STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295081	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nevada State Veterans Home - Boulder City	100 Veterans Memorial Dr Boulder City, NV 89005

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure physician orders were followed for a resident's indwelling catheter, specifically, following the correct Foley size for 1 of 34 sampled residents (Resident 177). The deficient practice had the potential to place the resident at risk for catheter-related complications such as urethral trauma and pain.Findings include:Resident 177 (R177) was admitted on [DATE], with diagnoses including neuromuscular dysfunction of the bladder and chronic Foley catheter use.On 02/10/2026 in the morning, R177 was seated in wheelchair with a covered urinary bag hanging below center of the wheelchair. R177 indicated taking oral antibiotics for a suspected urinary tract infection and had experienced burning and pain to the catheter site the day before. R177 indicated not being certain if the night nurse replaced the catheter but the resident was relieved with the nurse's intervention. The admission minimum data set (MDS) dated [DATE], documented R177 was admitted with an indwelling catheter.The physician admission orders dated 01/30/2026, documented continued use of the indwelling catheter 16 French (size in diameter)/10 milliliters (ml) balloon (amount of sterile water or saline used to inflate the balloon which served as an internal anchor) for obstructive uropathy.R177's medication administration record (MAR) revealed the resident's Foley catheter was last changed on 01/31/2026 by the charge nurse.On 02/12/2026 at 7:59 AM, R177 permitted the surveyor to be present for assessment of Foley catheter by the Licensed Practical Nurse (LPN). The LPN removed R177's blanket and gown which revealed a red-colored balloon inflation port with black markings which read 18 Fr/30 cubic centimeters (cc). R177 stated not being able to remember whether the catheter was last replaced at the urology clinic or at the facility.On 02/12/2026 at 8:02 AM, the LPN reviewed R177's medical record and confirmed the resident's Foley catheter order was a 16 Fr/10 ml but the catheter observed was a size 18 Fr/30 cc. The LPN indicated the charge nurse signed off for the last Foley catheter change on 01/31/2026.On 02/12/2026 in the morning, the charge nurse reviewed R177's medical record and confirmed signing for the resident's Foley catheter change on 01/31/2026. The charge nurse explained the Foley catheter was changed by the nurse practitioner (NP) on 01/30/2026 because the nurses were having difficulty replacing the catheter, but the RN documented the catheter change in the MAR since the NP did not.A physician encounter dated 01/30/2026, documented nursing was having difficulty with changing foley catheter due to obstruction during insertion. This provider was notified and able to exchange foley catheter without complications. Patient tolerated exchange well. No hematuria or suprapubic pain.The medical record lacked documented evidence regarding what Foley size and balloon amount the NP used for the catheter change.On 02/12/2026 in the morning, the charge nurse stated nurses should not sign for other nurse's medication or treatment services. The charge nurse indicated not being able to explain why R177 had an 18 Fr/30 cc Foley which was not in accordance with physician orders nor did it align with the urology visit notes on 02/06/2026 where the urology staff supposedly changed R177's catheter with a 16 Fr Foley catheter.The urology visit note dated 02/06/2026, revealed a simple exchange was performed when a 16 Fr two-way Foley catheter was removed and a 16 Fr two-way (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Foley catheter was placed using standard sterile technique. The balloon was inflated with 10 cc of fluid. R177 tolerated procedure well.On 02/12/2026 at 11:18 AM, the charge nurse explained the nurses were expected to assess the Foley catheter site once every shift during the day, evening and night shift. The charge nurse indicated not being able to explain why the medical records did not align with the actual observation of R177's Foley catheter but stated any of the nurses assigned to R177 could have identified the discrepancy and reported this to the provider. The charge nurse indicated not being informed of R177's report of pain and burning at catheter site on 02/09/2026 by night shift when the resident recounted an intervention by a night nurse. On 02/12/2026 at 11:33 AM, the Unit Manager (UM) indicated being on duty when R177 was admitted on [DATE] and recalled the nurse having difficulty inserting a regular catheter, so the NP inserted a Coude (a special catheter featuring a curved or angled tip designed to navigate obstructions). The UM could not explain why R177 had an 18 Fr/30 cc Foley catheter and stated physician orders must align with actual observation.The facility policy Catheters/Indwelling Urinary - Use and Care of revised 12/16/2019, documented catheter insertions and removal required a physician order. Procedural guidelines were written in the most recent publication of Clinical Nursing Skills and Techniques adopted by the Director of Nursing Services.The Clinical Nurses Skills and Techniques (10th edition - March 12, 2021), documented to check the resident's plan of care for size and type of catheter. Use the smallest-size catheter possible - size 14 Fr to 16 Fr most common for adults and 12 Fr to 14 Fr for older adults. Document reason for catheterization, type and size of catheter inserted and amount of fluid used to inflate balloon. Resident complaints of burning and dysuria, hematuria, urgency and lower abdominal pain were to be reported as this may indicate a UTI.

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, interviews, and document review, the facility failed to ensure:Prescribed parameters for blood pressure medications were consistently followed and the physician notified of low blood pressure readings for 1 of 34 sampled residents (Resident #2); and parameters for administering prescribed pain medication were followed for 1 of 34 sampled residents (Resident #134).These deficient practices had the potential to result in the inappropriate administration of blood pressure medication, leading to hypotension, dizziness, or falls, and the inappropriate administration of pain medication, which could have resulted in inadequate pain management.Findings include:Based on record review, observations, interviews, and document review, the facility failed to ensure: Prescribed parameters for blood pressure medications were consistently followed and the physician notified of low blood pressure readings for 1 of 34 sampled residents (Resident #2); and parameters for administering prescribed pain medication were followed for 1 of 34 sampled residents (Resident #134). These deficient practices had the potential to result in the inappropriate administration of blood pressure medication, leading to hypotension, dizziness, or falls, and the inappropriate administration of pain medication, which could have resulted in inadequate pain management. Findings include: Resident #2 (R2) was admitted on [DATE] with diagnoses including hypertension, diastolic congestive heart failure, hypertensive chronic kidney disease, ventricular fibrillation, chronic venous hypertension, and presence of a cardiac pacemaker. Record review showed physician orders for Carvedilol 3.125 milligrams (mg) one tablet by mouth twice daily for hypertension and heart failure, and Amiodarone HCl 200 mg one tablet by mouth once daily for ventricular fibrillation. Both orders included prescribed parameters to hold the medications if the systolic blood pressure was lower than 110 millimeters of mercury (mmHg), or a heart rate lower than 60 beats per minute. The medication administration record (MAR) for February 2026 documented parameters for holding the administration of medication were not followed, as shown below: 01/29/2026 at 7:30 AM Amiodarone 200 mg with B/P 104/65 02/04/2026 at 7:30 AM Amiodarone 200 mg with B/P 100/55 02/04/2026 at 7:30 AM Carvedilol 3.125 mg with B/P 100/55 02/06/2026 at 7:30 AM Amiodarone 200 mg with B/P 101/67 02/09/2026 at 6:00 PM Carvedilol 3.125 mg with B/P 98/52 On 02/13/2026 at 10:30 AM, a Licensed Practical Nurse (LPN) stated nurses were expected to verify residents' vital signs, including blood pressure and heart rate, prior to administering medications with holding parameters. The LPN indicated the failure to follow these parameters could result in adverse (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	effects, such as hypotension. On 02/13/2026 at 2:30 PM, the Director of Nursing Services (DNS) confirmed both medications had been administered without following the prescribed holding parameters. The DNS stated nurses were expected to follow physician orders. The DNS indicated the nurses should have notified the attending physician for possible dose adjustment or discontinuation of the medication. The facility policy titled Medication- Administration and Treatment last revised on 11/21/2024, documented scheduled cardiovascular medications should have been held if blood pressure or pulse were outside of the established parameters prescribed by the healthcare practitioner. R134 was admitted on [DATE], with diagnoses including unspecified dementia with other behavioral disturbance and radiculopathy lumbar region and lesion of sciatic nerve. The admission minimum data set (MD) dated 09/29/2025, revealed R134 received scheduled and needed pain (prn) medications. A physician encounter note dated 09/22/2025, revealed R134 was admitted to facility with chronic lower back pain. A physician order dated 09/18/2025, documented to give Acetaminophen tablet 325 milligrams (mg), two tablets by mouth every four hours prn for mild pain. A physician order dated 02/08/2026, documented to give Hydrocodone-Acetaminophen oral tablet 5 mg-325 mg, one tablet by mouth every eight hours prn for pain rated 7-10 for 30 days. On 12/12/2026 at 8:01 AM, during a medication pass observation R134 reported a pain level of 5 out of 10 (5/10) to the lower back. A Licensed Practical Nurse (LPN) administered one tablet of Hydrocodone-Acetaminophen 5mg-325 milligrams. On 02/12/2026 at 8:17 AM, R134 indicated having lower back pain which was 4 to 5/10 on the pain scale. R134 reported receiving pain medications three times a day but did not know the name of the medications the nurses administered. On 02/12/2026 at 8:34 AM, the LPN reviewed R134's Medication Administration Record (MAR) and confirmed the Hydrocodone was not administered according to the physician order, as it was given for a pain rating of 5/10 when the order was for pain rated 7 to10. The LPN indicated there was no medication order covering pain rated 4 to 6/10 and a clarification order should have been obtained to cover the pain scale from 1to10. The facility's Pain Management policy revised 11/30/2024, documented assessments would have been done utilizing a zero (0) to 10 pain scale. Review of R134's MAR revealed Hydrocodone-Acetaminophen 5 mg–325 mg was administered below the ordered pain scale of 7 to 10/10 on the following dates: 01/12/2026: one administration at 6/10; one administration at 4/10 01/13/2026: one administration at 4/10 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/14/2026: one administration at 6/10 01/17/2026: two administrations at 6/10 01/19/2026: one administration at 6/10 01/20/2026: one administration at 4/10 01/21/2026: two administrations at 6/10 01/22/2026: one administration at 6/10 01/24/2026: one administration at 6/10 01/25/2026: two administrations at 6/10 01/26/2026: one administration at 6/10 01/27/2026: one administration at 4/10 01/29/2026: one administration at 6/10 02/01/2026: one administration at 6/10 02/03/2026: one administration at 6/10; one administration at 4/10 02/04/2026: one administration at 6/10 02/09/2026: two administrations at 6/10 02/12/2026: one administration at 5/10 (by direct observation) On 02/12/2026 at 10:37 AM, the charge nurse reviewed R134's medical record and indicated there was no pain medication order covering a pain rating of 4 to 6/10. The charge nurse indicated Tylenol was ordered for mild pain and Hydrocodone for pain rated 7 to10, and a clarification order should have been obtained. The charge nurse confirmed Hydrocodone was administered below ordered parameters on the above dates, which was not in accordance with physician orders. On 02/12/2026 at 12:30 PM, the Unit Manager (UM) confirmed physician orders were not followed when Hydrocodone was administered for a pain report of 5/10 during the medication pass earlier in the morning as well as on other dates documented on the MAR when Hydrocodone was administered below pain rating of 7 to 10. According to the UM, R134 did not have pain medication orders to cover a pain rating of 4 to 6 out of 10 and any nurse could have sought clarification orders from the physician. R134's pain management care plan initiated on 09/22/2025, documented to monitor and record pain severity, location and characteristics and administer pain medications per physician's orders. The facility's Medication Administration and Treatment policy revised 11/21/2024, documented the pain level would have been documented in the medical record with each dose of pain medication administered.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review, the facility failed to ensure an abnormal Hemoglobin A1C (HgbA1C) was communicated to and addressed by a physician for 1 of 34 sampled residents (Resident 23) and physician orders for quarterly HgbA1C blood test were carried out for 2 of 34 sampled residents (Resident 23 and 104). The deficient practice had the potential to place the residents at risk for diabetes-related complications and delayed treatment. Findings include:Resident 23 (R23) was admitted on [DATE], with diagnoses including unspecified dementia with other behavioral disturbance and diabetes mellitus. The admission minimum data set (MDS) dated [DATE], revealed R23 was admitted with an active diagnosis of diabetes mellitus and was not receiving Insulin. A physician order dated 04/30/2025, documented to complete an HgbA1C every three months by night shift on the last day of month. Review of medical record revealed R23's HgbA1C on 05/07/2025 was 7.0 percent (%). A lab interpretation note revealed the reference range for HgbA1C was 5.7 % or less while a value equal to or greater than 7.0 % reflected suboptimal blood glucose control for known diabetics.The medical record lacked documented evidence R23's HgbA1C of 7.0 % collected on 05/07/2025 was communicated to and addressed by the physician and subsequent HgbA1C were drawn on a quarterly basis in accordance with physician orders. On 02/12/2026 at 3:47 PM, the charge nurse explained it was the facility protocol to draw quarterly an HgbA1C for all residents with diabetes. The charge nurse reviewed R23's medical record and confirmed there was no documentation nursing staff communicated R23's high HgbA1C result to the physician and no documentation a provider addressed the abnormal finding. On 02/12/2026 at 3:55 PM, the charge nurse indicated R23 had behaviors of refusing care such as showers and laboratory draws but blood draws were performed on 07/21/2025, 09/17/2025, 11/19/2025, 12/26/2025 and 01/30/2026 but none of the tests included an HgbA1C which were missed opportunities to follow physician order for R23's quarterly HgbA1C draws. The charge nurse recounted R23 used to be on Metformin but the medication was discontinued on 07/18/2025 due to weight loss. On 02/12/2026 at 4:18 PM, the charge nurse indicated pharmacy may not have caught the missed lab draws due to the discontinuation of Metformin. The charge nurse verbalized if the high HgbA1C value was reported to the physician in May 2025 and quarterly draws were not missed; the provider could have considered restarting R23 on diabetes medications whether Insulin or non-Insulin. On 02/12/2026 at 4:24 PM, the unit manager (UM) indicated failure to report R23's high HgbA1c to the physician in May 2025 and missing ordered quarterly HgbA1C draws placed the resident at risk for hyperglycemia and poor blood glucose control. The facility's Laboratory Services policy revised 11/30/2024, documented laboratory services ordered for residents would have been processed and monitored and the attending physician would be notified of laboratory results which fall outside clinical reference ranges. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 104 (R104) was admitted on [DATE] with diagnoses including type 2 diabetes mellitus with hyperglycemia. Physician admission orders dated 02/05/2025, documented to add HgbA1C (a blood test that shows the average level of blood glucose or blood sugar) if the resident was diabetic at admission and every three months. R104's medical record lacked documented evidence of HgbA1C testing results for the month of November 2025. On 02/13/2026 at 12:56 PM, A Registered Nurse (RN) verified the physician order required quarterly HgbA1C testing. The RN indicated R104 had HgbA1C tests completed on 02/06/2025, 05/08/2025, and 08/06/2025. There was no documentation of HgbA1C testing completed for November 2025. The RN confirmed the test should have been performed in November 2025. On 02/13/ 2026, at 1:49 PM, the Unit Manager confirmed the physician order for R104 HgbA1C testing was to be completed quarterly and acknowledged the test should have been completed in November 2025. The Unit Manager was unsure why the test was not completed in November 2005. On 02/13/ 2026 at 2:01 PM, the Health Information Coordinator was unable to locate R104's HgbA1C laboratory results for November 2025.