rails could be used depended on the care plan, physician orders, assessments, and family requests. After reviewing R168's medical records, the Regional Director of Clinical Services confirmed there were no physician orders, care plan documentation, or family requests for the rails. The Regional Director of Clinical Services stated the lower bed rails were considered a restraint and should not have been in place.</p> <p>On 03/28/25 at 9:15 AM, the Director of Maintenance (DOM) explained the facility did not track when bed rails were installed because all beds had upper rails as enablers. The DOM stated unaware lower rails could not be installed until the survey team identified R168's bed. The DOM reported walking through the facility and finding three additional beds with lower rails. The DOM explained the maintenance team secured all lower rails in the lowered position with zip ties until proper removal could be arranged.</p> <p>On 03/28/25 at 3:09 PM, the ADON acknowledged no in-service training had been conducted on bed rail guidelines. The ADON explained full side rails should not have been used as restraints and stated the facility could not determine when the rails had been installed. The ADON indicated side rails could have contributed to R168's past falls and stated an investigation should have been conducted, but no documented evidence of such an investigation was found.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/28/25 at 3:25 PM, a Registered Nurse Unit Manager explained full bed rails could result in injuries, particularly if residents attempted to self-transfer and became trapped between rails. The nurse stated a root cause analysis should always be conducted and reviewed by a supervisor, but no such analysis was found for R168.</p> <p>The facility policy titled Physical Restraints, undated, documented a physical restraint as a physical or mechanical device, equipment, or material which meets all the following criteria:</p> <ul style="list-style-type: none"> <li>-is attached or adjacent to the resident's body;</li> <li>-cannot be removed easily by the resident; and</li> <li>-restricts the resident's freedom of movement or normal access to the resident's body.</li> </ul> <p>The restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of fall. When the use of the restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need of restraints will be documented. The restraint will only be used upon the written order of a physician and after obtaining consent from the resident or representative.</p> <p>The facility policy titled Fall Protocol, undated, documented an investigation of the fall will be conducted to identify reason, contributing factors and/or root cause of the fall. The staff would conduct a comprehensive investigation to understand the how and why the fall occurred, protect the resident involved and other potential residents, and implement change in the care of system to minimize recurrence.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>50289</p> <p>Based on interview, record review and document review, the facility failed to ensure an alleged incident of physical abuse was reported to the State Agency (SA) within the required timeframes for 1 of 35 sampled residents (Resident #43). The deficient practice had the potential to place residents at risk for incidents of physical abuse to not be adequately protected.</p> <p>Findings include:</p> <p>Resident #43 (R43) was admitted to the facility 01/02/2025 with diagnoses including encephalopathy, urinary tract infection, hypothyroidism, and hypertension.</p> <p>A Behavior Note dated 02/25/2025, documented R43 was kicking at staff and had become more verbally aggressive by yelling profanity and more physically aggressive when not allowed to enter other resident rooms.</p> <p>In an email thread from the Director of Social Services (DSS) to the Administrator-In-Training (AIT), the DSS notified the AIT of the potential abuse allegation on 02/27/2025 at 11:36 AM and the AIT verified receipt of the message on 02/27/2025 at 11:48 AM.</p> <p>An initial Facility Reported Incident (FRI) was submitted to the SA on 02/27/2025 at 6:40 PM, documenting the staff's alleged physical abuse on 02/25/2025. No final report was received by the SA.</p> <p>On 03/28/2025 in the afternoon, the Administrator/Abuse Coordinator verbalized abuse without serious bodily harm should be initially reported to the SA within two hours of an abuse incident, with a final report to the SA within 5 working days of the incident. The Administrator/Abuse Coordinator was not sure it reported to the SA within the required timeframes as this Administrator/Abuse Coordinator was not working for the facility at the time of the event.</p> <p>The facility policy titled Abuse, revised 10/20/2022, documented alleged abuse would be reported to the appropriate State or Federal agencies immediately, but not later than two hours after the allegation is made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury.</p> <p>The State Operations Manual for Long Term Care (SOM) documented a facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The SOM also documents the facility will report the results of all investigations to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified the appropriate corrective action taken.</p> <p>Facility Reported Incident #NV00073562</p>		

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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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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46265</p> <p>Based on observations, interview, record review, and document review the facility failed to ensure a resident-centered care plan was revised and physician order obtained for use of side rails for 1 of 35 sampled residents (Resident 6). The deficient practice had the potential to put the resident at risk for harm due to lack of communication between staff.</p> <p>Findings include:</p> <p>Resident 6 (R6)</p> <p>R6 was admitted on [DATE] with diagnoses including Parkinson's disease and need for assistance with personal care.</p> <p>A brief interview for mental status (BIMS) was conducted on 01/01/2025 with a result of 05/15 which indicated the resident had a severe cognitive deficit.</p> <p>A minimum data set (MDS) assessment was conducted on 01/01/2025 and documented resident required maximal assistance in bed mobility.</p> <p>On 03/26/25 8:49 AM, resident was lying down in bed, bed was flat, and side rails were installed in the middle of bed frame on both sides. R6 indicated not knowing what the rails were for.</p> <p>03/28/25 09:48 AM, resident required assistance to get out of bed however was able to move upper extremities to position in bed with use of side rail. Resident verbalized not being aware of why side rails were on bed. Mats were placed on floor on both sides of bed.</p> <p>R6's medical record revealed a side rail assessment was completed on 03/05/2024 prior to use of side rail.</p> <p>The medical record revealed a side rail consent was obtained by phone on 03/05/2024.</p> <p>R6's medical record lacked documented evidence of a resident care plan for side rails prior to 01/14/2025.</p> <p>R6's medical record lacked documented evidence of a physician order prior to 03/28/2025.</p> <p>On 03/28/25 at 10:35 AM, a Licensed Practical Nurse (LPN) indicated during admission an assessment would have been completed to determine if side rails were needed and would get consent signed at time of admission and a physician order would be obtained. The LPN revealed if resident required side rails identified after the admission assessment, a new evaluation would have been completed and order obtained. The LPN indicated a care plan would have been completed and was normally updated by the unit manager. The LPN confirmed there were side rails on R6's bed used as enabler for transfers and bed mobility.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/28/25 at 10:45 AM, the Unit Manager indicated side rail consents were part of the admission packet and would be assessed if needed and physician order would be obtained. The Unit Manager verbalized the resident would have care plan initiated for use of side rails. The Unit Manager confirmed there was no care plan in place for use of side rails or no physician order.</p> <p>After the initial interview the Unit Manager followed up and was able to provide documentation revealing care plan for assistance with activities of daily living which documented an intervention of the use of side rails and was initiated on 01/14/2025.</p> <p>The facility policy (undated) titled Baseline Care Plans, documented the baseline care plan would be developed within 48 hours of admission and used until the staff could conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan.</p> <p>The facility policy (revised September 2010) titled Care Plans-Comprehensive, documented the comprehensive care plan was based on a thorough assessment and designed to incorporate identified problem areas and risk factors associated with identified problems. The comprehensive care plan would be developed within seven days of the completion of the comprehensive assessment.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51395</p> <p>Based on observation, interview, record review and document review, the facility failed to provide incontinent care for 2 of 35 sampled residents (Resident 25 and Resident 417) and 1 unsampled resident (Resident 468). The deficient practice had the potential for the resident's skin integrity to be compromised.</p> <p>Findings include:</p> <p>Resident 25 (R25)</p> <p>R25 was admitted on [DATE], discharged on [DATE], and readmitted [DATE] with diagnoses including displaced bicondylar (upper and lower parts) fracture of right tibia.</p> <p>The Quarterly Minimum Data Set (MDS) dated [DATE] documented R25 required maximal assistance with toileting hygiene: the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement.</p> <p>A Care Plan dated 01/10/2025 documented R25 was incontinent of bowel and urine due to generalized weakness with intervention to provide toileting hygiene as needed for incontinent episodes.</p> <p>On 03/25/2025 at 9:37 AM, R25 verbalized needing assistance with a brief change and having requested assistance since 6:00 AM. R25 explained staff stated being out of the brief R25 needed.</p> <p>On 03/25/2025 at 9:52 AM, a Certified Nurse Assistant (CNA) confirmed R25 had been requesting since 6:00 AM to be changed. The CNA explained checking with the nurse and central supply and the facility was out of the green brief R25 needed.</p> <p>On 03/25/2025 at 9:58 AM, the Central Supply Clerk confirmed the facility was currently out of green briefs. The Central Supply Clerk explained green briefs were bariatric sized briefs and there was currently no substitute available. The Central Supply Clerk verbalized having been on vacation and the backup supply clerk had not ordered enough supply. The facility order was placed on 03/24/2025 and would not arrive until 03/26/2025. The Central Supply Clerk explained the facility transportation driver would be going to purchase some briefs and would arrive by noon today.</p> <p>On 03/25/2025 at 10:50 AM, R25 stated the brief was changed. R25 verbalized the CNA informed the brief was taken from another resident room.</p> <p>On 03/25/2025 at 12:02 PM, the CNA confirmed had found a brief in another resident room to use for R25 and R25 was changed at approximately 10:30 AM.</p> <p>Resident 468 (R468)</p> <p>R468 was admitted on [DATE] and discharged on [DATE] with diagnoses including acute and chronic respiratory failure with hypoxia, pneumonia, malignant pleural effusion.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Admission Minimum Data Set (MDS) dated [DATE] documented R468 was always incontinent of urine and frequently incontinent of bowel. Maximal assistance with toileting hygiene: the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement.</p> <p>A Care plan dated 10/11/2024 documented R468 had mixed bladder incontinence, was frequently incontinent of bladder and bowels, and was not a candidate for a toileting program due to the inability to control bowel and bladder. The interventions include one person assist with toileting, provide toileting hygiene with brief changes, check, and change briefs frequently as needed. Provide toileting hygiene as needed for incontinent episodes.</p> <p>R468's ADL documentation for toilet use and personal hygiene during October 2024 documented not applicable (NA) for 10/11/2024 through 10/17/2024 and 10/19/2024 through 10/22/2023.</p> <p>On 03/27/25 at 10:32 AM, the MDS Director verified R468 required maximal assistance and was dependent on staff for providing toileting hygiene. The MDS Director stated R468 was always incontinent of urine and frequently incontinent of bowel.</p> <p>On 03/27/25 at 10:35 AM, the MDS Director confirmed R468's toileting hygiene charting documented NA, indicating no toileting hygiene was provided. The MDS Director confirmed there was no documented evidence R468 was provided daily and routine incontinent care consistently on every shift.</p> <p>On 03/27/25 at 1:51 PM, a Certified Nurse Assistant (CNA) explained ADLs were documented in the resident's medical record. The CNA confirmed an NA would indicate not applicable, stating everything was applicable, and it should not be documented as an NA.</p> <p>On 03/28/25 at 1:56 PM, the Assistant Director of Nursing (ADON) verbalized resident ADLs would be documented by the CNA's. The ADON confirmed the NA 's on R468's ADL record. The ADON acknowledged this would indicate the task was not completed. The ADON confirmed staff should not be utilizing the NA as it would look as if the service was not performed.</p> <p>The facility policy titled Activities of Daily Living (ADLs), undated, documented residents who were incontinent of bladder or bowel would be provided care in a timely manner.</p> <p>Complaint #NV00073444</p> <p>50513</p> <p>Resident 417 (R417)</p> <p>R417 had been admitted on [DATE] and was discharged on [DATE] with diagnoses including mononeuropathies of bilateral lower limbs (a nerve injury affecting both legs) and a need for assistance with personal care.</p> <p>R417's medical records revealed a lack of documented evidence showing toileting hygiene had been performed during the day shift (6:00 AM to 2:00 PM) on 01/16/25, 01/22/25, and 01/24/25.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/27/25 at 12:17 PM, the Minimum Data Set (MDS) Nurse reviewed R417's medical records and explained a lack of documentation meant the care had not been provided. The MDS Nurse confirmed there was no documented evidence indicating toileting hygiene had been performed during the day shift (6:00 AM to 2:00 PM) between:</p> <p>01/16/25 at 1:19 AM and 9:32 PM</p> <p>01/22/25 at 5:59 AM and 9:29 PM</p> <p>01/24/25 at 5:59 AM and 9:59 PM</p> <p>The MDS Nurse clarified the care staff during the day shift (6:00 AM to 2:00 PM) should have documented toileting care in the resident's chart.</p> <p>On 03/27/25 at 1:06 PM, a Certified Nursing Assistant (CNA) reported residents had been checked on three to four times during each eight-hour shift. The CNA confirmed resident care charting should have occurred at least once per eight-hour shift.</p> <p>On 03/27/25 at 1:08 PM, a Licensed Practical Nurse (LPN) explained CNAs should have documented activities of daily living (ADL) care in the system. The LPN emphasized if care had not been documented, it had not been performed.</p> <p>On 03/27/25 at 3:09 PM, the Regional Director of Clinical Services reviewed R417's toileting care on 01/16/25, 01/22/25, and 01/24/25 and verified toileting care had not been provided during the day shift (6:00 AM to 2:00 PM) between:</p> <p>01/16/25 at 1:19 AM and 9:32 PM</p> <p>01/22/25 at 5:59 AM and 9:29 PM</p> <p>01/24/25 at 5:59 AM and 9:59 PM</p> <p>The Regional Director of Clinical Services confirmed ADL care should have been documented in the resident's chart if it had been performed.</p> <p>The facility policy titled Activities of Daily Living (ADLs), undated, documented residents who were incontinent of bladder or bowel would be provided care in a timely manner. The activities of daily living and personal care must be documented in the clinical record.</p> <p>The facility policy titled Urinary Continence and Incontinence - Assessment and Management, undated, documented facility staff would provide peri-care in a timely manner.</p> <p>Complaint #NV00073538 and #NV00073444</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51395</p> <p>Based observation, interview, record review and document review, the facility failed to ensure physician orders were followed in medication administration and orders clarified for medication for 1 of 3 closed record sampled residents (Resident 469), a medication was administered per the physician's order for one unsampled resident (Resident 219), and staff administered medication in a timely manner for 2 of 35 sampled residents (Residents 210 and 147) and 2 unsampled residents (Residents 27 and 137). The deficient practice had the potential for the resident not achieving the therapeutic effect (specific and desired effect) of the medication.</p> <p>Findings include:</p> <p>Resident 469 (R469)</p> <p>R469 was admitted on [DATE] and discharged on [DATE] with diagnoses including include metabolic encephalopathy, type 2 diabetes, and abnormalities of gait and mobility.</p> <p>A physician order dated 12/17/2024, documented Humalog Solution 100 units/Milliliter (ML) (Insulin Lispro (Human)) inject per sliding scale:</p> <p>if 1-70 notify MD;</p> <p>150-199 = 1 unit;</p> <p>200-249 = 2 units,</p> <p>250-299 = 3 units;</p> <p>300-349 = 4 units;</p> <p>350+ = 5 units;</p> <p>Notify MD if greater than 400, subcutaneously before meals for diabetes.</p> <p>The physician order lacked direction for Humalog Solution 100 units/Milliliter (ML) (Insulin Lispro (Human)) inject per sliding scale for blood glucose results measuring 71-149.</p> <p>The Medication Administration Record (MAR) for December 2024 documented the following blood glucose results:</p> <p>-12/21/2024 at 4:00 PM results of 70 milligrams per deciliter (mg/dL).</p> <p>-12/23/2024 at 7:00 AM results of 71(mg/dL).</p> <p>R469's medical record lacked documented evidence the physician was contacted regarding the results.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/26/25 at 8:02 AM, a Registered Nurse (RN), explained the resident's blood glucose levels were monitored before meals and at hours of sleep. Blood glucose levels were documented in the MAR for routine testing. If required to notify the physician, the information was documented in the progress notes and the notification would happen as soon as results were received.</p> <p>On 03/26/25 at 8:30 AM, the Director of Nursing (DON) reviewed R469's orders and verified the Humalog order lacked direction of what to do when the residents blood glucose level was 71-149. The DON explained the expectation was to ensure readings at all levels would be covered in the medication orders. The DON confirmed the order would need clarified with the physician and would need to be put in correctly due to the missing information.</p> <p>On 03/26/25 8:34 AM, the DON verified there was no documentation noted in R469's medical record regarding the 12/21/2024 blood glucose level obtained at 4:00 PM resulting of 70 and the 12/23/2024 blood glucose level obtained at 7:00 AM resulting in 71. The DON acknowledged the expectation would be for the nurse to document the notification and follow the physician orders. The DON verified the physician orders were not followed.</p> <p>The facility policy titled Insulin Administration, dated 10/01/2021, documented the nurse would notify the DON and Attending Physician of any discrepancies, before giving the insulin.</p> <p>Complaint #NV00073031</p> <p>33980</p> <p>Resident 219 (R219)</p> <p>R219 was admitted on [DATE], with diagnoses including abnormalities of gait and mobility, and lack of coordination.</p> <p>The physician's order dated 03/09/2025, documented Calcium Carbonate Tablet 600 milligram (mg) one tablet by mouth daily.</p> <p>On 03/28/2025 at 8:23 AM, during the medication administration pass observation, a Licensed Practical Nurse (LPN) administered R219's medications including Calcium Carbonate 500 mg one tablet by mouth.</p> <p>On 03/28/2025 at 10:35 AM, the LPN confirmed Calcium Carbonate 500 mg was given to R219 during the medication administration pass observation. Upon verification of the physician's order, the LPN acknowledged the order was Calcium Carbonate 600 mg. The LPN indicated the physician's order was not followed. The LPN explained the order would be clarified with the physician because the facility had no supply of Calcium Carbonate 600 mg.</p> <p>On 03/28/2025 at 2:00 PM, the Assistant Director of Nursing (ADON) explained the nurses were expected to verify the physician's order prior to administering the medication to avoid medication error.</p> <p>On 03/28/2025 at 2:06 PM, the Central Supply Clerk confirmed the facility had no stock or supply of Calcium Carbonate 600 mg.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's policy titled Medication Administration Orals dated January 2023, documented review and confirm medication orders for each individual resident on the Medication Administration Record prior to administering medication.</p> <p>50289</p> <p>The March 2025 Medication Administration Record for Residents 27,137, 147, and 210 were reviewed and documentation revealed the following medications were not given to the residents and were marked as missed by Employee 28:</p> <ul style="list-style-type: none"> <li>- Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML; 10-unit injection for unsampled Resident 27.</li> <li>- Sodium Bicarbonate oral tablet 650 mg for unsampled Resident 27.</li> <li>- HumaLOG KwikPen subcutaneous solution Pen-Injector 100 UNIT/MG uses a sliding scale for unsampled Resident 27.</li> <li>- Oxcarbazepine oral tablet 300 MG for unsampled Resident 27.</li> <li>- Keppra oral tablet 500MG for unsampled Resident 27.</li> <li>- MiraLax oral powder 17 GM/Scoop for unsampled Resident 27.</li> <li>- Eliquis oral tablet 5 MG for unsampled Resident 27.</li> <li>- HydrALAZINE HCl oral tablet 50 MG for unsampled Resident 27.</li> <li>- Carvedilol oral tablet 6.25 MG for unsampled Resident 137.</li> <li>- Sevelamer Carbonate oral tablet 800 MG for unsampled Resident 137.</li> <li>- Aspercreme Lidocaine external patch 4% for unsampled Resident 137.</li> <li>- Atorvastatin Calcium oral tablet 80 MG for unsampled Resident 137.</li> <li>- Triamcinolone Acetonide external cream 0.1% for sampled Resident 210.</li> <li>- DiphenhydrAMINE-Zinc Acetate external cream 1-0.1% for sampled Resident 210.</li> <li>- Apixaban oral tablet 5 MG for sampled Resident 210.</li> <li>- Benadryl Allergy oral tablet 25MG for sampled Resident 210.</li> <li>- Magic Mouthwash 5 ml for sampled Resident 210.</li> <li>- Pepcid AC tablet 10 MG for sampled Resident 147.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/28/2025 at 9:45 AM, Employee 28 (E28) stated was asked to work on 03/03/2025 in the 500 hall from 6:00 PM to 6:30 AM to fill in for another nurse. However, since the facility was not able to get a nurse to work the 800 hall, and the supervisor called off, E28 was informed by the scheduler during the 500 hall medication pass, E28 was also going to be responsible for the 800 hall.</p> <p>E28 and some other nurses attempted to contact the DON and ADON but were unsuccessful and had to leave messages. E28 stated was unable to oversee both halls as they were on opposite sides of the building and the building layout made this impossible. Another nurse agreed to take the 500 hall keys from E28 which allowed E28 to move over to the 800 hall around midnight to relieve the nurse who had stayed from the previous shift until a replacement was found.</p> <p>E28 said when the Medication Administration Record was opened, there were some residents who had not had their PM medications yet. Some of the residents' refused some of the medications because the residents just wanted to go back to bed. E28 asserted the previous nurse had not documented, at this time, any PM medications had been given.</p> <p>E28 conveyed having written the same note for every resident showing as having missed medications which were not refused, I was informed at 9:00 PM by the scheduler that I was to go to the 800 hall which I was already assigned to the 500 hall and was still in the middle of a med pass. I was informed to give my keys to 3 different nurses from 200, 300, and 400 halls which they could not take as they were still completing their med pass. I am unaware as what medications have been administered. It is also past the time to be giving the medications within the legal guidelines as it would also interfere with their morning medications.</p> <p>On 03/28/2025 in the afternoon, the Regional Nurse consultant stated the facility did not have a general medication administration policy.</p> <p>On 04/01/2025 in the morning, the Director of Nursing stated the expectation for medication administration would be to follow the medication times as ordered and scheduled, allowing one hour before or after those times, unless there is a reason which should be documented and the physician notified.</p> <p>Complaint #NV00073609</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51395</p> <p>Based on observation, interview, record review and document review, the facility failed to ensure:</p> <ol style="list-style-type: none"> <li>1. The plan of care was followed regarding transfers and the staff was provided with transfer training after a resident fall for 1 of 35 sampled residents (Resident 25) and,</li> <li>2. An Oxygen tank was secured for 1 of 35 sampled residents (Resident 98). The deficient practice led to a resident's fall with injury and had the potential to cause a resident injury due to an unsecured Oxygen tank.</li> </ol> <p>Findings include:</p> <p>Resident 25 (R25)</p> <p>R25 was admitted on [DATE], discharged on [DATE], and readmitted [DATE] with diagnoses including displaced bicondylar (upper and lower parts) fracture of right tibia.</p> <p>The Annual Comprehensive Minimum Data Set (MDS) dated [DATE], documented R25 had lower extremity (hip, knee, ankle, foot) impairment on one side of the body.</p> <p>R25's Care Plan documented the following:</p> <ul style="list-style-type: none"> <li>-Resident at risk for spontaneous pathologic fracture, injury, and trauma secondary to osteoporosis. The interventions identified included two persons assist when providing care.</li> <li>-Resident had Activities of Daily Living (ADL) self-care performance deficit as evidenced by impaired mobility, limited range of motion right lower extremity, and activity intolerance.</li> <li>-Resident had limited physical mobility as evidenced by weakness, impaired range of motion right lower extremity, and activity intolerance. Resident utilizes a Hoyer lift (device that helps transfer residents with limited mobility).</li> </ul> <p>A Physical Therapy Evaluation and Plan of Treatment dated 07/04/2024, documented R25 had physical impairments and associated functional deficits. The resident was at risk for falls and required a Hoyer lift with transfers.</p> <p>A Nursing Progress Note dated 09/18/2024, documented a Certified Nurse Assistant (CNA) reported an assisted fall with R25 during a transfer from the bed to shower chair. R25's knee buckled and started to lean toward the CNA which resulted in R25 being assisted down to the floor. R25 complained of severe right knee and right ankle pain. An order was obtained for a right knee and ankle x-ray.</p> <p>Radiology results dated 09/18/2024 documented a right knee view impression: nondisplaced fracture of the proximal (situated nearer to the center of the body or the point of attachment) tibia.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The Hospital Course of the Discharge Summary dated 09/27/2024, documented R25 experienced a ground level fall while attempting to transfer to a shower chair while utilizing R25's less efficient right foot to balance and an X-ray suggested right tibial plateau (a break at the top of the tibia bone) fracture.</p> <p>On 03/25/2025 at 9:24 AM, R25 was lying in bed alert and oriented and stated, a CNA pulled the leg, picked them up and threw them to the floor.</p> <p>On 03/26/2025 at 12:54 PM, Certified Nurse Assistant 1 (CNA 1) described the attempted transfer of R25 to a shower chair but was unable to locate a sling for the transfer in September 2024. The CNA expressed the nurse stated R25 transferred with the Restorative Nurse Assistant (RNA) check with them regarding abilities. The CNA explained not speaking to the RNA and returning to R25's room. The CNA attempted the transfer independently, when pivoting, R25's feet buckled, and the CNA fell with R25 to the floor. The CNA explained had recently started working the hall where R25 resided and always asked the nurse about a resident's transfer abilities. The CNA stated R25 required a sling and lift with transfers.</p> <p>On 03/27/2025 at 10:24 AM, the MDS Director explained the CNAs would check the Kardex (a care plan used by CNAs) to obtain information regarding a resident level of assistance. The Kardex would indicate how much assistance was required and if a Hoyer lift was needed.</p> <p>On 03/27/2025 at 10:29 AM, the MDS Director confirmed in September of 2024 R25 was dependent and required a Hoyer lift for transfers.</p> <p>On 03/27/2025 at 1:51 PM, Certified Nurse Assistant 2 (CNA 2) explained a Hoyer lift required two staff members or more depending on the resident. Staff needed to check with the resident's assigned nurse or the plan of care to know the method of transfer for a resident.</p> <p>On 03/27/2025 at 2:20 PM, the Therapy Director confirmed R25 was evaluated in July 2024 by physical therapy prior to the fall event in September. At the time of the evaluation, R25 required a Hoyer lift for transfers and the CNAs were to utilize a Hoyer lift for R25's transfers.</p> <p>On 03/28/2025 at 11:25 AM, the Unit Manager stated an investigation for the fall event should have been documented in the progress notes. The Unit Manager confirmed the medical record lacked documentation the investigation occurred and the 9/18/2024 nurse notes for R25 had no indication of what new fall prevention interventions were implemented after the fall event. The Unit Manager confirmed R25 was a Hoyer lift transfer prior to the September 2024 fall. The Unit Manager stated education and counseling occurred with the CNA involved with the incident.</p> <p>On 03/28/2025 at 11:31 AM, the Unit Manager confirmed the CNA should have checked R25's ADLs to determine how to transfer the resident and the CNA should have implemented the use of the Hoyer lift. The root cause was the CNA not utilizing the Hoyer lift and the fall could have been prevented. The Unit Manager explained education needed to be conducted for the CNA staff that work R25's unit and education to all CNA's regarding how to check the plan of care and ADLs for residents prior to performing care, and ensure new interventions were in place related to the fall event.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/28/2025 at 11:39 AM, the Unit Manager explained the expectation was to ensure new interventions were in place related to the fall event and education to be conducted for the CNA staff who worked R25's unit. Education should have been provided to all CNA's on where to locate information regarding a residents ADL's prior to performing care.</p> <p>CNA1's employee file, lacked documented evidence education or counseling had occurred as a result of the 09/18/2024 fall event.</p> <p>On 03/28/2025 at 11:54 AM, the Unit Manager confirmed there was no record of education or counseling in the employee file for the CNA involved. The CNA had not completed ADL training after the fall event and there was no record of other CNAs having been trained.</p> <p>Throughout the week of the survey a skills competency for the CNA involved in the fall was requested and documentation was not provided, as of the last onsite date of survey 03/28/2025.</p> <p>On 03/28/25 at 1:01 PM, Certified Nurse Assistant 3 (CNA 3) verbalized R25 would require two staff and a Hoyer lift for transfers. The CNA explained looking at the resident care plan to determine a resident's ADLs and level of assistance. CNA 3 stated knowing another CNA had transferred R25 resulting in an injury.</p> <p>On 03/28/2025 at 3:18 PM, the Assistant Director of Nursing (ADON) verbalized when fall events occur a discussion is held to determine a root cause of the fall incident and ensure interventions are implemented.</p> <p>The facility policy titled Fall Protocols, undated, documented staff would conduct a comprehensive investigation to implement change in the care or system to minimize recurrence.</p> <p>Resident 98 (R98)</p> <p>R98 was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, Type 2 diabetes mellitus, and dependence on supplemental Oxygen.</p> <p>A physician order dated 03/19/2025 documented to administer Oxygen at two liters per minute (LPM) via nasal cannula continuously every shift for shortness of breath.</p> <p>On 03/25/25 at 11:15 AM, an Oxygen cylinder tank was noted to be unsecured in R98s room beside the bed. R98 stated the staff change the Oxygen out when needed and the tanks are normally placed on the floor without support.</p> <p>On 03/25/25 at 11:19 AM, a CNA verified the Oxygen cylinder tank was not secured in an Oxygen holder. The CNA explained the tank was half full and it should be placed in a holder so it cannot fall. The CNA stated a holder was needed for safety.</p> <p>On 03/28/25 at 3:19 PM, the ADON confirmed Oxygen cylinder tanks were to be secured in a holder when in resident rooms to prevent them from falling and potentially causing injury.</p> <p>(continued on next page)</p>		

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F 0689  Level of Harm - Actual harm  Residents Affected - Few	The facility policy titled Fire Safety and Prevention, dated 10/01/2021, Oxygen Safety section, documented to store Oxygen cylinders in sturdy portable carts or approved stands. Never leave Oxygen cylinders free-standing.		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50513</p> <p>Based on observation, interview, record review, and document review, the facility failed to obtain a physician's order for the removal or use of an intravenous (IV) access, including assessing and monitoring the site, for 1 of 35 sampled residents (Resident 90). This deficient practice had the potential to cause complications such as infection, infiltration, phlebitis, or impaired venous access.</p> <p>Findings include:</p> <p>Resident 90 (R90) was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including anoxic brain damage, seizures, and carrier of carbapenem-resistant Enterobacter [NAME].</p> <p>On 03/25/25 at 10:03 AM, R90 was observed in bed, sleeping and snoring. The resident had an undated IV port/site on the right arm.</p> <p>On 03/25/25 at 10:27 AM, the Director of Nursing (DON) inspected the IV site on R90's lower right arm. The DON confirmed there was no date on the dressing.</p> <p>On 03/25/25 at 10:33 AM, an Assistant Director of Nursing (ADON) inspected R90's arm and verbalized there was no date on the dressing. The ADON explained the dressing looked like it needed to be changed and R90 did not have any current orders for an IV.</p> <p>On 03/25/25 at 10:40 AM, the DON reviewed R90's physician orders and verbalized there was an order to insert the IV on 02/26/25 for IV antibiotics, but no orders to flush the IV line or monitor the dressing. The DON verbalized there should have been orders to flush the IV line, change and monitor the dressing weekly, and remove the IV line on 03/05/25 when R90 completed the IV antibiotics. The DON explained it was important to keep the site clean and flush the IV, as the risk of infection increased if the IV line and dressing were not monitored.</p> <p>R90's physician orders documented to insert a midline IV on 02/26/2025. The active physician orders lacked documented evidence of an order to flush the IV, change, or monitor the dressing for the IV site. An order for Meropenem IV solution dated 02/25/25 documented instructions to use 1 gram intravenously every 8 hours for a urinary tract infection for 7 days.</p> <p>The facility policy titled Removal of a Peripheral IV (Over the Needle, Peripheral Short) Catheter, undated, documented the peripheral IV catheter would be removed when therapy was discontinued.</p> <p>The facility policy titled Peripheral IV Dressing Changes, undated, documented the purpose of the procedure was to prevent catheter-related infections associated with contaminated, loosened, or soiled catheter-site dressings. The dressing should be changed at least every 5 to 7 days. The site dressing should include the date, time, and initials of staff. The following should be documented in the resident 's medical record:</p> <p>a. Date, time, type of dressing, and reason for dressing change.</p> <p>b. Any complications/interventions related to the insertion site or surrounding area.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>c. Resident's response to the procedure.</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50513</p> <p>Based on observations, record reviews, staff interviews, and facility policy reviews, the facility failed to ensure 1 of 35 sampled residents (Resident 168) was assessed and reviewed for risk and benefits, appropriate alternatives were attempted prior to installing the bed rail, and physician orders were obtained for bed rails. The deficient practice had the potential to place the resident at risk of injury such as falls, entrapment, and broken bones.</p> <p>Findings include:</p> <p>Resident 168 (R168)</p> <p>R168 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including muscle weakness, lack of coordination, major depressive disorder, anxiety disorder, chronic post-traumatic stress disorder, and a fracture of the base of the neck of the right femur.</p> <p>On 03/27/25 at 10:03 AM, R168 was observed sleeping in bed. The bed was in the lowest position with bilateral floor mats and full rails (two upper and two lower rails) raised.</p> <p>On 03/27/25 at 10:06 AM, a Certified Nursing Assistant (CNA) explained floor mats, bed rails, and lowering the bed were used for the safety of fall-risk residents.</p> <p>On 03/27/25 at 10:09 AM, a Licensed Practical Nurse (LPN) explained floor mats were placed beside beds to relieve pressure on staff's lower backs during care provision. The LPN also explained lower bed rails could be used for safety only if physician orders and bed rail assessments were conducted but stated lower bed rails were typically considered restraints. The LPN confirmed R168 had both upper and lower rails raised. The LPN was unable to recall how long the bed rails had been in place.</p> <p>R168's medical record revealed the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/13/25 documented a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. Under Section P0100, Physical Restraints Used in Bed was documented as Not used. Section GG0115, Functional Limitation in Range of Motion, documented no impairment of the upper extremities and impairment on both sides of the lower extremities.</p> <p>R168's medical record lacked documented evidence of physician orders for bilateral floor mats, upper side rails, lower side rails, or full side rails.</p> <p>The Comprehensive Care Plan, initiated on 11/23/24, documented R168 was at risk for falls due to cognitive impairment, functional impairments, muscle weakness, and unsteady gait. The interventions lacked documented evidence of the use of bilateral floor mats, upper bed rails, lower bed rails, or full bed rails.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Side Rail and Entrapment Risk Assessment, completed on 05/04/2024, documented the resident was not dependent in bed mobility but had altered safety awareness due to cognitive decline and poor decision-making. The assessment identified periods of confusion and unsafe behaviors placing the resident at risk.</p> <p>-The recommendations section lacked documented evidence of alternatives considered or trialed before implementing side rails. The use of both upper half-rails was recommended for independent bed mobility.</p> <p>-The interventions section documented full/half rails up per physician's order for safety during care provision, to assist with bed mobility, and to observe for injury or entrapment related to side rail use.</p> <p>R168's medical record lacked documented evidence of another Side Rail and Entrapment Risk Assessment completed after the resident's readmission on 11/23/24 to a different room and bed.</p> <p>The medical record lacked documented evidence less restrictive approaches were unsuccessful prior to the use of side rails.</p> <p>R168's medical record revealed a document titled Siderail Consent which documented, Full Rails on both sides to assist the resident in turning and positioning while in bed, transferring to and from bed, stabilizing while sitting on the side of the bed, and promoting safety while receiving care in bed. However, the document lacked the resident's name, signature, or the signature of a resident representative. A facility representative had signed and dated the document on 01/31/25.</p> <p>On 03/27/25 at 10:38 AM, an Assistant Director of Nursing (ADON) explained the facility did not have beds with full side rails. The ADON confirmed upper side rails used as enablers required a side rail assessment and bilateral fall mats and upper rails required a physician ' s order. The ADON verified R168's bed had bilateral fall mats and both full upper and full lower rails raised. The ADON was unaware of when the full rails had been installed.</p> <p>On 03/27/25 at 11:01 AM, the Regional Director of Clinical Services verified R168 had both upper and lower rails raised. The consultant explained whether lower rails could be used depended on the care plan, physician orders, assessments, and family requests. After reviewing R168's medical records, the Regional Director of Clinical Services confirmed there were no physician orders, care plan documentation, or family requests for the rails.</p> <p>On 03/28/25 at 9:15 AM, the Director of Maintenance (DOM) explained the facility did not track when bed rails were installed because all beds had upper rails as enablers.</p> <p>On 03/28/25 at 3:09 PM, the ADON acknowledged no in-service training had been conducted on bed rail guidelines. The ADON stated the facility could not determine when the rails had been installed.</p> <p>On 03/28/25 at 3:25 PM, a Registered Nurse Unit Manager explained full bed rails could result in injuries, particularly if residents attempted to self-transfer and became trapped between rails.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy titled Bed Rail Guideline, dated 04/2023, documented the purpose of the guideline is to ensure safe use of siderails as only permissible if they are used to treat a resident's medical symptoms or assist with mobility and transfer of resident.</p> <p>A Side Rail and Entrapment Assessment will be conducted to determine the resident's reason for using side rails, and an evaluation of bed mobility or ability to change positions.</p> <p>The use of side rails as an assistive device would be addressed in the resident care plan.</p> <p>The less restrictive interventions will be incorporated in the care planning.</p> <p>Documentation will indicate if less restrictive approaches were not successful.</p> <p>The risk and benefit of side rails will be considered for each resident.</p> <p>Consent for using side rails will be obtained from the resident or legal representative after presenting potential benefits and risks. While the resident or family (representative) may request a restraint, the facility would be responsible for evaluating the appropriateness of the request.</p> <p>If side rails are used, there would be an interdisciplinary assessment of the resident, a consultation with the Attending Physician, and input from the resident and/or legal representative.</p> <p>The facility document titled Bed Rail Audit Tool, dated 04/27/23 and located in the Bed Rail Guideline packet, documented a checklist to ensure:</p> <ul style="list-style-type: none"> <li>- Was the Point Click Care (PCC) side rail and entrapment assessment completed prior to placing the side rails on the resident's bed?</li> <li>- Does the resident meet all the criteria for side rails?</li> <li>- Was the resident/representative educated on the risk and benefits and documented in the medical record?</li> <li>- Was the Side Rail Consent signed by the resident and/or representative?</li> <li>- Is there a Medical Doctor (MD) order for bed rails?</li> <li>- Were all 7 entrapment zones measured and meet FDA dimensional limits?</li> <li>- When used together; bed frame, mattress and bed rails provide a snug fit without gaps between rail, mattress and head/foot boards?</li> <li>- Does the Care Plan reflect the use of bed rails?</li> <li>- Is the PCC side rail and entrapment assessment completed quarterly, annually, and with a change of condition?</li> </ul> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Are the side rails used to treat a resident's medical symptom or to assist with mobility and transfer for residents?</p> <p>The facility policy titled Physical Restraints, undated, documented a restraint will only be used upon the written order of a physician and after obtaining consent from the resident or representative.</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>50289</p> <p>Based on observation, document review and interview, the facility failed to ensure pre-made foods were stored, labeled, dated, and used within seven days in the refrigerator. This deficient practice posed a potential risk to safety and health standards which could lead to food spoilage and place residents at risk of foodborne illness.</p> <p>Findings include:</p> <p>On 03/26/2025 in the morning, during a follow-up tour of the kitchen and dietary areas, there were three sandwiches in a plastic tub which were wrapped but not labeled or dated. The tub of sandwiches was in the walk-in cooler.</p> <p>The Dietary Account Manager acknowledged the sandwiches should have been labeled and dated so the kitchen staff would know how long the items had been stored in the cooler.</p> <p>A Healthcare Services Group Policy, revised 02/2023, with the subject entitled Food Storage: Cold Food revealed all foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51395</p> <p>Based on interview and record review, the facility failed to ensure the medical records were complete and accurate for 1 of 35 sampled residents (Resident 98) and 2 unsampled residents (Resident 467 and Resident 469). The deficient practice had the potential for residents not to receive timely interventions needed and for the facility missing the opportunity to identify care issues.</p> <p>Findings include:</p> <p>Resident 98 (R98)</p> <p>R98 was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, Type 2 diabetes mellitus, and dependence on supplemental oxygen.</p> <p>A physician order dated 08/13/2024 documented drug test, general toxicology one time only.</p> <p>Throughout the week of the survey the facility was unable to produce results for the ordered drug test. The Regional Director of Clinical Services verbalized the resident had refused the testing. The medical record lacked document evidence the resident refused the testing.</p> <p>On 03/28/25 at 1:50 PM, the Assistant Director of Nursing (ADON) confirmed being aware of the physician order for drug testing and R98 having refused the test. The ADON confirmed there was no documentation of R98's refusal.</p> <p>Resident 467 (R467)</p> <p>R467 was admitted on [DATE] and discharged on [DATE] with diagnoses including Venous insufficiency (Chronic Peripheral), Peripheral Vascular disease, and Down Syndrome.</p> <p>A physician order dated 01/11/2025 documented to call 911 and send to emergency room (ER).</p> <p>A Physician progress note dated 01/11/2025 documented the Nurse Practitioner (NP) received a call from the supervisor's phone around midnight today. R467's oxygen (O2) saturation was in the 60s and was placed on O2 at five liters. R467 was ordered to be sent to the ER for evaluation. However, R467 was not transferred. No documentation of the change in condition, no documentation of the low O2 saturation or that the provider was notified R467 was not sent to the hospital.</p> <p>A review of R467's oxygen saturation levels for 01/01/2025 through 01/12/2025 documented 92%- 98% on room air.</p> <p>On 03/27/2025 at 1:26 PM, a Registered Nurse (RN) explained when a resident has a change in condition, staff would call the physician and complete a change of condition assessment to summarize the events.</p> <p>(continued on next page)</p>		

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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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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/27/2025 at 2:38 PM, the NP explained as documented in the progress note had received a call around midnight, R467 was at 60% O2 saturation and was placed on five liters, the NP ordered for the R467 to be sent out to ER for evaluation. The NP explained had followed up with staff regarding why R467 was not sent out, had asked for nurse that called regarding the low O2 saturation to document. The NP stated being dependent on staff to provide information for treatment recommendations. The NP explained expecting the staff would complete a change of condition and document the events. If R467 was okay and no longer required to be sent out, the nurse would contact the NP again regarding the changes and inform of not being sent to the ER.</p> <p>On 03/27/2025 at 3:30 PM, the ADON verified the nurse reporting the low O2 saturation was not available for interview due to being on vacation out of the country.</p> <p>On 03/28/2025 at 1:43 PM, the ADON confirmed R467's medical record had no abnormal O2 saturations documented. The ADON explained the nurse should have completed a change in condition for R467 and documented in the progress notes. The ADON verbalized the nurse needed to talk with the NP and explain what was happening with R467 and document why the discharge did not occur.</p> <p>Resident 469 (R469)</p> <p>R469 was admitted on [DATE] and discharged on [DATE] with diagnoses including metabolic encephalopathy, type 2 diabetes, and abnormalities of gait and mobility.</p> <p>A Physician order dated 12/16/2024 documented, Metformin HCL oral tablet 850 milligrams (mg) give one tablet by mouth two times a day for diabetes mellitus unsupervised self-administration with breakfast and dinner.</p> <p>The Medication Administration Record (MAR) for 12/16/2024 through 12/23/2024 documented Metformin HCL tablet 850 mg as U-SA indicating unsupervised self-administration.</p> <p>On 03/26/25 at 8:14 AM, a Registered Nurse (RN) verbalized unsupervised self-administration means the resident would give medication to themselves without knowledge of the staff. This was not allowed for staff to do. The RN explained if the doctor would order medication for self-administration there would be a form to complete listing criteria, such as an assessment for the nurse or Charge Nurse to complete. Aside from obtaining a physician order and completing the assessment, the resident would require a care plan for self-administration. The medication would be stored in the medication room or medication cart. If the resident was allowed to keep the medication at bedside there would need to be an order. To ensure the resident is getting the medication the nurse would monitor the condition of the resident, based on symptoms of the resident, and check the remaining amount of the medications.</p> <p>On 03/27/25 at 1:28 PM, an RN reviewed the MAR for R469 and explained had never seen U-SA before. The RN confirmed residents would be supervised with medication and R469s order would need to be clarified by calling the supervisor or the MD before administering.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/26/2025 at 8:18 AM, the Director of Nursing (DON) verbalized the self-administration expectations would be for the nurse to verify the resident had an order and assessment to self-administer. The DON acknowledged R469 had no assessment to self-administer nor a care plan in place regarding self-administration. The location of the medication storage would also need to be documented in the R469's record. The DON stated would need to look further into the resident record to verify why the order was placed for self-administration. The DON verified there was no documented evidence the nurses administered the medication. The DON confirmed the expectation would be for the nurses to follow up with the physician when seeing an order to self-administer.</p> <p>On 03/26/2025 at 8:30 AM, The DON verified the Metformin order was transcribed wrong, staff clicked an unsupervised self-administration button that should not have been selected. The DON confirmed the order would need clarified with the physician and would need to be entered correctly.</p> <p>Complaint #NV00073186</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>50289</p> <p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>Based on interview and document review, the facility failed to maintain documentation and demonstrate evidence of its ongoing Quality Assurance and Performance Improvement (QAPI) program. This deficient practice has the potential to negatively affect the outcomes of resident care and the quality of each resident's life.</p> <p>Findings include:</p> <p>On 03/28/2025 in the afternoon, the administrator acknowledged the facility was not able to produce documentation providing evidence the facility had developed, implemented, and maintained an effective, comprehensive QAPI program. The Administrator provided evidence the facility had a QAPI meeting on 02/27/2025, 09/24/2024, and 07/30/2024. The administrator stated had been the administrator at this facility for a short time and was not able find where the electronic documents were filed or if they were filed.</p> <p>A facility policy titled, Quality Assurance and Performance Improvement (QAPI) Committee, undated, documented the facility will maintain documentation and demonstrate evidence of its ongoing QAPI program.</p> <p>The State Operations Manual documented, the facility must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must also maintain documentation and demonstrate evidence of its ongoing QAPI program along with documentation and evidence of its ongoing QAPI program's implementation. The governing body and/or executive leadership is responsible and accountable for ensuring that the QAPI program is sustained during transitions in leadership and staffing.</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>50289</p> <p>Based on interview and document review, the facility failed to maintain documented evidence of maintaining a Quality Assurance and Performance Improvement (QAPI) Committee consisting at a minimum of: the Director of Nursing services; the Medical Director or his/her designee; at least three other members of the facility's staff, at least one of who must be the administrator, owner, or board member; and the infection preventionist. The facility also failed to maintain documentation of evidence of the committee meeting at least quarterly. This deficient practice has the potential to negatively affect the outcomes of resident care and the quality of each resident's life.</p> <p>Findings include:</p> <p>On 03/28/2025 in the afternoon, the Administrator acknowledged the facility was unable to provide documented evidence the facility had a QAPI Committee meeting on 02/27/2025, 09/24/2024, and 07/30/2024.</p> <p>The Administrator acknowledged the 02/27/2025 QAPI Committee meeting was missing the Director of Nursing and the Administrator, Owner, or Board Member.</p> <p>The Administrator acknowledged the 09/24/2024 QAPI Committee meeting was missing the Medical Director or his/her designee and the Administrator, Owner, or Board Member.</p> <p>The Administrator acknowledged the 07/30/2024 QAPI Committee meeting was missing the Medical Director or his/her designee.</p> <p>The Administrator also acknowledged the facility was not in compliance with the requirement to hold a QAPI Committee meeting at least quarterly. The administrator stated had been the administrator at this facility for a short time and was not able find where the electronic documents were filed or if they were filed.</p> <p>A facility policy titled, Quality Assurance and Performance Improvement (QAPI) Committee, undated, documented the facility will maintain a (QAPI) Committee consisting at a minimum of the Director of Nursing services; the Medical Director or his/her designee; at least three other members of the facility's staff, at least one of who must be the administrator, owner, or board member; and the infection preventionist. The policy also documented the committee will meet at least regularly and as needed to coordinate and evaluate activities under the QAPI program.</p> <p>The state operations manual documented, the facility must have maintained a quality assurance and performance improvement committee consisting at a minimum: the director of nursing services; the Medical Director or his/her designee; at least three other members of the facility's staff, at least one of who must be the administrator, owner, or a board member; and the infection preventionist. It also documented the QAPI committee meetings must be held at least quarterly or more often as necessary to fulfill the committee's responsibilities to identify and correct quality deficiencies effectively.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51395</p> <p>Based on observation, interview, record review and document review, the facility failed to ensure infection control practices were maintained for 1 of 35 sampled residents (Resident 25). The deficient practice had the potential to increase risk of cross-contamination, spread infectious diseases, and compromise health and safety for residents.</p> <p>Findings include:</p> <p>Resident 25 (R25)</p> <p>R25 was admitted on [DATE] discharged on [DATE] and readmitted [DATE] with diagnoses including displaced bicondylar (upper and lower parts) fracture of right tibia.</p> <p>On 03/25/2025 at 9:37 AM, R25 verbalized needing assistance with a brief change. R25 explained staff stated being out of the brief R25 needed.</p> <p>On 03/25/2025 at 9:52 AM, a Certified Nurse Assistant (CNA) explained checking with the nurse and central supply and the facility was out of the green brief R25 needed.</p> <p>On 03/25/2025 at 9:58 AM, the Central Supply Clerk confirmed the facility was currently out of green briefs. The Central Supply Clerk explained green briefs were bariatric sized briefs and there was currently no substitute available. The Central Supply Clerk verbalized having been on vacation and the backup supply clerk had not ordered enough supply. The facility order was placed on 03/24/2025 and would not arrive until 03/26/2025. The Central Supply Clerk explained the facility transportation driver would be going to purchase some briefs and</p> <p>would arrive by noon today.</p> <p>On 03/25/2025 at 10:50 AM, R25 stated the brief was changed. R25 verbalized the CNA informed the resident the brief was taken from another resident.</p> <p>On 03/25/2025 at 12:02 PM, the CNA confirmed had found a brief in another resident's room to use for R25 and R25 was changed.</p> <p>On 03/28/25 at 12:42 PM, the Infection Preventionist verbalized staff were not to obtain items from one resident room and take to another resident room. This would be cross contamination. The Infection Preventionist confirmed staff should not utilize briefs from one resident room for another due to the risk for spread of infections.</p> <p>On 03/28/2025 at 1:41 PM, the Assistant Director of Nursing (ADON) explained when staff are out of care items such as briefs, staff would contact the charge nurse who would call central supply. If central supply was unable to provide the needed items, the Administrator would be notified so the facility could purchase the item. The ADON verbalized staff were not to take items from other resident rooms to use for other residents due to infection control practices, by doing this would cause cross contamination and create a risk for spread of infection.</p>		