STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295072	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Ridge Healthcare Center	1151 Torrey Pines Dr. Las Vegas, NV 89146

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40142 Based on observation, interview, record review, and document review the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) level two referral was completed for 1 of 29 sampled residents (Resident 67). The deficient practice had the potential to deprive the resident of concern and other residents of necessary behavioral health services. Findings include: Resident 67 (R67) R67 was admitted on [DATE], with primary diagnoses including bipolar disorder, new schizophrenia and schizoaffective disorder and a secondary diagnosis of unspecified dementia. On 04/23/2024 in the morning, R67 laid in bed with eyes on television. R67 appeared lethargic with flat affect and spoke softly stating R67 had been in the facility for a long time. On 04/25/24 in the morning, R67 laid in bed with eyes on television and appeared lethargic with flat affect. A PASSAR level one document dated 08/17/2021, revealed R67 did not have dementia, mental illness (MI), intellectual disability, (ID) mental retardation (MR) or any related condition (RC) and was deemed appropriate for nursing facility placement. The admission minimum data set (MDS) dated [DATE], documented R67 had a negative PASSAR one (no MI, MR, ID, or RC), impaired cognition, had a diagnosis of bipolar disorder but did not have schizophrenia, schizoaffective disorder, psychotic disorder, or dementia. The quarterly MDS dated [DATE], documented R67 had new diagnoses of anxiety disorder, depression, psychotic disorder, and schizophrenia. A review of psychiatry notes revealed R67's schizophrenia had an onset date of 03/05/2022, schizoaffective disorder on 12/01/2022 and unspecified dementia on 03/14/2024 and R67 was prescribed Bupropion 75 milligrams (mg) (anti-depressant) and Olanzapine 2.5 mg (anti-psychotic.). (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident Assessment - Coordination with PASARR program policy dated October 2022, documented any resident who exhibited a newly evident or possible serious mental disorder, intellectual disability and, or a related condition would be referred promptly to the state mental health or intellectual disability authority for a Level II resident review. Examples include: a resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting a presence of a mental disorder (where dementia is not the primary diagnoses), or an intellectual disability or related condition was not previously identified and evaluated through PASSAR. Social services would be responsible for keeping track of each resident's PASARR screening status and referring to appropriate authority. The medical record lacked documented evidence R67 was referred for a PASSAR level two. On 04/26/2024 at 12:10 PM, the MDS Director confirmed R67 had a negative PASSAR one when first admitted on [DATE] but had new diagnoses of anxiety disorder, depression, psychotic disorder, and schizophrenia by the completion of the resident's quarterly MDS on 09/15/2022. The MDS Director stated the purpose of PASSAR was to ensure residents were appropriately placed and the facility could meet the needs of the residents. The MDS Director indicated MDS nurses were not involved in the process of identifying and referring residents who met criteria for a new level of care (LOC) assessment or a PASSAR level two referral. The MDS Director deferred to the social services department for information on PASSAR two. On 04/26/2024 at 12:28 PM, the Admission Director indicated being responsible for ensuring all newly admitted residents had a PASSAR level one or two in place. The Admissions Director indicated not being involved in the process of identifying and referring residents who met criteria for a PASSAR two referral after new behaviors and psychiatric diagnoses were identified during their stay in the facility. On 04/26/2024 at 1:20 PM, the Social Services Director (SSD) explained being employed three months ago and was informed the SSD was responsible for completing a form which would be provided to the state PASSAR representatives who came to audit PASSAR two residents during quarterly visits. The SSD indicated not being informed nor trained regarding social services' involvement with identifying and referring residents who met criteria for PASARR two referral. On 04/26/2024 at 1:53 PM, the Director of Nursing (DON) and the Assistant DON were present when the charge nurse verbalized being responsible for monitoring residents who were on psychotropic medications and worked closely with the psychiatrist regarding behavior residents. The charge nurse, DON and ADON indicated the facility currently did not have a process for identifying and referring residents for a new LOC or PASSAR two because the former SSD who used to perform this task was no longer employed at the facility.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interviews, record review, and document review, the facility failed to ensure a baseline care plan was developed within 48 hours for the use of a leg brace following admission for 1 of 29 sampled residents (Resident 189). This deficient practice could have the potential to result in further injury, delayed recovery, or increased risk of falls, compromising the resident's overall safety and well-being. Findings include: Resident 189 (R189) R189 was admitted on [DATE], with diagnoses including presence of left artificial knee joint, cellulitis of left lower limb, left knee pain and unsteadiness of feet. On 04/23/2024 at 9:10 AM, R189 was seated on the edge of the bed, the left leg was wrapped with a kerlix/ace wrap (elastic bandage) and on top was a black full length knee brace or immobilizer. R189 indicated the brace was applied by the wound care treatment nurse (WCTN) after the completion of the treatment. R189 indicated the hospital provided the brace and was admitted with it. The hospital Transfer/Discharge Summary dated 04/19/2024, documented to maintain knee brace in full extension at all times. The History and Physical dated 04/20/2024, documented to maintain knee brace in full extension at all times. R189's medical records lacked documented evidence the knee brace was assessed and care plan was completed for the use of a knee brace were implemented following R189's admission. On 04/24/2024 at 1:15 PM, a Registered Nurse (RN) indicated upon R189's admission the knee brace should have been assessed and care planned. The RN verified the knee brace had not been identified in the admission assessment and not care planned. The RN indicated there should have been a person-centered care plan within 48 hours which included the goals and care instructions necessary for the use of the full length knee brace. On 04/24/2024 at 2:47 PM, the Charge Nurse in 100 hall indicated upon resident's admission there should have been an assessment, matched with the transfer summary and care planned. The CN indicated the hospital transfer summary should have been reviewed and R189 should have been assessed appropriately, orders obtained, and care planned. On 04/25/2024 at 3:07 PM, the Director of Rehabilitation Services (DORS) indicated R189 was admitted with knee brace to immobilize the left leg post knee surgery. The DORS indicated R189's knee brace was mentioned in the transfer summary. The nursing department was responsible in developing the care plan following R189's admission. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/26/2024 at 11:30 AM, the Assistant Director of Nursing (ADON) indicated the admission nurse or the charge nurse was responsible in developing a baseline care plan within 48 hours following R189's admission and the person-centered care instructions orders should have been in place and implemented. A facility policy titled Baseline Care Plan dated 10/2022, documented the facility would develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan would be developed within 48 hours of a resident's admission. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to initial goals based on admission order.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40142 Based on observation, interview, record review and document review, the facility failed to ensure a care plan for range of motion was updated to include a physician's order for a cervical collar for 1 of 29 residents (Resident 82). The deficient practice may have resulted in a delay in the use of the cervical collar potentially causing increased discomfort to the resident due to poor alignment and positioning of the head and neck. Findings include: R82 was admitted on [DATE], with diagnoses including Parkinson's disease and gastrostomy status. A restorative note dated 03/26/2024, revealed R82 had a tendency to lean on one side and would benefit from having a soft collar for repositioning of neck while in bed. Restorative nurse aide (RNA) to obtain order for cervical collar. A physician's order dated 04/17/2024, documented soft cervical collar for repositioning and alignment, on every day shift (AM) and off every night shift (PM). A care plan for range of motion (ROM) initiated 02/07/2024, lacked documented evidence the care plan was revised to include use of a soft collar device on 04/17/2024. On 04/24/2024 at 11:33 AM, the Assistant Director of Nursing (ADON) reviewed R82's care plan and confirmed the care plan was not but should have been updated to include use of the soft collar device which was initially recommended by therapy on 03/26/2024 and ordered by the physician on 04/17/2024. The ADON stated R82's range of motion care plan was not updated due to an oversight. The Comprehensive Care Plan policy (undated), documented the care plan was directed towards achieving and maintaining optimal status of health, functional ability, and quality of life. The care plan was reviewed and revised when there were changes.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observations, interviews, record reviews, and document review, the facility failed to ensure a resident who was identified as having a very high risk of developing a pressure ulcer was turned and repositioned per policy and provided with a cushion while seated in the Geri-chair as care planned for 1 of 29 sampled residents (Resident 191). These deficient practices have the potential to reopen previously healed pressure ulcers, develop new pressure ulcers, and compromise skin integrity. Findings include: Resident 191 (R191) R191 was admitted on [DATE], with diagnoses including stages two and three pressure ulcers in the sacral region, hemiplegia (complete or nearly complete one-sided muscle paralysis or weakness), and hemiparesis (a stroke-related partial muscle weakness). The Braden Scale for Predicting Pressure Sore Risk dated 04/22/2024, documented a score of eight, which indicated R191 had a very high risk (Very High Risk: Total Score 9 or less, High Risk: Total Score 10-12, Moderate Risk: Total Score 13-14, Mild Risk: Total Score 15-18) of developing pressure ulcers. R191 was on bedrest and had problems with friction and shear. A Care Plan (undated), documented R191 had an actual pressure ulcer in the coccyx and required assistance with turning and repositioning. The interventions included providing Roho cushion while in Geri-chair at only two-hour increments. On 04/24/2024 at 9:30 AM, R191 was placed in a supine position in the Geri-chair without a cushion. On 04/24/2024 at 1:00 PM and 3:00 PM, R191 was awake but non-verbal. The Geri-chair had not been cushioned. R191 was restless while in a supine position, which caused the gown to be displaced and the upper body to be exposed. On 04/24/2024 at 3:03 PM, a Registered Nurse (RN) confirmed R191 had been in the Geri-chair since 7:00 AM that morning. The RN explained R191 had experienced multiple recurrent fall incidents, which led to the placement in the Geri-chair. The RN indicated R191 had recently healed wounds on the sacrum. On 04/24/2024 at 3:44 PM, a Certified Nursing Assistant (CNA) confirmed having transferred R191 to the Geri-chair around 7:30 AM and was on the verge of returning R191 to the bed. The CNA confirmed no one had turned or repositioned R191 or provided continence care for more than an eight-hour period since this morning. On 04/24/2024 at 4:00 PM, the RN indicated the wound care treatment nurse and the CNA transferred R191 back to the bed and cleaned R189 after eight hours. Verification revealed a wound scar on R191's sacrum, which was covered with a dressing dated 04/24/2024. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/25/2024 at 9:55 AM, the wound coordinator explained R191's sacral wound had been healed but advised against prolonged sitting in the Geri-chair without the Roho cushion. The Wound Care Treatment Nurse (WCTN) presented the Roho cushion, which featured air pockets and a weight distribution design to alleviate pressure. The wound coordinator acknowledged the risk of reopening healed wounds or worsening the existing wound if a resident was placed in the Geri-chair for extended periods. The wound coordinator explained the timely continent care, turning, repositioning, and offloading were important measures to maintain the R191's skin integrity. On 04/25/24 at 10:05 AM, the WCTN indicated the interdisciplinary team determined the care of the resident who was at risk for the development of a wound or had existing wounds. The WCTN explained R191's sacral pressure ulcer had been healed, but the pressure of the Geri-chair without a cushion could potentially reopen it. The WCTN indicated the wound team was unaware R191 was placed in the Geri-chair for extended periods. On 04/25/2024 in the morning, the primary physician conveyed the turning and repositioning or offloading pressure were vital for wound prevention and healing. A facility policy titled Skin Integrity, dated 12/2016, indicated that the residents who were identified as being at risk for skin breakdown (pressure ulcers) would have a routine assessment and IDT [Interdisciplinary Team] care plan process implemented to maintain and/or improve skin integrity. The objective was to create an on-going process to identify and actively manage risk and/or skin integrity issues, and determine appropriate interventions to achieve positive clinical outcomes. Residents should be turned and repositioned at least every two hours while in bed or in a chair. Dependent residents who were sitting or lying in bed may need to change positions more frequently for tissue offloading. The use of pressure-reducing beds, mattresses, and chairs can be beneficial.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40142 Based on observation, interview, record review and document review, the facility failed to ensure a physician's order was followed for use of a cervical collar for 1 of 29 residents (Resident 82). The deficient practice may have resulted in increased discomfort to the resident due to poor alignment and positioning of head and neck. Findings include: Resident 82 (R82) R82 was admitted on [DATE], with diagnoses including Parkinson's disease and gastrostomy status. A restorative note dated 03/26/2024, revealed R82 had a tendency to lean on one side and would benefit from having a soft collar for repositioning of neck while in bed. Restorative nurse aide (RNA) to obtain order for cervical collar. A physician's order dated 04/17/2024, documented soft cervical collar for repositioning and alignment, on every day shift (AM) and off every night shift (PM). On 04/23/2024 at 10:47 AM, R82's eyes were opened but the resident was unable to communicate verbally nor non-verbally by moving head or blinking eyes. The resident's head of bed was elevated approximately 30 degrees while tube feeding was infusing via enteral pump. The resident's head and neck were leaning towards the left side. R82 did not have a cervical collar around neck. On 04/24/24 at 10:46 AM, R82's eyes were opened with tube feeding infusing. R82's head was leaning towards the left side. R82 did not have a cervical collar around neck. On 04/24/2024 at 10:47 AM, the Director of Staff Development (DSD) walked by R82's room and confirmed R82 was not wearing a soft cervical collar. The DSD entered R82's room, opened R82's cabinet and drawers and confirmed a cervical collar was nowhere to be found. On 04/24/2024 at 10:50 AM, the RNA explained R82's head had the tendency to fall on to the left side instead of center and therapy had recommended a soft cervical collar to maintain good alignment to R82's neck. The RNA explained a purchase order for R82's cervical collar was ordered and was delivered on 04/17/2024, the same day a physician's order was obtained. The RNA indicated not knowing why the cervical collar device was not being worn by R82 and why the collar was not in R82's room. The RNA verbalized the cervical collar was recommended and ordered to increase comfort for R82 whose head fell to left side which caused discomfort and increased muscle tightness to the neck. On 04/24/2024 at 11:01 AM, a Certified Nursing Assistant (CNA) indicated being steadily assigned to R82 whose neck always leaned towards left side. The CNA indicated not being aware R82 had an order for a soft cervical collar and the CNA had not seen a collar in R82's room. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/24/2024 at 11:20 AM, the Director of Rehabilitation was carrying a blue box labeled cervical collar. The DOR indicated being familiar with the recommendation and order to have R82 use a soft cervical collar to help maintain alignment and decrease discomfort to the resident's neck. The DOR indicated the cervical collar was delivered to the facility on [DATE] and placed in the therapy room. The DOR confirmed the collar device had remained in the therapy room since 04/17/2024 due to a breakdown in communication among therapy staff members and RNA services. The blue box labeled Gentle Support Cervical Collar documented the cervical collar was designed to alleviate discomfort with tightness of neck and pinched nerves. The cervical collar should be used as directed. The Cervical Collar policy (undated), revealed cervical collars were used to provide neck support and were applied in accordance with physician's orders.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interviews, record review, and document review, the facility failed to ensure the use of a full-length knee brace or immobilizer was identified, assessed, monitored, and care orders were obtained for 1 of 29 sampled residents (Resident 189). This deficient practice could have led to increased risk for falls, improper usage, or misuse of the knee brace, and compromise the resident's over all safety and well-being. Findings include: Resident 189 (R189) R189 was admitted on [DATE], with diagnoses including the presence of a left artificial knee joint, cellulitis of the left lower limb, left knee pain, and unsteadiness of the feet. The Fall risk assessment dated [DATE], documented R189's gait was impaired with a score of 70, which indicated R189 was a high risk for falls. On 04/23/24 at 9:10 AM, R189 sat on the bed's edge, with the left leg wrapped in an elastic bandage. On top of the bandage the left leg was wrapped with a full-length brace, splint, or immobilizer. R116 indicated the facility staff had applied the bandage and brace. R189 verbalized the knee surgery had been performed in the hospital, got infected and had complications which provided the brace to immobilize the left leg. R189 expressed the brace had limited mobility, but was still able to walk to the bathroom. R189 indicated having had multiple fall incidents in the past prior to admission. The hospital Transfer/Discharge Summary dated 04/19/2024, documented the need to maintain knee braces and splints in full extension at all times. R189's medical records lacked documented evidence the knee brace, splint, or immobilizer was identified, assessed, and monitored following R189's admission to the facility. There were no care instructions for how to manage and maintain R189's full-length left knee brace. On 04/24/2024 at 1:15 PM, a Registered Nurse (RN) confirmed R189 was admitted with a full-length knee brace but had not been identified, assessed, or monitored following admission. The RN indicated R189 was a high risk for fall due to underlying comorbidities, including the unsteadiness of feet and a history of multiple fall incidents. The RN verbalized the interventions should have been taken into consideration to ensure R189's safety. On 04/24/2024 at 1:38 PM, R189 was lying in bed horizontally with the full-length brace in place. Approximately half of R189's body was hanging off the bed, with the left leg resting on the floor and the right leg remaining on the bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/24/2024 at 2:47 PM, the Charge Nurse in 100 hall indicated upon R189's admission, there should have been an assessment for any device R189 had currently utilized. The CN stated the admission nurse should have conducted an appropriate assessment on R189 and notified the provider to obtain care orders for brace management. On 04/25/2024 at 1:40 PM, R189 indicated fell this early morning when attempting to go to the bathroom. The brace's Velcro loosened and became stuck on the top sheet, contributing to the fall. R189 indicated could not reach to unwrap the left lower extremity, lost balance, and fell to the floor. The Interdisciplinary Team Progress Notes dated 04/25/2024, documented R189 was at risk of falling with diagnoses including the internal joint prosthesis and unsteadiness on the feet. On 04/25/2024, R189 had an unwitnessed fall and was found sitting on the floor. R189 had attempted to use the bathroom, causing the sheet to wrap around R189'2 leg due to the brace's Velcro catching on it. On 04/25/2024 at 3:07 PM, the Director of Rehabilitation Services (DORS) indicated R189 underwent a physical and occupational therapy evaluation with the aim of improving mobility, gait, and transfers. The DORS confirmed R189's full length brace or immobilizer was not identified by nursing and rehabilitation staff. The DORS indicated there should have been interventions implemented to care for and manage R189's braces for safety. The DORS indicated R189 fell when the brace's Velcro stuck to the sheets and wrapped around R189's left leg. The DORS acknowledged the lack of identification and management of R189's brace contributed to the fall incident. On 04/26/2024 at 11:30 AM, the Assistant Director of Nursing acknowledged R189's brace was not identified upon R189's admission. The ADON conveyed R189's fall was avoidable. The ADON indicated R189 needed assistance with mobility and transfer. A facility policy titled Fall Prevention and Response dated 08/2023, documented each resident would be assessed for fall risk factors and would receive care and services in accordance with an individualized level of risk to minimize the likelihood of falls. Providing supervision and physical assistance in accordance with assessed needs.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observations, interviews, record reviews, and document reviews, the facility failed to ensure: 1) The tube feeding (TF) (enteral nutrition via a tube to the stomach) was administered as ordered for 1 of 29 sampled residents (Resident 191), and 2) The head of bed was elevated during the TF administration, and the TF bottle had been in use for no longer than 24 hours per policy for 1 of 29 sampled residents (Resident 54). These deficient practices could pose risks such as malnutrition, dehydration, aspiration, and the potential exacerbation of underlying health conditions. Findings include: Resident 191 (R191) R191 was admitted on [DATE], with diagnoses including dysphagia (difficulty swallowing) and gastrostomy status. On 04/23/2024 at 1:49 PM, R191 was in bed with eyes open and non-verbal. The Glucerna TF was infusing at 60 milliliters (ml)/hour (hr./s), and the water flushes at 60 ml/hr. The head of the bed was elevated. A physician order dated 04/23/2024, documented to administer Glucerna 1.5 via an enteral pump and infuse at 65 ml/hr. x (times) 20 hrs. The goal was to deliver 1300 ml/1949 total calories and 107 grams of total protein per day via enteral nutrition, starting at 2:00 PM, and continuing until the dose was delivered. A Care Plan (undated) documented R191 required TF related to dysphagia status post-stroke and was dependent on TF and water flushes. The intervention involved verifying the current feeding orders. A Care Plan (undated) documented R191 had altered nutrition and hydration risks related to nothing per mouth. R191 was dependent on TF and water flushes. The intervention involved verifying and providing the current feeding orders. On 04/24/2024 at 9:30 AM, R191 was seated in the Geri chair, and the Glucerna TF 1.5 was infusing at 60 ml/hr. On 04/24/2024 at 3:10 PM, R191 was seated in the Geri-chair and the Glucerna TF 1.5 was infusing at 60 ml/hr. A Registered Nurse (RN) verified and confirmed the TF order was 65 ml/hr. The RN verified the total volume delivered was only 1200 ml, but it should have been 1300. The RN explained there was no endorsement R191's TF rate was increased. The RN indicated the order was placed by the Registered Dietitian (RD) and acknowledged by the Charge Nurse on 04/23/2024 at 1:06 PM, it could have been adjusted right after the order was acknowledged, whether by the Charge Nurse or the Licensed Nurse assigned to R191, but had failed to implement. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/24/2024 at 3:15 PM, the RD indicated R191's weight was fluctuating and had wounds. The RD indicated R191 was non-verbal and incoherent. The RD indicated R191 had NPO (nil per os, or nothing by mouth) status and was dependent on TF. The RD explained the order was not communicated to the nursing department, but was placed electronically and was confirmed the same day. The RN explained the TF increase was for R191's weight loss with the aim of promoting adequate calories and protein to aid in wound healing. The RD indicated the staff were expected to comply with the orders. On 04/24/2024 at 3:21 PM, the Charge Nurse indicated the current TF order was at 65 ml/hr., and the staff were expected to follow the order. The Charge Nurse indicated the provider would be notified the total dose of 1300 had not been delivered as ordered. On 04/26/2024 at 11:30 AM, the Assistant Director of Nursing indicated the Licensed Nurses were expected to verify, prepare, and deliver the ordered dose. A facility titled Gastrostomy Tube Feeding (undated), documented to ensure safe practices in providing tube feedings. The resident's feeding was prepared in accordance with the physician's order. 46265 Resident 54 (R54) R54 was admitted on [DATE] and readmitted on [DATE] with diagnoses including protein-calorie malnutrition and muscle weakness. A physician order dated 12/22/2023 documented R54 diet was nothing by mouth. A physician order dated 12/28/2023 documented an enteral feed order by pump at 45 milliliters per hour for 20 hours. Begin feeding at 2:00 PM and continue until dose delivered. On 04/23/2024 at 11:14 AM, the bed for R54 was in low position, head slightly elevated with pillow. Tube feed was infused at 45 milliliters per hour by pump with water supplement bag. Tube feed solution bottle was nearly 75% full and labeled with date of 04/22/2024. R54 was resting in bed with eyes closed. A Certified Nursing Assistant (CNA) confirmed date on bottle and head of bed was not raised above 30 degrees. On 04/24/2024 at 12:10 PM, a Licensed Practical Nurse (LPN) indicated when resident was receiving enteral feed the bottle would be used for a maximum of 24 hours. The LPN explained if resident had any remaining formula in the bottle it would be discarded after 24 hours and new bottle would be initiated if the total volume to infuse had not been reached. On 04/26/24 11:29 AM, the Assistant Director of Nursing indicated tube feed bottle should be discarded after 24 hours. The ADON explained the 24 hour rule was based on clock hours and a bottle could potentially be used over the period of two separate days. The ADON acknowledged an enteral feed scheduled for R54 was to be started at 2:00 PM and would run for 20 hours and should be empty by 10:00 AM the following day. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The LPN and ADON both verbalized when a resident was receiving feeding solution through tube, the head of the bed should be raised at least 30 degrees to help prevent aspiration. The facility policy titled Nasogastric/Gastrostomy Tube Feeding (2012) documented to change feeding every 8 hours unless ordered differently and feeding container, tubing, and syringe was to be changed every 24 hours.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observations, interviews, record reviews, and document review, the facility failed to ensure Oxygen (O2) was administered as ordered for 2 of 29 sampled residents (Residents 4 and 131). This deficient practice could have led to serious health complications, including hypoxemia (low level of O2), O2 toxicity, and respiratory failure. Findings include: Resident 44 (R44) R44 was admitted on [DATE], with diagnoses including acute respiratory distress with hypoxia (low levels of O2) and chronic obstructive pulmonary disease. A Physician's order dated 03/01/2024, documented O2 at 3 LPM continuously via nasal cannula (NC). On 04/23/2024 at 9:40 AM, R44's O2 was flowing at 4 liters per minute (LPM) through NC. A Care Plan documented R44 had O2 therapy. The interventions included administering the O2 via NC as ordered. On 04/24/2024 at 10:56 AM, a Registered Nurse (RN) explained the process of O2 use was to check the ordered O2 flow rate and the patency of the tubing, ensuring proper delivery of O2. The RN confirmed the O2 was flowing at 4 LPM, which was over the ordered flow rate. The RN indicated R44's O2 saturation was 95% (percent), and the O2 order should have been followed at 3 LPM. The RN indicated an incorrect flow rate could have the potential to cause hypoxemia or carbon dioxide retention. On 04/24/2024 at 11:00 AM, the Charge Nurse (CN) indicated the Licensed Nurses were expected to check the ordered O2 flow rate during shift change and perform rounds to ensure residents' safety. The CN explained the monitoring and implementation of the appropriate O2 flow rate were crucial for the residents' care. Resident 131 (R131) R131 was admitted on [DATE], with diagnoses including shortness of breath and dependence on supplemental O2. A physician order was documented to administer O2 continuously at 2 LPM. On 04/23/2024 at 9:11 AM, R131 was in bed and verbally responsive, and O2 was flowing at 3 LPM via NC. There were no signs of respiratory distress. On 04/24/24 at 10:51 AM, R131 sat in the wheelchair with O2 flowing at 3 LPM via nasal cannula. R131 expressed no shortness of breath. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/24/2024 at 10:56 AM, the RN confirmed R131's O2 was flowing at 4 LPM, which was over the ordered flow rate. The RN reported R131's O2 saturation was 99%, and there was no shortness of breath. The RN indicated R131's O2 flow rate should have been administered as ordered. On 04/26/24 at 11:20 AM, the Assistant Director of Nursing (ADON) indicated the Licensed Nurses were expected to verify and follow the O2 flow rate as ordered. A facility policy titled Medication Administration dated 05/23/2024, indicated medications were administered as ordered by the physician and in accordance with professional standards of practice.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40142 Based on observation, interview, record review and document review, the facility failed to ensure a resident's infection status was communicated with the dialysis provider for 1 of 29 sampled residents (Resident 99). The deficient practice placed dialysis staff members and patients at risk for transmission of Candida auris (C. auris). Findings include: Resident 99 (R99) Resident 99 was admitted on [DATE], with diagnoses including end-stage renal disease (ESRD) and dependence on renal dialysis. On 04/24/24 at 11:37 AM, a Certified Nursing Assistant (CNA) was removing personal protective equipment (PPE) specifically, gown and gloves after providing care to R99. The CNA pointed to a yellow signage outside R99's door and explained R99 was on enhanced barrier precautions for C. auris (a fungal infection which could cause serious illness, was difficult to treat and could easily spread by contact in healthcare settings) and caregivers were required to don gown and gloves during care. The Enhanced Barrier Precautions signage read, Clean hands before leaving and entering the room. Wear gloves and gown during high-contact resident care activities. A polymerase chain reaction (PCR) test collected on 04/21/2023 and reported on 04/26/2023, revealed R99 tested positive for C. auris. Review of medical record revealed R99 was scheduled for dialysis treatment three times a week on Mondays, Wednesdays, and Fridays at an outpatient dialysis provider. The medical record lacked documented evidence the facility communicated R99's C. auris status with the dialysis provider. On 04/25/2024 at 3:31 PM, R99's primary nurse at the dialysis facility indicated not being aware R99 had C. auris since April 2023. The Registered Nurse (RN) indicated C. auris was a highly contagious disease which was managed by the dialysis provider using contact precautions and co-horting measures. The RN indicated R99 had been receiving dialysis treatments in the general area due to staff not being aware of R99's infection status. The RN verbalized the skilled nursing facility's (SNF's) failure to notify the dialysis clinic placed staff and patients at risk for contracting C. auris. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/25/2024 at 3:45 PM, the dialysis charge nurse reviewed R99's medical record and confirmed the SNF had not communicated R99's C. auris status with the dialysis provider since April 2023. The charge nurse indicated R99 started receiving dialysis treatments on 04/24/2023 and had been assigned a chair in the general area where staff employed standard precautions (PPE as appropriate using common sense practices, no need to change gown between patients). The charge nurse explained the clinic currently had 25 patients with C. auris who were being cohorted at a unit comprising of eight chairs with a dedicated dialysis technician and nurse who employed contact precautions (full PPE requiring gown and glove changes between patients). On 04/25/2024 at 3:59 PM, the dialysis facility administrator (FA) confirmed the SNF failed to communicate R99's C. auris status with the clinic, thereby placing staff and patients at risk for contracting C. auris. The FA indicated the nephrologist would not be ordering a new swab because all patients with C. auris whether infected or colonized were assigned to receive treatment at the designated cohort unit following center for disease control (CDC) guidelines. On 04/26/2024 at 8:02 AM, the charge nurse indicated reviewing R99's medical record and acknowledged not finding any documented evidence R99's C. auris status was communicated to the dialysis clinic. The charge nurse indicated significant changes in health status such as an infections were required to be communicated to the dialysis clinic. The charge nurse deferred to the Infection Preventionist (IP). On 04/26/2024 at 8:09 AM, the IP explained the facility tested all residents for C. auris on admission. The IP recounted R99 was admitted on [DATE] and positive results indicating R99 had C. auris were received by the facility on 04/26/2023. The IP confirmed there was no documented evidence Resident 99's C. auris was communicated with the dialysis provider. The IP verbalized not communicating the resident's Candida status placed dialysis staff and patients at risk for transmission of the disease. The IP indicated R99 was currently on enhanced barrier precautions per center for disease control (CDC) guidelines. The IP provided the following CDC information: The CDC guidance titled Candida auris: a drug-resistant fungus in healthcare facilities (dated 02/19/2020), documented C. auris could be transmitted in healthcare settings and cause outbreaks. It could colonize patients for many months, persist in the environment, and withstand some commonly used healthcare facility disinfectants. Facilities must ensure adherence to CDC recommendations by placing infected and colonized patients on transmission-based precautions, making sure gown and gloves were accessible and used appropriately. On 04/26/2024 at 8:26 AM, the Director of Nursing (DON) indicated R99's C. auris status should have been communicated with the dialysis clinic to protect dialysis staff members and patients from risk of exposure. The DON explained enhanced barrier precautions was aimed to prevent spread by requiring staff providing care to don full PPE during direct care. The Dialysis agreement dated 04/11/2019, the long-term care facility shall provide for an interchange of information useful or necessary for the care of all ESRD residents. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Hemodialysis policy dated December 2022, documented the facility would maintain ongoing communication and collaboration with the dialysis facility regarding care and services and for the development and implementation of the dialysis care plan by nursing home and dialysis staff. The facility would immediately contact dialysis staff and the nephrologist when any significant changes in the resident's status related to clinical complications or emergent situations which may impact the dialysis portion of the care plan.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46265 Based on observation, interview, and document review, the facility failed to ensure handwashing stations were properly controlled to provide hot water, food items were labeled and dated after opening, and maintain a clean and sanitary environment in the kitchen. The deficient practice posed a potential risk to safety and health standards which could lead to contamination, inadequate storage, and place residents at risk of foodborne illness. On [DATE] at 8:05 AM, the initial tour of the kitchen was completed with the following findings: - temperature of handwashing stations were measured at 68 degrees Fahrenheit. - there was a black tarry build up under the shelf on the stove. - food and debris were found under the preparation table. - in the dry storage area there were four containers of thickened apple juice which expired on [DATE]. - in the walk-in refrigerator there was an undated, partially used package of ground beef. - by the dishwasher there was a sanitizer station which was continuously leaking onto the counter. On [DATE] at 8:30 AM, the dietitian verbalized maintenance was responsible for adjusting the temperature control for the handwashing stations. The dietitian indicated staff was responsible for ensuring daily cleaning and would complete log once completed. The Dietitian explained it was part of the storage policy to label and date all perishable items in the refrigerator, freezer, and dry storage. On [DATE] at 8:35 AM, the maintenance director indicated monthly logs were completed to verify temperatures in kitchen, the maintenance director completed adjustment of water temperatures while surveyors completed walk through of kitchen. The maintenance director explained when the temperature was low or high the kitchen staff would normally contact maintenance and make a report to have it fixed. On [DATE] at 8:45 AM, in the nourishment rooms the following concerns were identified: - the nourishment room on the 200 unit had expired items in the refrigerator for resident use and several items did not have name or use by date. - the nourishment room on the 300 unit had a container of soup or noodles in a bag which was not labeled or dated, and dietitian believed items belonged to staff. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- under the sink the bottom board of cabinet was warped and broken and had orange-brown residue. On [DATE] at 10:56 AM, the Dietary Manager verbalized the appropriate procedure for storage of food items was to label and date all food items in the refrigerator, freezer, and dry storage. Items in the refrigerator and freezer should be labeled with delivery date, opened date, and use by date. The Dietary Manager indicated it was important to label and date items in order to protect against foodborne illness and spoilage of food. The Dietary Manager verbalized the nourishment rooms monitored by both the kitchen staff and nursing staff on the specific unit. The dietary aides would label and date food and snack items while in kitchen and will restock the nourishment rooms. The Dietary Manager explained part of the responsibility while restocking was to also check the expiration dates of items in the refrigerator in the nourishment rooms. The facility policy titled Food Safety in Receiving and Storage (,d+[DATE]), documented expiration dates and use-by dates would be checked to ensure dates were within acceptable parameters. Repackaged food would be placed in a leak-proof, pest-proof, non-absorbent, sanitary container with a tight fitting lid. The container would be labeled with the name of the contents and dated with the date it was transferred to the new container.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 46265 Based on observation, interview, record review and document review the facility failed to ensure the pest control program was effective. The deficient practice had the potential of leading to a widespread infestation and having a negative impact on the residents of the facility. On 04/23/2024 at 8:05 AM during the initial tour of the kitchen, ants were discovered in large quantity on the side wall next to the dishwasher. The ants were in a line from a small hole in the kitchen wall near a seam and moving back and forth along the wall from the opening to the end of the wall by the food preparation station. On 04/23/2024 at 8:20 AM, the dietitian and maintenance director confirmed the presence of ants. On 04/26/2024 at 10:56 AM, the Dietary Manager indicated the maintenance director was responsible for the pest control program at the facility. The Dietary Manager explained once a staff member identified a concern it would be verbally reported to the maintenance department. On 04/26/2024 at 11:14 AM, the Maintenance Director explained when a staff member had a concern it would be reported verbally or through the electronic system. The Maintenance Director indicated the pest control company would generally visit the same day or next day if a concern was identified. The kitchen was scheduled monthly for complete cleaning including power wash. The Maintenance Director reported the pest control company would come out to facility monthly to check the kitchen and would notify maintenance if there was a concern and provide treatment as needed. The facility policy titled Pest Control (02/2009), documented there was a program established for the control of insects and rodents. The food and dining services department would institute programs to prevent or eliminate infestation of pests and prevent the contamination of food.