

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  12/06/2024
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40131</p> <p>Based on observation, interview, record review, and document review, the facility failed to ensure a physician / physician extender, and the resident representative were notified when a resident experienced poor appetite and a significant weight loss for 1 of 30 sampled residents (Resident 139). The deficient practice had the potential for the physician or family to not be aware of a change in a resident's condition which could result in a delay in a resident's plan of care.</p> <p>Findings include:</p> <p>Resident 139 (R139) was admitted on [DATE], with diagnoses including chronic kidney disease (CKD), anemia, and malignant melanoma of the face.</p> <p>R139's census documented received hospice services from 05/16/2024 to 06/11/2024. The Director of Nursing (DON) confirmed R139 was discharged from hospice services on 07/11/2024.</p> <p>A Physician Order dated 05/16/2024, documented a regular diet, regular texture, and thin consistency.</p> <p>1) A Care Plan initiated on 05/17/2024 documented R139's diet was provided and served as ordered. The Registered Dietitian (RD) evaluated and made diet change recommendations as needed. Potential for nutritional problems related to end-stage diagnosis was identified. Interventions included monitoring and reporting signs and symptoms of malnutrition to the physician as needed, such as muscle wasting and poor appetite. The goal focused on maintaining adequate nutritional status, evidenced by the absence of malnutrition signs and symptoms and consuming 50-75% of every meal daily through the review date.</p> <p>A Nursing Progress Note dated 06/02/2024, documented R139's baseline as eating breakfast in the dining area with a good appetite and adequate fluid intake. Alert and able to communicate needs and wants. Self-fed without any issues.</p> <p>On 12/03/2024 at 12:59 PM, R139 was observed seated in a wheelchair, appearing weak and stuporous, and having dry, scaly skin. R139 did not respond to questions.</p> <p>On 12/05/2024 at 8:15 AM, the breakfast tray was untouched. R139 verbalized a lack of appetite but expressed a desire to get well.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/05/2024 at 11:50 AM, a Licensed Practical Nurse (LPN) explained R139 had been admitted in May and was previously under hospice care and discontinued due to the need for eye surgery. Prior to surgery, R139 demonstrated a good appetite. A notable decline in R139's condition was observed from late October through November. The LPN explained a gradual decrease in appetite and social engagement was noted, with diminished participation in activities and meals. The LPN further explained R139 began withdrawing, becoming weaker, and showing visible signs of physical decline.</p> <p>On 12/05/2024 at 1:50 PM, R139's Power of Attorney (POA) indicated not having been informed of R139's poor appetite but acknowledged observing the decline. The POA indicated visiting the facility every two weeks and previously observed R139 eating in the dining room with a good appetite. The POA indicated early November, a decrease in appetite and less engagement was observed. The POA mentioned R139 had been discharged from hospice services before undergoing eye surgery, and R139 expressed a desire not to return to hospice care.</p> <p>The Point of Care History documented 15 meal refusals between November 6 and December 4, 2024. From November 19 to December 5, 2024, R139's average meal intake ranged from 0-25%, falling short of the goal of 50-75% daily intake to maintain adequate nutritional status.</p> <p>On 12/04/2024 at 2:58 PM, the Registered Dietitian (RD) confirmed R139 had previously been eating approximately 65% of meals. The RD explained a recent decrease in the resident's oral intake likely contributed to the resident's weight loss. The resident's current intake was 0-25% for most meals, averaging around 20% over the past 14 days. The resident frequently refused meals. The RD confirmed there was a significant decline compared to R139's baseline. The RD confirmed a lack of documented evidence the attending physician or the POA were notified of R139's poor oral intake.</p> <p>On 12/05/2024 at 12:30 PM, the Registered Nurse (RN) Manager indicated the RD was responsible for collaborating with the physician regarding resident significant weight loss. The Nurse Manager explained monthly weights were taken by CNAs, with results encoded by the nurse manager and monitored by the RD. The Nurse Manager was unaware of R139's weight loss and verbalized it was not discussed during the interdisciplinary team meeting (IDT). The Nurse Manager confirmed no documentation existed indicating notification or collaboration with the resident, nursing staff, physician, and POA.</p> <p>2) R139's Weight Summary documented the following:</p> <p>-12/2/2024: 145.0 lbs. (Weight loss of 15 lbs.)</p> <p>-10/04/2024: 160.0 lbs.</p> <p>-09/04/2024: 161.0 lbs.</p> <p>-08/02/2024: 147.0 lbs. (Weight loss of 18 lbs.)</p> <p>-07/01/2024: 165.0 lbs. (Weight loss of 12 lbs.)</p> <p>-06/07/2024: 177.0 lbs.</p> <p>-06/03/2024: 170.0 lbs.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-05/31/2024: 170.0 lbs.</p> <p>-05/24/2024: 169.0 lbs.</p> <p>-05/18/2024: 169.0 lbs.</p> <p>-05/17/2024: 168.0 lbs.</p> <p>-05/16/2024: 170.0 lbs. (Baseline weight upon admission)</p> <p>On 12/04/2024 at 2:58 PM, the RD confirmed there were significant weight changes in July-August. R139's weight loss was unplanned and undesirable. The RD explained R139's weight was previously stable and at risk for weight fluctuations. R139 was previously eating 65% of meals, but recent decreases in oral intake were likely contributing to weight loss, and now eating 0-25% of most meals. The RD confirmed there was no documented evidence the physician or resident representative was notified of R139's weight loss</p> <p>On 12/05/2024 at 3:25 PM, the Director of Nursing (DON) indicated the staff were expected to notify the physician promptly of any changes in a resident's condition to ensure timely initiation of necessary interventions and document the notification in the progress notes.</p> <p>On 12/05/2024 at 12:30 PM, the Registered Nurse (RN) Manager indicated the RD was responsible for notifying the physician regarding the weight loss. The Nurse Manager confirmed there was no documentation the physician was notified regarding R139's significant weight loss The Nurse Manager indicated the physician should have been notified to obtain orders to promptly address the resident's change of condition.</p> <p>On 12/05/2024 at 1:28 PM, the Nurse Manager indicated the significant weight loss was a change of condition. The CRN indicated R139 had a decrease in appetite and the resident's family was informed of the weight loss in early December.</p> <p>On 12/05/2024 at 1:50 PM, R139's POA was unaware of the significant weight loss but acknowledged having observed a decline in R139's condition The POA confirmed no discussion had taken place regarding R139's weight loss until December 4, 2024.</p> <p>On 12/05/2024 in the afternoon, the Nurse Practitioner indicated staff were expected to notify the provider immediately regarding any changes in a resident's condition, including significant weight changes to address the issues promptly with an appetite stimulant, provide supplements, and order a blood workup.</p> <p>On 12/06/2024 at 12:46 PM, the attending physician was unaware of R139's significant weight loss after discharge from hospice. The physician emphasized staff were expected to promptly report changes in the resident's condition, particularly significant weight loss. The physician indicated an appetite stimulant, and supplements could have been initiated if informed.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility policy titled Change of Condition, revised on 02/09/2024, documented nursing staff intervened promptly and thoroughly once an observed change in a resident's condition was identified. Significant change referred to a change in the resident's physical, mental, or psychosocial status, including deterioration in health, mental, or psychosocial status due to life-threatening conditions or clinical complications. A change of condition included any unusual signs or symptoms involving changes in physical or mental assessment. The charge nurse called the attending physician or physician extender and notified the family member or responsible party. The resident's condition was monitored, and documentation should have been completed.</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41903</p> <p>Based on observation, interview, record review, and document review, the facility failed to follow the facility policy on referring residents for a Preadmission Screening and Resident Review (PASARR) Level 2 evaluation who acquired a new diagnosis indicative of a mental illness or begin a new psychotropic medication for 3 of 30 sampled residents (Resident 72, 139, and 98). The deficient practice had the potential to place residents at risk of not being evaluated for appropriate determination of necessary behavioral health services.</p> <p>Findings include:</p> <p>1.) Resident 72 (R72) was admitted on [DATE] and readmitted [DATE], with diagnosis including type 2 diabetes mellitus with hyperglycemia, major depressive disorder, and senile degeneration of brain.</p> <p>On 12/03/2024 at 9:11 AM, R72 was observed in the dining room sitting on wheelchair with eyes closed and calm. R72 did not display concerning behaviors or symptoms of distress.</p> <p>A Nevada PASARR Level 1 Identification Determination dated 08/02/2021, revealed R72 did not have dementia, mental illness (MI), mental retardation (MR), or any related condition (RC), and was deemed appropriate for nursing facility placement.</p> <p>R72's Admission Record Diagnosis Information documented new diagnosis of anxiety disorder with onset date of 10/26/2023, major depressive disorder with onset date of 12/15/2023, and post-traumatic stress disorder with onset date of 04/16/2024.</p> <p>R72's medical record lacked documented evidence a referral was made for PASARR Level 2 evaluation after the resident was diagnosed with anxiety disorder, major depressive disorder, and post-traumatic stress disorder.</p> <p>On 12/06/2024 at 10:05 AM, a Licensed Social Worker (LSW 1), explained was not familiar with the PASARR Level 2 evaluation process. LSW 1 reported not knowing if R72 was referred for PASARR Level 2 evaluation.</p> <p>On 12/06/2024 at 11:05 AM, a Licensed Social Worker (LSW 2), was unaware of the policy for PASARR a Level 2 evaluation. LSW 2 acknowledged not knowing social services involvement and responsibilities in the process to request a PASARR Level 2 evaluation after a resident had a new diagnosis of mental illness.</p> <p>On 12/06/2024 at 11:53 AM, the Social Services Supervisor confirmed R72's medical record lacked documented evidence a referral for a PASARR Level 2 evaluation was completed. The Social Services Supervisor acknowledged a referral for evaluation should have been completed after the diagnoses were identified.</p> <p>40131</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2.) Resident 139 (R139) was admitted on [DATE], with diagnoses including chronic kidney disease, heart disease and post-traumatic disease syndrome (PTSD).</p> <p>The medical record lacked documented evidence R139 was referred for a new level of care assessment (LOC) and/or a PASARR Level 2 referral after new psychiatric diagnoses was identified since R139 last comprehensive assessment.</p> <p>On 12/06/24 at 1:00 PM, the Social Services Supervisor confirmed there was no documented evidence R139 was referred for a new level of care assessment (LOC) and/or a PASARR Level 2 referral after a new psychiatric diagnosis was identified.</p> <p>40142</p> <p>3.) Resident 98 (R98) was admitted on [DATE], with diagnoses including Parkinson's disease, major depressive disorder and post-traumatic stress disorder (PTSD).</p> <p>A pre-admission screening and resident review (PASARR) Level 1 dated 01/19/2023, documented R98 did not have any mental illness, mental retardation, intellectual disability or dementia (negative PASARR). R98 was determined to be appropriate for nursing facility placement but may require a level of care (LOC) assessment.</p> <p>The Admission Minimum Data Set (MDS) dated [DATE], revealed R98 did not have any psychiatric mood disorders and was not on any psychoactive medications.</p> <p>A Psychiatric Note dated 05/08/2023, documented R98 had PTSD and would have flashbacks from being a paratrooper, unspecified schizophrenia, delusional disorder and major depression. Start Sertraline (an anti-depressant).</p> <p>The Annual MDS dated [DATE], revealed R98 had a diagnosis of depression, PTSD and psychotic disorder and was receiving psychoactive medication specifically an anti-depressant.</p> <p>The medical record lacked documented evidence R98 was referred for a new level of care assessment (LOC) and/or a PASARR Level 2 referral after new psychiatric diagnoses was identified since R98's last comprehensive assessment.</p> <p>On 12/06/2024 at 10:53 AM, the Administrator confirmed residents admitted with a negative PASSAR and was diagnosed with new psychiatric illness met the criteria for a referral for a PASARR Level 2 evaluation. The Administrator deferred to social services for the facility's PASARR process.</p> <p>On 12/06/24 at 11:13 AM, Licensed Social Worker (LSW 1) indicated being employed for [AGE] years and explained social services was not involved in the PASARR referral process. LSW 1 verbalized not being well-versed on the PASARR process and explained the former medical records director who left the facility early this year oversaw all PASARR referrals. LSW 1 reviewed the facility's PASARR policy and indicated not being aware of the responsibilities the social services had with PASARR referrals.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/06/24 at 11:53 AM, the Social Services Supervisor indicated the PASARR process was new to social services because the former medical records director used to be solely responsible for identifying and referring residents for LOC assessments and/or PASSAR Level 2 evaluation. The social services supervisor indicated PASARR was delegated to social services around March or April 2024, but no clear process had been developed with regards to identifying and referring residents for PASARR Level 2. The social services supervisor indicated not being well-versed with the PASARR referral process and confirmed there had been no residents referred for a new LOC assessment or PASARR Level 2 evaluation ever since the former medical records director left in early 2024.</p> <p>On/12/06/2024 at 1:19 PM, the Administrator confirmed the social services supervisor's account where no residents have been referred for new LOC or PASSAR Level 2 evaluation since the former medical records director left in March-April 2024. The Administrator indicated starting employment in the middle of May 2024 verbalized being inclined to believe the social services department received no training on PASARR and confirmed the facility currently had no clear process on how to identify residents who meet the criteria for an LOC/PASARR Level 2 referral.</p> <p>The PASRR and Level of Care Screening policy revised 02/22/2028, revealed a PASARR was required to be completed prior to admission on all residents. If there has been a change of condition since the last PASARR prospective resident would be referred of LOC assessment. PASARR screening shall be requested by the unit social worker on residents who acquire a new diagnoses indicative of mental illness or beginning on a new psychotropic medication. Social services would forward the PASARR requests to medical records department. Medical records personnel would be responsible for faxing the PASARR requests to the screening entity and tracking their status.</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>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> 50289</p> <p>Based on observations, interviews, record review, and document review, the facility failed to ensure a care plan was revised to include current communication practices for 1 of 30 sampled residents (Resident 69). The deficient practice placed the resident at risk for inaccurate communication leading to inappropriate care.</p> <p>Findings include:</p> <p>Resident 69 (R69) was admitted to the facility on [DATE] with diagnoses including multiple sclerosis, dysarthria following unspecified cerebrovascular Disease, major depressive disorder, dysphagia, and dysphonia.</p> <p>On 12/03/2024 in the morning, the resident was lying in bed with a Dynavox box (a type of communication device) in the room, but it did not appear R69 was using it. R69 was only able to answer yes/no questions.</p> <p>On 12/04/2024 at 9:18 AM the Speech-Language Pathologist (SLP) explained R69 had a hard time vocalizing and articulating. The resident's voice was inconsistent and dysarthric (a motor speech disorder in which the muscle used for speech are weak). The SLP stated R69 had a history of stroke and currently had head and eye tremors. The SLP indicated the resident may not be utilizing the Dynavox for communication due to the Dynavox utilized eye gaze technology. It was not easy for R69 to use due to the eye tremors. The SLP explained R69 did use alternate communication methods to get needs and wants known. R69 used communication spelling boards, finger spelling via sign language, and was very accurate with responding to yes/no questions.</p> <p>A care plan for communication had documented R69 had difficulty with communicating their needs. The care plan provided an intervention of using the computer (Dynavox) for communication as it provided R69 with a feeling R69 had some control left. The care plan had not been revised with the new communication intervention methods of the alphabet communication board, finger spelling via sign language, and yes/no questioning.</p> <p>On 12/04/2024 in the morning, the Registered Nurse (RN) Charge Nurse explained the care plan was a resident centered outline which informed all the caregivers how to best care for the individual resident including their preferences, needs, and equipment to be used. Without a correct care plan, it could lead to incorrect care being given.</p> <p>On 12/04/2024 at 10:36 AM the RN Unit Manager stated R69 communicated using: an alphabet communication board where R69 spelled out words, yes/no responses to staff yes/no questions, a computer to assist with communication (Dynavox), and R69 could use sign language for the alphabet to spell out words to communicate. The RN Unit Manager acknowledged the only communication intervention method care planned was the computer (Dynavox). The RN Unit Manager confirmed the other communication intervention methods should have been in the care plan for R69.</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>A facility policy titled Care Planning revised 04/24/2019 documented the care plan will be updated as changes in resident status occur, but not less than every 92 days. The policy documented the care plan will be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51397</p> <p>Based on observation, interview, record review and document review, the facility failed to identify a new skin impairment for 1 of 30 sampled residents (Resident 26). The deficient practice placed the resident at risk for worsening skin impairments and diminished quality of life.</p> <p>Findings include:</p> <p>Resident 26 (R26) admitted to the facility on [DATE] with diagnoses including stage 4 pressure ulcer upon admission.</p> <p>On 12/04/24 at 9:46 AM, R26 stated having a pressure ulcer acquired from another facility but developed one while in the current facility. R26 believed the new pressure ulcer developed because of lying in bed all day and sometimes in excrement for long periods of time.</p> <p>Review of R26's care plan revised on 10/09/2024 identified the following:</p> <p>R26 was at risk for skin breakdown, skin tears, bruising/skin discoloration and pressure ulcers related to impairment of physical mobility post total left hip surgery, refusal to be turned and repositioned, and fragile/sensitive skin. Goals included: Resident will not develop pressure ulcers through the next review date; the resident will have intact skin free of blisters, redness, discoloration; administer treatments as ordered and monitor for effectiveness. Interventions included: monitor/document/report as needed any changes in skin status; appearance, color, wound healing, signs/symptoms of infection, wound size (length x width x depth), stage; and provide skin care each shift and as needed.</p> <p>On 12/05/2024 at 11:22 AM, the Minimum Data Set (MDS) Nurse stated R26 was admitted with a stage 4 pressure that healed in May 2024. The MDS Nurse stated R26 resident did not have any other pressure ulcers or wounds at this time.</p> <p>On 12/05/2024 at 12:12 PM, the Wound Care Nurse (WCN) stated new resident skin issues were reported to them by the Certified Nursing Assistant (CNA). The nurse indicated R26 had a healed stage 4 pressure ulcer wound and did not have any other wounds.</p> <p>On 12/05/2024 at 12:57 PM, R26's CNA turned R26's body to the left side that revealed 2 dressings located on mid to outer right buttock. The CNA peeled back the two dressings that revealed the outer dressing, with a reddened area with broken skin.</p> <p>On 12/05/2024 at 1:01 PM, the Charge Nurse on the unit stated the R26 was not on any wound management based on a list of all residents on wound care and was not receiving any wound care.</p> <p>On 12/05/2024 at 12:24 PM, the Unit Charge Nurse, WCN and R26's CNA looked at the resident's buttock where the open wound was located. The WCN indicated the dressings were placed days ago for protection and confirmed the skin was not open. The WCN was not aware the resident's skin was open as no one had reported it. The WCN stated the open skin wound appeared to be a moisture associated skin damage (MASD) and had a high likely hood of developing into a pressure ulcer.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/05/2024 at 2:43 PM, the Director of Nursing (DON) stated the CNA would report any new skin issues to the nurse who would then contact the WCN. DON stated the WCN was not aware of the wound because no one reported it.</p> <p>Review of a facility policy titled Pressure ulcer prevention and care dated 10/16/2016, documented the following:</p> <ol style="list-style-type: none"> <li>1. All residents were to have a daily head to toe skin check</li> <li>2. Check resident more frequently if incontinent</li> <li>3. CNA's and Licensed Practical Nurses (LPN) will notify the charge nurse of any abnormal skin findings.</li> </ol>		

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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	

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40131</p> <p>Based on observation, interview, record review, and document review, the facility failed to ensure: 1) A nutritional assessment was completed when significant weight loss was identified; 2) Interventions were implemented; and 3) A resident was reweighed when significant weight loss was identified, and weight was obtained monthly per policy for 1 of 30 sampled residents (Resident 139). The deficient practices had the potential to lead to further weight loss.</p> <p>Findings include:</p> <p>Resident 139 (R139) was admitted on [DATE], with diagnoses including chronic kidney disease (CKD), anemia, and malignant melanoma of the face.</p> <p>1) R139's medical records lacked documented evidence nutritional assessments were completed when significant weight loss was identified.</p> <p>R139's Weight Summary documented as follows:</p> <p>-12/02/2024: 145.0 lbs. (Weight loss of 15 lbs.)</p> <p>-10/04/2024: 160.0 lbs.</p> <p>-09/04/2024: 161.0 lbs.</p> <p>-08/02/2024: 147.0 lbs. (Weight loss of 18 lbs.)</p> <p>-07/01/2024: 165.0 lbs. (Weight loss of 12 lbs.)</p> <p>-06/07/2024: 177.0 lbs.</p> <p>-06/03/2024: 170.0 lbs.</p> <p>-05/31/2024: 170.0 lbs.</p> <p>-05/24/2024: 169.0 lbs.</p> <p>-05/18/2024: 169.0 lbs.</p> <p>-05/17/2024: 168.0 lbs.</p> <p>-05/16/2024: 170.0 lbs. (Baseline weight upon admission)</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/04/2024 at 2:58 PM, the Registered Dietitian (RD) started working at the facility on 10/07/2024, following a gap of approximately three months after the previous RD left. The RD indicated R139's height was 68 inches with a body mass index (BMI) of 22.0, indicating risk for weight fluctuations due to chronic heart failure, CKD, and a diuretic regimen. The RD confirmed the resident experienced a significant weight change from July to August. There was no nutritional assessment completed in August.</p> <p>The RD confirmed R139's BMI was 22, with a target goal of 25, and the weight loss was identified as unplanned and undesirable. The RD conveyed a nutritional assessment was vital for addressing significant weight changes and should have been completed to ensure interventions were implemented.</p> <p>On 12/05/2024 in the afternoon, the Director of Nursing (DON) confirmed the previous RD's last workday was 07/19/2024, and there was a gap when the new RD began working in October.</p> <p>The Food and Nutrition policy, revised 08/16/2024, documented resident assessments by an RD or RN within seven days of admission. RD assessments were required at least annually or with any significant status change. Significant weight changes prompted evaluation by the RD in collaboration with the resident, responsible party, nursing staff, and primary care physician.</p> <p>A Care Plan dated 05/17/2024 documented the Registered Dietitian (RD) was tasked with evaluating and recommending dietary changes as needed. Interventions included monitoring and reporting signs and symptoms of malnutrition to the physician, such as emaciation (cachexia), muscle wasting, and poor appetite. The goal aimed to maintain adequate nutritional status, evidenced by the absence of malnutrition signs and consumption of 50-75% of each meal daily through the review date.</p> <p>2) R139's medical records lacked documented evidence interventions were implemented when significant weight loss was identified.</p> <p>On 12/05/2024 at 8:15 AM, the breakfast tray was untouched. R139 stated no appetite but expressed a desire to get well.</p> <p>On 12/05/2024 at 11:50 AM, a Licensed Practical Nurse (LPN) explained R139 had been admitted in May and was previously under hospice care, which was discontinued due to the need for eye surgery. Prior to this, R139 had a good appetite. The LPN indicated a notable decline in R139's condition had been observed, particularly from late October through November. A gradual decline in appetite and social engagement had been noted, with diminished participation in activities and meals. The LPN indicated R139 began withdrawing, becoming weaker, and showing visible signs of physical decline.</p> <p>On 12/05/2024 01:50 PM, R139's Power of Attorney (POA) indicated being unaware of R139's significant weight loss but had observed the decline. The POA mentioned was visiting the facility every two weeks and noted previously R139 had been going to the dining room to eat and had a good appetite. However, last month (November), the POA observed a poor appetite and less engagement. The POA indicated R139 had been discharged from hospice services before undergoing eye surgery and had expressed a desire not to return to hospice care.</p> <p>The Point of Care History documented 15 meal refusals between November 6 and December 4, 2024. From November 19 to December 5, 2024, R139's average meal intake ranged from 0-25%.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/04/2024 at 2:58 PM, the RD confirmed documenting the 06/04/2024 and 08/02/2024 weights as an error correction, despite not being employed at the facility when the weights were taken. The RD explained the significant weight loss was identified and documented as an error to resolve the trigger, but no interventions were implemented.</p> <p>The RD indicated R139 had previously been eating approximately 65% of meals. The RD explained a recent decrease in oral intake likely contributed to the weight loss, with current intake now at 0-25% of most meals, averaging around 20% over the past 14 days. Meal refusal occurred frequently. The RD explained R139's weight loss was unplanned and undesirable, and interventions such as appetite stimulants, oral nutritional supplements, laboratory assessments, or reweighs were not implemented.</p> <p>On 12/06/2024 at 12:46 PM, the attending physician was unaware of R139's significant weight loss after discharge from hospice and indicated potential interventions could have been implemented if notified earlier.</p> <p>3) R139's medical records lacked documented evidence R139 was reweighed when significant weight loss was identified, and weight was obtained monthly per policy.</p> <p>R139's Weight Summary lacked documented evidence a weight was obtained in November 2024. The resident was not reweighed on 08/02/2024 after the weight obtained identified an 18-pound weight loss and on 07/01/2024 after the weight obtained identified a 12-pound weight loss.</p> <p>On 12/05/2024 12:30 PM, the Nurse Manager indicated the weight taken should not have been documented as an error correction, as it could have been interpreted as inaccurate. The Nurse Manager confirmed the process required reweighing residents for three consecutive days if weight changes were significant. The Nurse Manager confirmed no reweighs were completed in July and August, and R139's weight was missed in November. R139 was on isolation until November 4 and should have been reweighed after isolation.</p> <p>The Nurse Manager indicated reweighs were not conducted without direction from the RD, who issued weight alerts or email notifications for significant changes. The Charge Nurse was responsible for collaborating with the RD regarding weight concerns. The Charge Nurse explained monthly weights were taken by CNAs, with results encoded and monitored by the RD. The Nurse Manager was unaware of R139's weight loss and it was not discussed during the interdisciplinary team meeting (IDT).</p> <p>On 12/05/2024 at 1:28 PM, the Charge Nurse explained monthly weights were performed by day-shift CNAs for A beds and evening-shift CNAs for B beds. The Charge Nurse indicated weights were given to the unit secretary for encoding, the RD monitored residents' weights and advised nursing staff when reweighs were needed due to significant changes. Newly admitted residents were weighed weekly, then monthly, with reweighs directed as necessary. The Charge Nurse confirmed R139's November weight was not obtained, likely missed after isolation ended.</p> <p>On 12/05/2024 at 1:41 PM, the Unit Secretary explained residents' weights were obtained by CNAs on the first day of each month and handed to the Unit Secretary for encoding. Weight changes were highlighted in red, the Charge Nurse was notified, and the RD monitored residents' weights. The Unit Secretary indicated the weight forms were scanned into the electronic record after encoding. The Unit Secretary confirmed there was no weight encoded for R139 in November.</p> <p>(continued on next page)</p>		

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F 0692  Level of Harm - Actual harm  Residents Affected - Few	<p>On 12/04/2024 at 2:58 PM, the RD indicated the process required reweighing residents for three consecutive days to confirm significant weight changes but was unsure why this was not done. The RD indicated the weight discrepancy between R139's July and August weights were noted, and the resident should have been reweighed. No weight was taken in November due to COVID isolation, but this was not deemed valid given R139's significant weight loss. The RD expressed weight documentation was crucial for assessing nutritional status and preventing further decline.</p> <p>The facility policy titled Weight and Height Monitoring, revised 11/03/2024, documented weight recording upon admission and weekly for the first four weeks. Significant weight changes required reweighs for three consecutive days to determine an accurate weight, with the RD's notification to the IDT.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41903</p> <p>Based on interview, record review, and document review, the facility failed to ensure a pharmacy recommendation for a gradual dose reduction (GDR) was communicated to the physician for 1 of 30 sampled residents (Resident 45). The deficient practice had the potential to cause the resident to be administered a higher dose of medication than was necessary.</p> <p>Findings include:</p> <p>Resident 45 (R45) was admitted on [DATE], with diagnosis including Alzheimer's disease with late onset, dementia, and major depressive disorder.</p> <p>On 12/05/2024 at 7:15 AM, the resident was observed lying in bed, eyes closed, no signs and symptoms of pain or distress.</p> <p>A Physician Order dated 07/24/2024, documented Escitalopram Oxalate Oral Tablet 20 milligrams (mg) 1 tablet by mouth in the morning for depression/anxiety.</p> <p>A Psychoactive Medication Consent dated 07/25/2024, documented Escitalopram 20 mg 1 tablet by mouth in the morning, specific target behaviors depression/anxiety. Potential side effects included headache, constipation, and decreased appetite.</p> <p>A Care Plan dated 04/02/2024 documented R45 was at risk for side effects related to the use of antidepressants, including Escitalopram for depression.</p> <p>A Medication Regimen Review dated 09/01/2024 - 09/23/2024 listed a group of residents, including R45, who received recommendations made by the pharmacy regarding their medication regimen.</p> <p>R45's medical record lacked documented evidence of the recommendations made by the pharmacy between 09/01/2024 - 09/23/2024.</p> <p>On 12/06/2024 at 1:18 PM, the Health Information Coordinator, reported the medical record lacked the pharmacy medication regimen recommendation for R45, for 09/01/2024 - 09/23/2024. The Health Information Coordinator obtained a copy of the recommendations directly from the pharmacy consultant. The Health Information Coordinator acknowledged the section of the form for the physician was blank, was not marked reviewed or signed by the physician. The Health Information Coordinator explained the medical record lacked documented evidence the physician reviewed the recommendations.</p> <p>Note to Attending Physician/Prescriber dated 09/19/2024, addressed to the physician, documented a dose decrease to Escitalopram 10 mg daily was to be considered due to R45's advanced age. The physician/prescriber response and signature section of the form was blank.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/06/2024 at 1:36 PM, the Administrator explained when recommendations were received from the pharmacy, they were placed in a binder for the physician to review and sign. The Administrator acknowledged the recommendation form for R45 was not found in the binder. The Administrator acknowledged the recommendation was not reviewed by the physician.</p> <p>On 12/06/2024 at 1:55 PM, a Nurse Manager acknowledged there was no documentation confirming the recommendation made by the pharmacy was provided to the physician for review.</p> <p>A facility policy titled Medication Regimen Review dated 07/2/12017, documented the consultant pharmacy performed a comprehensive review of each resident's medication regimen. Findings and recommendations were reported to the director of nursing and the attending physician. Copies of the medication regimen should have been on file as part of the resident's permanent medical record.</p>		

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p>50289</p> <p>Based on interview and document review, the facility failed to ensure 1) the arbitration agreement stated neither the resident or their representative is required to sign the agreement as a condition of admission or to receive care at the facility, and 2) the arbitration agreement explicitly grant the resident or their representative the right to rescind the agreement within 30 calendar days of signing it. The deficient practice had the potential to deny admitted residents or their representatives the right to withdraw from the agreement within the 30-day after the signature as well as to deny the resident or representative their right to resolve their dispute in the court of law.</p> <p>Findings include:</p> <p>A facility document titled .Home Admission Contract, documented by signing, a resident confirmed to have received a copy of the document, and the provisions of the contract had been explained in a clear and understandable manner. The document indicated all the questions formulated by the resident had been answered. Section 10 of this contract was Arbitration. This section of the document revealed by signing this contract, the resident or resident representative agreed to have any dispute between the resident and the facility decided by arbitration, and the resident was giving up their right to a jury or court trial. The arbitration section contained lacked documented evidence the resident or resident representative were required to sign the arbitration section as a condition of admission or as a requirement to continue receiving care at the facility. The arbitration section lacked documented evidence the resident or resident representative could revoke the agreement by providing written notice to the facility within 30 calendar days of signature. There was no separate signature available for this section of the contract.</p> <p>Section 4 of this contract was Consent to Services. This section of the document revealed by signing this contract, the resident or their representative consents to the facility providing skilled nursing care as directed by said attending physician.</p> <p>On 12/06/2024 at 12:34 PM the administrative assistant in admissions explained the admissions agreement was sent out to the perspective resident/resident representative via email three to four days in advance of the potential resident being admitted to the facility. If there were any questions or issues with the admission agreement, the potential resident/resident's representative would call, email, or ask us on the day of admission to discuss any of their questions/issues. The administrative assistant in admissions stated there have been no issues where the resident or resident's representative did not want to sign the agreement because of the arbitration clause. But the agreement must be signed because it included the consent for the facility to treat the potential resident.</p> <p>On 12/06/2024 at 2:02 PM, the compliance officer acknowledged the arbitration section of the admissions contract did not say the potential resident or resident representative were not required to sign this section of the admissions contract. The compliance officer acknowledged the arbitration section of the admissions contract did not explicitly grant the resident or resident representative the right to rescind the arbitration agreement within 30 days of signing it. The compliance officer did reiterate that signing the arbitration agreement was not a condition of admission or to receive care at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/06/2024 in the afternoon, the administrative assistant in admissions acknowledged all current residents had a signed contract on file.</p> <p>On 12/06/2024 in the afternoon, the compliance officer stated the facility had no policy regarding arbitration.</p>		

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<p>F 0848</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>50289</p> <p>Provide a neutral and fair arbitration process and agree to arbitrator and venue.</p> <p>Based on interview and document review, the facility failed to ensure the Arbitration Agreement provided for the selection of a neutral arbitrator agreed upon by both parties; and for the selection of a venue that was convenient to both parties. The deficient practice had the potential to obstruct a resident's ability to make a well-informed decision about signing the arbitration agreement.</p> <p>Findings include:</p> <p>A facility document titled .Home Admission Contract, documented by signing, a resident confirmed to have received a copy of the document, and the provisions of the contract had been explained in a clear and understandable manner. The document indicated all the questions formulated by the resident had been answered. Section 10 of this contract is Arbitration. This section of the document revealed by signing this contract, the resident or their representative agreed to have any dispute between the resident and the facility decided by arbitration administered by the National Health Lawyers Association and not a neutral arbitrator agreed upon by both parties. The arbitration section did not provide for the selection of a venue that was convenient to both parties.</p> <p>On 12/06/2024 at 2:02 PM the compliance officer acknowledged the arbitration section of the admissions contract did not provide for the selection of a neutral arbitrator agreed upon by both parties, but instead had to use the National Health Lawyers Association to arbitrate disputes. The compliance officer acknowledged the arbitration section of the admissions contract did not provide for the selection of a venue that was convenient to both parties. The Compliance Officer stated the facility did not have a policy for arbitration.</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> 41903</p> <p>Based on observation, record review, document review, and interview, the facility failed to ensure a nurse performed hand hygiene after medication administration of an intradermal patch, after removing gloves and prior to administration of another resident's medication for 1 unsampled resident (Resident 113). The deficient practice had the potential for cross-contamination and the spread of infection.</p> <p>Finding Include:</p> <p>Resident 113 (R113) was admitted on [DATE] with diagnosis including Parkinson's disease without dyskinesia, Alzheimer's disease, and dementia.</p> <p>A Physician Order dated 09/19/2024 documented Exelon Patch 4.6 milligrams (mg), 1 patch every day transdermal. Indication diagnosis was dementia with behaviors.</p> <p>On 12/04/2024 at 7:44 AM, R113 was observed in the dining area. A nurse removed the existing Exelon Transdermal Patch and replaced it with a new patch. The nurse failed to perform hand hygiene after removing gloves and prior to administration of medication to another resident.</p> <p>On 12/04/2024 at 8:00 AM, the nurse acknowledged not performing hand hygiene after administering medication to R113. The nurse confirmed hand hygiene should have been completed after medication administration and removal of gloves, to prevent cross-contamination and prevent the spread of infection.</p> <p>On 12/04/2024 at 1:54 PM, a Charge Nurse, acknowledged hand hygiene should be performed after removal of gloves and prior to the start of care for another resident.</p> <p>A facility policy titled Infection Prevention and Control Policy and Procedure Hand Hygiene dated 11/17/2010, documented all healthcare workers shall practice effective hand hygiene when providing care to residents. When to utilize effective hand hygiene included before and after resident contact (even if gloves were worn), and handling medication. Hand hygiene was to be performed before putting on gloves and after removal of gloves.</p>