

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295081	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025
NAME OF PROVIDER OR SUPPLIER Nevada State Veterans Home - Boulder City		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Veterans Memorial Dr Boulder City, NV 89005	

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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131</p> <p>Based on observation, interview, record review, and document review, the facility failed to ensure the resident who had dementia was free from physical restraints for 1 of 6 sampled residents (Resident 6). This deficient practice had the potential to cause diminished physical functioning, increased confusion, psychosocial distress, and a decline in quality of life.</p> <p>Findings include:</p> <p>Resident 6 (R6)</p> <p>R6 was admitted on [DATE], with diagnoses including dementia, hearing loss, and major depressive disorder.</p> <p>The Admission Minimum Data Set, dated dated dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 5 out of 15, indicating severely impaired cognitive status. R6 had routinely used a walker.</p> <p>The Nursing Progress Notes for the month of March documented multiple instances when R6 was confused, agitated, and restless.</p> <p>The Psychiatric Evaluation dated 03/25/2025, documented the encounter had been conducted in person. R6's safety had been assessed, and the current risk was deemed low; therefore, a safety plan was not required. The target behavior had been identified as sundowning. Residents with dementia had been noted to become more confused after sunset, which could involve agitation, pacing, wandering, exit-seeking, and other problematic behaviors. Psychotherapy had been encouraged, and medications had been prescribed.</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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Employee Statement signed dated 03/31/2025, documented Certified Nursing Assistant (CNA1) had been instructed to place R6 in another resident's Broda chair (a type of wheelchair which make it easier for caregivers to provide care with less stress on the resident and the caregiver) and secure the seat belt. CNA1 responded to the Charge Nurse (CN) had no knowledge of a physician's order to apply a seat belt. The Charge Nurse then stated in front of the staff, 'If you guys speak out, you guys will all be fired.' Due to fear of retaliation, CNA1 and Certified Nursing Assistant 2 (CNA2) complied with the instruction, placed R6 in the Broda chair, and secured the seat belt as directed. At approximately 10:30 PM, R6 remained at the nurse station until 1:30 AM and then was assisted back to the room upon appearing sleepy.</p> <p>A Physical Therapy Evaluation and Plan of Treatment dated 04/01/2025, documented a [AGE] year-old resident with a diagnosis of dementia. R6 was independent in bed mobility, transfers, and ambulation using a platform walker but required supervision to prevent falls. R6's gross motor coordination, sensation, and sensory processing were intact.</p> <p>The Interview Statement dated 04/04/2025, documented the Charge Nurse (CN) acknowledged R6 had been placed in the regular wheelchair and other times was in a Broda chair. The CN stated the chair had been reclined to reduce R6's pain and confirmed the positioning had a calming effect. The CN reported not considering the Broda chair a restraint because R6 could stand up and the chair was slightly reclined close to 90 degrees, but not more than 80 degrees, and denied the seatbelt had been fastened. The CN acknowledged R6 had verbally expressed, Odios mios, don't leave me, translated as Oh my God, don't leave me.</p> <p>The Interview Transcript dated 04/04/2025, documented CNA1 indicated R6 had been placed in a Broda chair, slightly reclined, and R6's feet were approximately 3 to 4 inches from touching the floor. CNA1 reported R6 requested to return to the room; however, the RN did not permit the transfer. Instead, the RN instructed CNA1 and CNA2 to transition R6 from the wheelchair and place in the Broda chair. CNA1 indicated R6 was sometimes anxious and agitated but was not considered at risk for falling.</p> <p>The Interview Transcript dated 04/04/2025, documented CNA 2 confirmed R6 had been at the nurse station a couple of times when R6 was agitated. CNA2 admitted having assisted in transferring R6 from the wheelchair to a Broda chair, but the seatbelt was not fastened. CNA2 confirmed the Broda chair was slightly reclined.</p> <p>On 05/01/2025 at 3:10 PM, R6 was observed in bed, coloring a book. R6 appeared pleasant and calm but exhibited confusion. During the conversation, R6 was verbally responsive.</p> <p>On 05/01/2025 at 3:20 PM, CNA2 indicated having witnessed R6 being placed multiple times in the Broda chair at the nurse station when agitated. CNA2 clarified the Broda chair had been tilted or reclined halfway back. CNA2 was uncertain about personally assisting with the transfer of R6 from the wheelchair to the Broda chair. CNA2 verbalized R6 was unable to independently adjust the Broda chair from its reclined position to its normal position, leaving R6 confined to the chair. CNA2 explained even if R6 wanted to get up from the Broda chair, it would have been difficult without sufficient strength. CNA2 indicated the Broda chair was typically used for transport, not for daily use or for behavioral management. CNA2 described a restraint as preventing a resident from moving freely or going where desired, thereby limiting the resident's mobility. CNA2 indicated the facility had provided education on abuse and restraint.</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 05/01/2025 at 2:24 PM, the Director of Rehabilitation Services (DORS) explained R6 had been evaluated on 04/01/2025 and did not require rehabilitation services, as R6 had been independent and able to ambulate. The DORS explained the Broda chair was not typically used as a regular chair but rather for individuals requiring specialized positioning, such as those with Amyotrophic Lateral Sclerosis (ALS). The DORS explained although the Broda chair included tilt and recline functions, once tilted or reclined, it was unlikely a resident could exit independently due to the control mechanisms located at the back.</p> <p>The DORS explained use of a Broda chair required a physician order, clinical team evaluation, and frequent monitoring while in use, particularly for residents who tended to lean forward, which was unsafe. The DORS clarified the Broda chair could not be used to manage the resident's behavior or agitation by limiting mobility or solely for fall prevention. The DORS conveyed the use of a Broda chair for R6 was inappropriate and would constitute a restraint and a violation of resident rights if not properly authorized.</p> <p>On 05/01/2025 at 2:55 PM, the Nurse Practitioner (NP) indicated R6 had been agitated and restless, and the psychiatrist had evaluated R6, ordered medications and clinical interventions. The NP indicated the interdisciplinary team's recommendations required staff to alert providers. The NP had no recollection of ordering the Broda chair for R6 and stated it may have been ordered by another provider.</p> <p>On 05/01/2025 at 3:04 PM, the Minimum Data Set (MDS) Coordinator indicated R6 had been independent and able to get up. The MDS Coordinator explained the Broda chair was not recommended for R6 to treat medical symptoms, as the risks outweigh the benefits. The MDS Coordinator confirmed there had been no indication of Broda chair use for R6.</p> <p>On 05/01/2025 at 3:35 PM, another Charge Nurse (CN) indicated the use of a Broda chair required justification, a physician order, consent, a care plan, and monitoring. The CN explained the Broda chair was not intended to manage a resident's agitation or restlessness, nor to prevent falls, but was designated for residents with special needs. The CN acknowledged the Broda chair could be considered a restraint when an independent resident was contained in the reclined position, limiting mobility.</p> <p>R6's medical record lacked documented evidence a physician had been notified, or a physician order had been obtained for the use of the Broda chair. No justification, consent, or care plan had been completed.</p> <p>On 05/01/2025 at 3:50 PM, the Nurse Manager indicated the other staff involved or who witnessed the incident were unavailable for interview, remained employed at the facility, and worked night shifts or on other days. The Nurse Manager confirmed there was no order or justification in place for R6's use of the Broda chair and no documentation the concern had been discussed during the interdisciplinary team meeting. The Nurse Manager confirmed the medical record lacked documented evidence a physician's order had been obtained for the use of a Broda chair for R6. The Nurse Manager acknowledged limiting a resident's mobility was considered a restraint.</p> <p>On 05/01/2025 in the afternoon, the Administrator indicated the incident was investigated and the investigation process had been documented. The Administrator acknowledged the facility protocol had not been followed regarding the use of the Broda chair, and the involved staff was suspended, educated, and later reinstated.</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>A facility policy titled Physical Devices, revised on 11/30/2024, indicated restraint-free care was supported through quality improvement, evidence-based practice, staff education, and informed decision-making. Physical restraints were defined as any device the resident could not remove easily that restricted movement. If a physical device was recommended, it required review and approval by the nurse manager or, in emergencies, the House Support Nurse. Documentation of need and completion of a physical device evaluation were required.</p> <p>A facility policy titled Abuse, Neglect, and Exploitation, revised on 03/15/2017, indicated residents had the right to be free from physical restraints not required to treat medical symptoms. The use of such restraints was considered abuse and strictly prohibited.</p>		