STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295083	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heights of Summerlin, LLC	10550 Park Run Drive Las Vegas, NV 89144

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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 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. Based on observation, interview, and document review the facility failed to ensure 1) the kitchen was maintained in a sanitary manner, 2) there was no backed up water on the kitchen floor due to a broken drain line in the dishwasher area and a broken sewer line in the beverage area, 3) a nourishment refrigerator did not contain opened food items which were undated, and snacks were stored in proper temperature. The deficient practice placed residents at risk for foodborne illness.Findings include: On 03/24/2026 at 7:40 AM, an initial tour of the kitchen with the Assistant Dietary Manager (DM) revealed the following findings:1. Kitchen- Floor in food prep area had crumbs and other food debris more pronounced at corners and sides of food prep table. - Shelves underneath steam table dirty with dust, food crumbs and stains of unknown origin- Food transport carts dirty with stains and buildup of unknown origin- Back of oven heavy with dust and old food debris- Second food prep table dirty with old food debris and stains of unknown origin- Dirt build-up inside broiler located behind the tray line- Bulk container labeled Sugar was contaminated with oats - Top and bottom oven with heavy buildup of food debris and grease stains on glass door making it unable to visualize contents of oven.- By the two-compartment sink area, there were six clean pitchers inverted downwards on a dirty surface which was dusty with food debris.- Floors were sticky and dirty inside the walk-in freezer and refrigerator- Another gray food transportation cart was found to be dirty.- An 18-quart container of salt was dusty and dirty on the exterior. - Heavy buildup of food debris on top of the commercial dishwasherOn 03/24/2026 at 3:35 PM, the Dietary manager (DM) explained a form was created and finalized on 03/10/2026 which would ensure all kitchen tasks would be completed for kitchen cooks and dietary aides. The DM provided the forms titled: 1) Deep Cleaning schedule, 2) [NAME] cleaning schedule, and 3) Washer Daily schedule. The DM indicated the forms could not be utilized until in-services for staff were completed but the DM had not been able to provide staff in-services.The facility's Environment policy revised June 2025, documented all food preparation areas would be maintained in a clean and sanitary condition. The Dietary Manager would ensure the kitchen was maintained in a clean sanitary manner, including floors, ceilings, food service equipment and surfaces. A routine cleaning schedule would be in place for all cooking equipment, food storage areas and surfaces.2. Backed up water in kitchen due to broken drain/sewer lineOn 03/24/2026 in the morning, there was backed up water pool surrounding a drain spout in the dishwasher area. The beverage area/coffee station flooring black soot and accumulated dirt visible on the red tiles. Heavy water backed up from broken sewer line was causing the floor on the left side of beverage/coffee station to become wet.On 03/24/2026 at 8:45 AM, the Director of Maintenance (DOM) indicated being aware of the broken sewer drain causing flooding in the beverage area. According to the DOM, the drain was being vacuumed manually to evacuate water until the sewer line or main drain line could be replaced. The DOM indicated a work order had been submitted, and estimates had been obtained and was waiting on corporate approval. The DOM indicated not being informed of the broken drain line in the dishwashing area of the kitchen.The facility's Equipment policy revised September 2017, documented the Dietary Manager would submit requests for maintenance or repair to the Administrator of Director of Maintenance as needed. 3. Nourishment RoomOn 03/24/2026 at 8:15 AM, the Director of Staff (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Development (DSD) accompanied survey team to the East unit nourishment room. Inside a small refrigerator was a thermometer which read 60 degrees Fahrenheit. The refrigerator contained partially consumed butter and cream cheese with no open date, 15 cups of fruit cups, puddings and yogurt and two 46-oz thickened apple juice. The internal temperature of sampled yogurt was 52.7 degrees Fahrenheit while the apple juice 44.8 degrees Fahrenheit. The DSD indicated the unit clerks were responsible for maintaining temperature logs for nourishment room refrigerators.On 03/23/2026 at 8:50 AM, the Unit Clerk provided the temperature log for the East Unit which revealed the refrigerator temperature was 39 degrees Fahrenheit earlier in the morning. According to the Unit Clerk, the reading was taken at 8:05AM. The Unit clerk could not speak to how the temperature changed from 39 degrees Fahrenheit to 60 degrees Fahrenheit in 10 minutes. On 03/24/2026 at 8:55AM, the Dietary Manager indicated the refrigerator temperature could not have changed from 39 degrees Fahrenheit to 60 degrees Fahrenheit in 10 minutes. The DM indicated it appeared to be a case of mechanical documentation on the part of the Unit Clerk. The facility's Cold Foods policy revised February 2023 documented all perishable foods would be maintained at a temperature of 41 degrees Fahrenheit or below except during periods of preparation and service. A written record of daily temperatures would be recorded. All foods would be wrapped or stored in covered containers, labeled and dated.

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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** Based on observation interview, record review and document review, the facility failed to ensure, a baseline care plan was developed for a resident admitted with an indwelling catheter for 1 of 38 sampled residents (Resident 199). The deficient practice placed residents at risk for inadequate Foley catheter care and potential for infection. Findings include: Resident 199 (R199) was admitted on [DATE], with diagnoses including prostate cancer, benign prostatic hyperplasia and urinary tract infection (UTI).On 03/24/2026 in the morning, R199 lay awake in bed with family at bedside. A urine meter bag (a specialized drainage device with an integrated calibrated chamber attached to a larger drainage bag) hung on the left side of the bed, filled with 350 milliliters (ml) of clear yellow urine. R199 reported no one had emptied the urinary bag this morning, the Foley catheter had not been replaced since admission and no one cleansed R199's insertion site routinely. A family member indicated visiting R199 often and personally took care of R199's cleaning needs by themselves because staff were not providing care consistently.The admission minimum data set (MDS) dated [DATE], revealed R199 had intact cognition, and was admitted with an indwelling catheter. A nursing documentation evaluation completed on 03/04/2026, documented R199 was admitted with a Foley catheter device.The medical record lacked documented evidence, a baseline care plan was developed for R199's indwelling urinary catheter.On 03/24/2026 at 10:41 AM, A Registered Nurse (RN) assigned to R199 reviewed the electronic health record (EHR) confirmed R199's baseline care plan did not include the resident's indwelling urinary catheter.On 03/26/2026 at 1:45 PM, the Director of Nursing (DON) reviewed R199's EHR and confirmed there was no baseline care plan for the indwelling catheter and there should have been.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview, record review, and document review, the facility failed to ensure care plan interventions for an indwelling catheter were implemented for 1 of 38 sampled residents (Resident 199).The deficient practice placed Resident 199 at risk for inadequate Foley catheter care and potential for infection.Findings include: Resident 199 (R199) was admitted on [DATE], with diagnoses including prostate cancer, benign prostatic hyperplasia and urinary tract infection (UTI).On 03/24/2026 in the morning, R199 lay awake in bed with family at bedside. A urine meter bag (a specialized drainage device with an integrated calibrated chamber attached to a larger drainage bag) hung on the left side of the bed, filled with 350 milliliters (ml) of clear yellow urine. R199 reported no one had emptied the urinary bag this morning, the Foley catheter had not been replaced since admission and no one cleansed R199's insertion site routinely. A family member indicated visiting R199 often and personally took care of R199's cleaning needs by themselves because staff were not providing care consistently.The admission minimum data set (MDS) dated [DATE], revealed R199 had intact cognition, and was admitted with an indwelling catheter. A nursing documentation evaluation completed on 03/04/2026, documented R199 was admitted with a Foley catheter device.R199's indwelling catheter care plan initiated 03/16/2026, revealed R199 had a Foley catheter due to obstructive uropathy with a goal of not having UTI. Interventions included monitor for signs and symptoms of infection, monitor for skin irritation with daily care, monitor urine for sediments, cloudy, odor, blood and amount and report abnormalities to physician immediately and catheter care twice a day and use 16 French Foley catheter.The medical record lacked documented evidence care and management orders were obtained from the attending physician, transcribed into medical record and routine care was documented for R199's Foley catheter.On 03/26/2026 at 1:46 PM, the Director of Nursing (DON) confirmed R199's care plan for indwelling catheter initiated 03/16/2026 included interventions which were not implemented due to care orders not being entered into the medical record. The facility Comprehensive Care plan policy dated 08/25/2021, documented the inter-disciplinary team (IDT) in coordination with resident and resident's representative must develop and implement a comprehensive care plan for each resident designed to identify problem areas. Reflect currently recognized standards of practice for problem areas and conditions.

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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** Based on observation, interview, record review and document review, the facility failed to ensure a comprehensive care plan for skin integrity was reviewed and updated when a resident with existing pressure ulcers and assessed to be at high risk for developing and worsening pressure ulcers returned from hospitalization to treat an infected wound for 1 of 38 sampled residents (Resident 15). The deficient practice placed the resident at risk for recurrent wound infection. Findings include: Resident 15 (R15) was admitted on [DATE] and readmitted on [DATE], with diagnoses including quadriplegia, acute sepsis, and presence of pressure ulcers. A quarterly minimum data set (MDS) dated [DATE], documented R15 had intact cognition, was a quadriplegic, and was at risk for developing pressure ulcers, had unhealed pressure ulcers, specifically, two stage three pressure ulcers, and four unstageable pressure ulcers.A change of condition document dated 03/04/2026, revealed R15 was transferred to the hospital due to fever, weakness, confusion and drowsiness.A hospital Discharge summary dated [DATE], revealed R15 was admitted for acute sepsis and altered mental status. R15 was found to have a right hip wound with significant purulent discharge and secretions concerning osteomyelitis and septic arthritis. Infectious disease treated sepsis. Discharge to skilled nursing facility.The medical record lacked documented evidence R15's comprehensive care plan for skin breakdown was reviewed and updated when R15 returned from the hospital on [DATE].On 03/25/2026 at 11:14 AM, a House Supervisor reviewed R15's medical record confirmed R15's care plan for skin integrity was not updated by wound team upon readmission on [DATE]. According to the House Supervisor, the wound care team would have been responsible to conduct a reassessment upon return and update the care plan accordingly. The facility Comprehensive Care Plan policy dated 08/25/2021, documented assessments of residents were ongoing, and care plans were reviewed and revised as information about the resident's condition changed and when a resident was readmitted from a hospital stay.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to ensure a scheduled shower was provided for a resident who required assistance with bathing for 1 of 38 sampled residents (Resident 231). The deficient practice placed the residents at risk for infection and worsening of skin breakdown.Findings include: Resident 231 (R231) was admitted on [DATE], with diagnoses including lymphedema (swelling in body tissues usually arms and legs caused by lymphatic system not working properly), and bilateral chronic venous stasis ulcers.On 03/26/2026 in the morning, R231 indicated being admitted on [DATE] in the late afternoon but no one had provided nor offered the resident a shower since admission. R231 expressed worry over chronic wounds on bilateral legs which had been infected in the past.The admission minimum data set (MDS) dated [DATE], revealed R231 required maximal assistance with bathing.On 03/26/2026 in the morning, a certified nursing assistant (CNA) checked the shower book for R231's unit and indicated R231's showers were scheduled for Monday and Thursday afternoons. The CNA indicated not being able to locate a shower sheet for R231.On 03/26/2026 at 11:53 AM, the wound physician assistant (PA) indicated it was unfortunate the resident missed scheduled shower because it would have been an opportunity to do a skin check, relieve the resident from the compression device and cleanse and moisturize the resident's legs. On 03/26/2026 at 12:02 PM, the Registered Nurse (RN) assigned to R231 indicated reviewing the shower book and interviewed CNAs. The RN was able to confirm R231 had not been provided, offered nor re-offered a shower since admission on [DATE]. The RN indicated the resident had a scheduled shower on 03/23/2026 but the RN could not speak as to why the resident's assigned CNA did not offer or provide one. The RN verbalized the shower was missed opportunity to perform a skin assessment, relieve the resident from compression device, ensure the resident's legs were cleaned and moisturized.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to ensure 1) appropriate care and services were provided to prevent recurrent gastrostomy tube dislodgement for 1 of 38 sampled residents (Resident 239) and, care and management orders were obtained for a compression device for 1 of 38 sampled residents (Resident 231). The deficient practice placed Resident 239 at risk for repeat G-tube dislodgement and Resident 231 at risk for recurrent cellulitis. Findings include: Resident #239 (R239) was originally admitted on [DATE] and re-admitted on 02/2202026, with diagnoses including functional quadriplegia and dysphagia. The resident had a G-tube. The medical record revealed a change of condition evaluation dated 02/20/2026, indicating the G-tube was dislocated. The resident was sent to the hospital for a G-tube placement following a physician's order. Hospital records revealed R239 transferred from the nursing facility for evaluation and replacement of a gastrostomy tube that reportedly fell out spontaneously without trauma or manipulation. Facility staff and the emergency medical services (EMS) reported the patient has been at their baseline; R239 was nonverbal due to severe cognitive impairment and exhibited no acute changes in mental status. There were no reported symptoms such as fever, abdominal pain, vomiting, diarrhea, cough, or congestion. The medical record revealed three similar episodes of changes in condition related to G-tube displacement that occurred on 10/03/2025, 06/16/2025, and 05/05/2025, requiring R239 to be hospitalized for Gˆtube replacement. A physician order dated 10/09/2025 included the following Gˆtube care instructions: Change the closedˆsystem feeding spike set every shift. Administer free water flushes of 50 mL every hour. Flush the feeding tube with 5 mL of water between each medication and 30 mL of water before and after medication administration. Maintain the head of the bed elevated at least 30 degrees during feedings and for one hour afterward. Cleanse the gastrostomy site every shift. Check residuals and verify tube placement prior to each feeding, flush, or medication administration. Change the feeding syringe every night shift. The physician order did not include instructions to prevent displacement of the Gˆtube. On 03/27/2026 at 12:10 PM, a Registered Nurse confirmed the G-tube was found displaced when medications were about to be administered on 02/20/2026. The RN indicated the displacement was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not trauma related and there was no evidence to explain how the tube was dislocated. The RN indicated R239 was transported the hospital for G-tube placement and returned on 02/22/2026. The RN confirmed the history of R239's G-tube displacement and could not explain how the device was dislocated several times since the resident was quadriplegic and unable to use their hands or move. On 03/27/2026 at 12:15 PM, an observation was conducted with the RN to confirm the status of R239's G-tube. It was found R239 did not have an abdominal binder in place to prevent further G-tube dislocations. The facility did not provide a policy for G-tube care or management of G-tube dislocation. The Director of Nursing indicated staff provided G-tube care following the physician orders. Resident 231 (R231) was admitted on [DATE], with diagnoses including lymphedema (swelling of body tissues usually arms and legs caused by lymphatic system not working properly), and bilateral chronic venous stasis ulcers. On 03/24/2026 at 10:01 AM, R231 was seated in wheelchair with a pair of red socks over white compression device on bilateral lower legs. R231 expressed concerns with wound care at the facility. R231received daily wound treatments at the hospital but had been seen once by a wound nurse in the facility on 03/23/2026. R231 reported the wound nurse removed honey sheets and gauze from their legs which were from the hospital and informed R231 they were no longer needed. The resident indicated the wound nurse applied compression stockings without explaining the purpose. On 03/26/2026 at 10:33 AM, R231indicated being upset over not seeing anyone from wound care since 03/23/2026. R231 pointed to their legs and stated no one had come to remove the compression stockings since the wound nurse put them on the resident on 03/23/2026. R231 reported severe pain of 10 out of 10 (10/10) on pain scale from the compression device. A physician encounter note dated 03/23/2026, revealed the resident was admitted to the facility on [DATE] after being treated in the hospital for progressive lower extremity edema, pain, and weeping stasis with superimposed cellulitis. Antibiotic course was completed. The medical record lacked documented evidence of a physician order for a compression device and management thereof such as a wearing schedule. On 03/26/2026 at 11:11 AM, a surveyor asked the House Supervisor to remove R231's compression device and examine R231's lower extremities, the House Supervisor responded, that's not me, I won't be unwrapping anything. On 03/26/2026 at 11:24 AM, a treatment nurse knelt in front of the resident and removed the compression device with gloved hands. The nurse inspected the resident's calves and indicated there were no open lesions or discoloration but just very dry skin and significant pitting edema. The treatment nurse was present when the resident asked for pain medication due to 10/10 pain on lower legs. On 03/26/2026 at 11:53 AM, a wound physician assistant (PA) reported personally examining R231's skin and removing the honey sheets after determining the skin was intact with no open lesions. The PA stated the skin was very dry and required moisturizer and that Tubiˆgrips (a type of compression device) were applied for edema and venous insufficiency management. The PA explained Tubiˆgrips (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should be changed daily or every other day due to loss of elasticity and was unaware the device had not been removed or replaced since 03/23/2026. The PA stated the missed shower was a missed opportunity for a skin assessment, removal of the compression device, and cleansing and moisturizing of the resident's legs On 03/26/2026 at 11:27 AM, the treatment nurse indicated not being certain of use of a Tubi-grip required a physician's order and care plan, and the nurse did not clarify a wearing schedule with the PA. On 03/26/2026 at 11:44 AM, the RN assigned to R231 indicated the Tubi-grip was a compression device used for edema management and post-surgery. The RN indicated the device cannot be worn 24 hours because this could cause injury to the patient. The RN explained when encountering a resident wearing a Tubi-grip, the RN would seek clarification orders for wearing and the RN would not be applying any compression device without a physician's order. The RN Indicated Tubi-grip needed to be care planned and interventions should include, wearing schedule, cleaning the device, skin assessment daily on compressed site, report abnormality to physician. On 03/26/2026 at 2:25 PM, the Director of Nursing (DON) indicated if the device was for the purpose of compression such as edema management and venous insufficiency then a physician order would be required. According to the DON, an edema care plan should be initiated to include the use of the compression device as an intervention, putting on/removing schedule, skin monitoring and cleansing and moisturize as needed. The DON confirmed there was no order for use of a compression device for R231 with proper interventions for the management. The facility Physician Orders policy dated 03/22/2022, documented treatment orders would include a description of the treatment, including treatment site, frequency of treatment and duration of order and the condition/diagnoses for which the treatment was ordered. Orders would include description clearly enough to ensure clarity of the physician's order.

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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** Based on observation, interview, record review and document review, the facility failed to ensure a comprehensive skin assessment was performed by the wound care team upon readmission of a resident who had existing pressure ulcers and the resident was assessed as a high risk for developing and worsening pressure ulcers for 1 of 38 sampled residents (Resident 15). The deficient practice placed the residents at risk for recurrent wound infection. Findings include:Resident 15 (R15) was admitted on [DATE] and readmitted on [DATE], with diagnoses including quadriplegia, acute sepsis, and presence of pressure ulcers. A quarterly minimum data set (MDS) dated [DATE], documented R15 had intact cognition, was a quadriplegic, and was at risk for developing pressure ulcers, had unhealed pressure ulcers, specifically, two stage three pressure ulcers, and four unstageable pressure ulcers.A change of condition document dated 03/04/2026, revealed R15 was transferred to the hospital due to fever, weakness, confusion and drowsiness.A hospital Discharge summary dated [DATE], revealed R15 was admitted for acute sepsis and altered mental status. R15 was found to have a right hip wound with significant purulent discharge and secretions concerning osteomyelitis and septic arthritis. Infectious disease treated sepsis. Discharge to skilled nursing facility.The facility admission Assessment and Follow up: Role of the Nurse revised September 2012, documented an admission physical assessment would be conducted which would include a skin assessment. Supplemental assessments would be conducted following facility forms and protocols. The Nursing Documentation Evaluation dated 03/09/2026, revealed a body check by the admitting nurse identified: 1) a moisture-associated skin damage (MASD) on coccyx, 2) right hip wound with foam dressing, 3) left hip wound with foam dressing, 4) dressing on left side of neck, 5) right outer ankle wound with protective dressing, and 6) left outer ankle wound with protective dressing.The medical record lacked documented evidence a comprehensive skin assessment was completed by the wound care team upon the resident's readmission to the facility.On 03/25/2026 at 9:37 AM, R15 permitted the surveyor to be present for an activity of daily living (ADL) care observation by a certified nursing assistant (CNA). R15 was turned to left side during care which revealed a beige foam dressing over coccyx area dated 03/07. In addition, R15 had a beige protective dressing on lateral right foot dated 03/04, on right heel dated 03/04, left lateral foot dated 03/04 and left heel dated 03/04. The bilateral foot dressings were coming loose at the edges. A foul odor was evident during care in the absence of urine or feces.On 03/25/2026 at 9:37 AM, the CNA assigned to R15 indicated the foam dressing on R15's coccyx did not appear to be new, and a foul odor was more pronounced when the CNA rolled R15 to left side and came closer to visualize the foam dressing on coccyx. The CNA confirmed bilateral foot dressings were all dated 03/04/2026 and were starting to come off. The CNA indicated the dressings were most likely placed at the hospital because R15 was not in the facility on 03/04/2026 and 03/07/2026. The CNA could not speak to why the dressings had not been removed by the nurses or wound care team.On 03/25/2026 at 9:47 AM, the Registered Nurse (RN) assigned to R15 indicated not being well-versed on R15's wounds because the resident was followed by the wound care team. The RN acknowledged awareness of R15's history of a coccyx pressure ulcer and bilateral foot wounds but was uncertain whether the wounds were active or resolved. The RN expected CNAs to report any abnormalities such as old wound dressings with foul odor to the nurse who would either perform the wound care themselves or report the findings to the wound care team.On 03/25/2026 at 10:01 AM, a treatment nurse indicated being the only wound nurse for the day and had 40 residents on case load. The treatment nurse indicated the wound care team rounded on R15 yesterday to treat R15's right hip wound. The treatment nurse indicated the dressings dated 03/07 on the coccyx and 03/04 on the coccyx were most likely placed at the hospital because R15 was at the hospital during this time.On 03/25/2026 at 10:14 AM, the treatment nurse reviewed R15's electronic health record (EHR) and confirmed the wound care team did not complete an admission (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	skin assessment when R15's was readmitted on [DATE]. The treatment nurse explained there were two ways to inform the wound care team regarding residents needing to be seen by wound care upon new admission or readmission. First, a wound care team member could generate a report of new admissions and secondly, when a floor nurse completed a wound consult report in EHR.On 03/25/2026 at 10:21 AM, the RN assigned to R15 corroborated the treatment nurse's interview and stated a new admission report could be generated and nurse could complete a wound consult report within EHR which would alert the wound care team to see the resident but this did not appear to be done for R15.On 03/25/2026 at 10:23 AM, the treatment nurse indicated if they were informed R15 had returned to the facility, the wound team would have done a thorough skin assessment and obtain orders for any new or existing skin impairments. The treatment nurse confirmed there was no documented evidence clarification was sought by any nurse regarding R15's dressings on coccyx and bilateral feet.On 03/25/2026 at 10:54 AM, the treatment nurse indicated the the admitting nurse did not complete a wound consult report to alert the wound team R15 had returned from hospital and did not communicate the presence of old dressings on coccyx and bilateral feet which could be identified during care. On 03/25/2026 at 10:51 AM, the treatment nurse came out of R15's room and confirmed there was an old foam dressing dated 03/07 underneath was a healed area over bony prominence. The wound nurse confirmed R15 had old dressings dated 03/04 on bilateral feet with edges coming loose. The treatment nurse indicated R15 was at high risk for developing and worsening pressure ulcers due to being quadriplegic, poor nutrition, incontinence and other co-morbidities. The treatment nurse stated the oversight placed R15 at risk for recurrent wound infections.A Braden scale for pressure ulcer risk dated 03/23/2026, revealed R15 scored six (very high risk for developing or worsening pressure ulcers due to bedfast status, being constantly moist, completely immobile, very poor nutritional status, and friction and sheer.On 03/25/2026 at 11:14 AM, the House Supervisor reviewed R15's EHR and confirmed a comprehensive skin assessment should have been completed by the wound care team upon R15's readmission on [DATE] but this was not performed.On 03/26/2026 at 1:49 PM, the Director of Nursing (DON) indicated the admitting nurse completed a head-to-toe on 03/09/2026 identifying multiple wounds. According to the DON, a wound consult report would need to be completed for new admissions with wounds or an existing resident with new wounds therefore a wound consult form was not necessary for R15 who was already on the case load for wound care. The DON could not speak to why the hospital dressings were still on R15's lower back and bilateral feet. On 03/27/2026 in the morning, the wound physician assistant (PA) indicated wound care team typically removed hospital dressings to be able to visualize and evaluate skin condition underneath. The PA could not recall if they themselves had seen R15 recently but stated if R15's foam dressings on coccyx and bilateral feet were being used for protection, they should not be on longer than seven to 10 days as standard of practice otherwise this would place R15 at risk for recurrent wound infection.The facility's Skin Integrity Management policy dated 05/26/2021 documented the purpose of the policy was to provide safe and effective care to prevent the occurrence of pressure ulcers, manage treatment, and promote healing of wounds. A comprehensive skin evaluation was to be completed upon admission or readmission, and the physician was to be notified to obtain orders. Nursing staff were to observe any signs of potential or active pressure injuries daily or while providing nursing care.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review and document review, the facility failed to ensure proper foot hygiene and podiatry care for 1 of 38 sampled residents (Resident R86). This deficient practice placed the resident at risk for pain and foot infection. Findings include:Resident 86 (R86) was admitted on [DATE] with diagnoses including scar condition fibrosis of the skin, and chronic kidney disease stage 3A.On 03/24/2026, observation of R86's bilateral feet revealed and a brown buildup underneath the toenails on both feet. R86 reported their toenails were long and dirty and had also not been addressed.On 03/25/2026 at 11:50 AM, R86's great toenails extended approximately 1.5 inches beyond the nail bed, with brown buildup noted underneath. All toenails appeared thickened. A significant amount of brown debris was also observed on the plantar forefoot (metatarsal) areas. R86 attributed the condition to not receiving routine podiatry care. R86 reported being unable to perform personal skin care and relied on staff for assistance. R86 received bed baths on Wednesdays and Saturdays, staff had not washed the legs and feet with soap and water or applied lotion. R86 had not been seen by podiatry services for approximately four to five months.On 03/25/2026 at 12:10 PM, Certified Nurse Assistant (CNA) reported the residents' nails were thickened, discolored, and very long, and acknowledged the resident required services for nail care. On 03/25/2026 at 12:20 PM, a Registered Nurse (RN confirmed there was no documentation indicating when the resident was last seen by podiatry, nor was the resident listed for podiatry services.On 03/25/2026 at 12:35 PM, the Unit Clerk stated nursing staff notified when residents needing podiatry services. The Unit Clerk then entered the request into the podiatry log. The Unit Clerk indicated the Social Services Director was responsible for scheduling podiatry appointments for the residents.On 03/25/2026 at 1:30 PM, the Social Services Director stated nurses maintained a podiatry binder to identify residents requiring podiatry services, and social services scheduled the appointments. The Social Services Director indicated the podiatrist visited the facility once per month. Record review revealed R86 was last seen by the podiatrist on 12/17/2025. The Social Services Director confirmed the resident was due for podiatry care.The facility's policy titled foot care dated October 2022 stated residents were provided with foot care and treatments. Foot care, personal care, residents were assisted in making appointments and with transportation to and from specialists (podiatrists) as needed, and trained staff may provide routine foot care, for residents without complicating disease processes.

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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** Based on observation, interview, and record review, the facility failed to ensure a resident with nonˆweightˆbearing status was safely transferred from bed to wheelchair using a mechanical lift harness in good repair for 1 of 38 sampled residents (Resident #132). This deficient practice placed the resident at risk for an accident, fall, and injury during transfer.Findings included:Resident #132 (R132) was admitted on [DATE], with diagnoses including bilateral acute ischemic stroke.The minimum data set assessment dated [DATE] revealed R132 was dependent for chair-to-bed transfers.On 03/26/2026 at 9:49 AM, two Certified Nursing Assistants (CNA #3 and CNA #4) were observed transferring R132 from the bed to a wheelchair using a mechanical lift to assist the resident to stand. It was noted the safety straps of the grip sling were not secured, and one strap was missing its buckle. During the transfer, R132 used their arm strength to self-support by holding onto the sling loops. CNA #3 stated the safety strap was not used because the buckle clip was missing. Inspection of the mechanical lift confirmed the buckle clip for the safety strap was absent. CNA #3 acknowledged the safety strap should have been secured to prevent a potential fall.On 03/26/2026 at 11:50 AM, a Physical Therapist (PT) explained R132's last PT evaluation was in 2024 and R132 was discharged from PT services on 03/25/2024 due to reaching maximal potential and was totally assisted with transfers. The PT verbalized R132 needed maximum assistance and was dependent for bed-chair-bed transfer, the resident might have had nonˆweightˆbearing to stand and transfer, and the harness's safety strap should have been used to prevent a fall.On 03/26/2026, in the afternoon, the Administrator confirmed the buckle clip for the harness's safety strap was missing. The Administrator acknowledged the harness should not have been used in this condition, as it created an unsafe transfer.The facility's policy titled Using a Lifting Machine (undated) documented before using the mechanical lift, the resident should be assessed to determine whether the resident could assist with the transfer, and all hooks, clips, and fasteners should be examined.

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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 care and management orders for indwelling Foley catheter were obtained and implemented for 2 of 38 sampled residents (Resident 226 and Resident 199). The deficient practice had the potential to place residents at risk for infection. Findings include:Resident 226 (R226) was admitted on [DATE] and discharged on 01/11/2026 with diagnoses including polyneuropathy, acute respiratory failure and acute pulmonary edema. A Nursing Documentation Evaluation dated 12/19/2025 documented urinary devices: Foley catheter. The admission Minimum Data Set (MDS) dated [DATE] documented R226 had an indwelling Foley catheter. R226's medical record lacked physician orders for the care and management of the Foley catheter. On 03/27/2026 at 9:16 AM, the Director of Nursing (DON) reviewed R226's medical record and confirmed R226 lacked physician orders regarding care and maintenance of the Foley catheter. The DON expected monitoring and maintenance orders for the Foley catheter to have been implemented. Resident 199 (R199) was admitted on [DATE], with diagnoses including prostate cancer, benign prostatic hyperplasia and urinary tract infection (UTI). On 03/24/2026 in the morning, R199 laid awake in bed with family at bedside. A urine meter bag (a specialized drainage device with an integrated calibrated chamber attached to a larger drainage bag) hung on the left side of the bed, filled with 350 milliliters (ml) of clear yellow urine. R199 reported no one had emptied the urinary bag this morning, the Foley catheter had not been replaced since admission and no one cleansed R199's insertion site routinely. The family member indicated visiting R199 often and personally took care of R199's cleaning needs by themselves because staff was not providing care consistently. On 03/24/2026 at 10:32 AM, a certified nursing assistant (CNA) indicated not being assigned to R199 and confirmed R199's urinary bag was full and should have been emptied at start of shift by the assigned CNA. The CNA lifted blanket which revealed R199 had a French 16/10 ml balloon sized Foley catheter with white stabilizer attached to left thigh. The CNA indicated the stabilizer was undated with edges coming loose at the edges. The admission minimum data set MDS dated [DATE], revealed R199 had intact cognition, and was admitted with an indwelling catheter. An admission history and physical dated 03/03/2026, revealed R199 was treated for urinary tract infection (UTI) at the hospital. A Foley catheter was placed which improved urine retention. A nursing documentation evaluation completed on 03/04/2026, documented R199 was admitted with a Foley catheter device. The medical record lacked documented evidence, care and management orders for R199's Foley (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	catheter were obtained, transcribed into electronic health record (EHR) and carried out. On 03/24/2026 at 10:40 AM, a Registered Nurse (RN) working in the unit indicated not being assigned to R199's but accessed the resident's EHR and confirmed there were no care orders entered for R199's indwelling catheter since admission on [DATE] and therefore no documented routine care. On 03/24/2026 at 10:41 AM, the RN assigned to R199 entered the room while the CNA was emptying the resident's urinary bag. The RN confirmed the stabilizer on R199's left thigh was undated and was loose at the edges. The RN was present when R199 and family stated the Foley catheter had not been replaced since admission and cleansing of site was not being routinely performed. On 03/24/2026 at 10:41 AM, the RN left the resident's room and reviewed R199's EHR. The RN indicated being aware R199 was admitted with a Foley catheter and was treated for UTI at the hospital prior to admission. The RN confirmed care and management orders for R199's indwelling catheter were not obtained from the physician, transcribed into EHR, and therefore there was no documentation routine care was performed for the resident's Foley catheter. On 03/24/2026 at 10:44 AM, the RN explained when a resident was admitted with a Foley catheter, the nurse would obtain the following from the attending physician: 1) justification for continued use, 2) perineal cleansing every shift, 3) Foley and balloon size when device needed to be replaced for dislodgement or leakage, 4) record output if needed, and 5) assessment of site and urine characteristics and reporting abnormal findings to physician. The RN indicated there was an oversight on the part of the admitting nurse which placed the resident at risk for recurrent UTI. On 03/26/2026 at 1:32 PM, the Director of Nursing (DON) confirmed care orders were not obtained and entered by the admitting nurse which would include: 1) general order for Foley size, 2) justification for use 3) irrigation as needed 4) twice daily catheter care which included cleaning around insertion site and emptying the bag. According to the DON, no orders resulted in no documented care in the medication administration record. The Urinary Catheter policy dated 11/15/2021, documented each indwelling catheter must have a valid medical justification for use. Catheters would not be replaced on a routine basis but rather when there was leakage, dislodged or clogged. The facility's admission Assessment and Follow Up: Role of the Nurse policy (undated), documented an admission assessment would be conducted on all new residents and communicate findings of the initial assessment to the attending physician and obtain admission orders based on these findings. Complaint 2715581

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than 5%, as required. This deficient practice placed residents at risk for adverse drug outcomes, decreased therapeutic effectiveness, and compromised safety.Findings include: Resident #191 (R191) was originally admitted on [DATE] and re-admitted on [DATE] with diagnoses including chronic pain syndrome.On 03/25/2026 in the morning, medication administration observations were conducted with R191 and a Registered Nurse. Medications administered included oxycodone hydrochloride (HCl) 10 milligrams (mg) and aspirin 81 mg (entericˆcoated), both administered orally.A review of the physician's orders revealed the following:Oxycodone HCl 10 mg oral tablet: give one tablet by mouth every 6 hours as needed for moderate to severe pain. The order did not document Oxycodone was to be the immediateˆrelease formulation that was administered.Aspirin 81 mg by mouth once daily for coronary artery disease. The order did not specify the aspirin was to be the entericˆcoated form.On 03/25/2026 at 11:00 AM, a Registered Nurse (RN) verified the oxycodone order did not specify immediateˆrelease and the aspirin given was entericˆcoated rather than regular aspirin. The RN acknowledged the orders should have been confirmed prior to administration.The facility's policy titled Administering Medications (undated) documented medications were administered in accordance with the prescriber's order, and the individual administering the medications should check the label three times to ensure the correct medication before administering.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review the facility failed to ensure medications were secured for 1 of 38 sampled residents (Resident 175) expired medication was disposed of. The deficient practice had the potential for the facility staff to administer expired and contaminated medications.Findings include: Resident 175 (R175) was admitted on [DATE] with diagnoses including spina bifida with hydrocephalus, chronic respiratory failure with hypoxia, paraplegia, type 2 diabetes mellitus and dysphagia. On 03/24/2026 at 10:56 AM, the refrigerator in Resident 175's (R175) room contained: -one opened bottle of Latanoprost Solution 0.005% eye drops dated 09/06/2025. -one opened bottle of Latanoprost Solution 0.005% eye drops dated 02/11/2026. On 03/24/2026 at 11:17 AM, a Licensed Practical Nurse (LPN) confirmed the medication bottles were in the resident's refrigerator and should have been kept securely in the medicine room refrigerator. On 03/27/2026 at 8:33 AM, the Director of Nursing (DON) explained the expectation for medication storage was for medications to be safely stored on medication cart for staff to administer unless the resident had an order for self-administration of medications. The DON confirmed R175 did not have an order to keep medications at the bedside or in the resident's refrigerator. The DON stated the eyedrops should have been in the medication cart or in the refrigerator in the medication room if needed to be refrigerated. On 03/27/2026 at 12:02 PM, during an inspection of the third floor 300 high medication cart with the Assistant Director of Nursing (ADON), two bottles of Visine eye drops labeled date open 02/22/2026 were in the top drawer of the cart. The ADON explained the eye drops should have been disposed of one month after opening. The facility policy titled Storage of Medication, revised 11/2020, documented drugs and biologicals used in the facility were stored in locked compartments under proper temperature, only persons authorized to administer medications would have access to locked medications. The nursing staff was responsible for maintaining medication storage, and medications requiring refrigeration were stored in a refrigerator located in the drug room at the nurses' station or other secured locations. Medications were stored separately from food and were labeled accordingly. Discontinued, outdated, or deteriorated drugs or biologicals were returned to the dispensing pharmacy or destroyed.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and document review, the facility failed to ensure there was sufficient number of kitchen personnel to provide the residents with meals delivered timely, and at proper temperature. The deficient practice placed residents at risk for negatively impacting quality of life.Findings include: The facility assessment tool updated 08/29/2025 and reviewed by the quality assurance committee on 12/30/2025, revealed the facility was licensed for 190 beds with an average daily census of 160 residents. The staffing plan was based on resident population and their needs for care and support, with sufficient staff to meet the residents needs which included: 1) a director of dining services 2) undetermined number of cooks to prepare all meals and snacks (one to four cooks per day) and dining services aides/servers were scheduled to set up, serve and clean up meals and snacks (one to five aides/servers per meal). Staffing levels were adjusted based on census or center needs.On 03/24/2026 in the morning, the facility's census was 170.On 03/24/2026 at 7:40 AM, there were three kitchen staff members preparing meal trays for breakfast meal service. One staff member introduced themself as the Assistant Dietary Manager (DM) who indicated the other two were dietary aides.On 03/24/2026 in the morning, five residents on the 100-Hall, four residents on the 200-Hall and six residents on the 300-Hall complained about meals being served late, the food was cold and often not good (unpalatable).A tray line observation conducted on 03/27/2026 during the breakfast meal service revealed meals were served late based on the facility's delivery schedule and not at appropriate temperatures per facility policy (135 degrees Fahrenheit for hot foods and less than 41 degrees Fahrenheit for cold foods).On 03/27/2026 at 9:52 AM the dietary manager (DM) indicated the average daily census ranged from 170 to 175 residents per day. The DM reported the kitchen was staffed with one dietary manager, one assistant dietary manager who doubled as a cook and two dietary aides who also served as transporters.The dietary manager job description (undated), indicated the position was fullˆtime (40 hours per week) and responsible for managing food and kitchen supply budgets, interviewing, hiring, and orienting new dietary staff, recommending dismissals, conducting supply inventories, touring the kitchen multiple times daily to assess work quality, and performing essential duties of dietary aides, cooks, and dishwashers for training or in the event of callˆins.The assistant dietary manager job description (undated), indicated the position was hourly and responsible for assisting with staff orientation, maintaining adequate staffing levels, supervising and coordinating dining services staff during food preparation, service, and cleaning, and supporting the dietary manager with planning, budgeting, purchasing, inventory management, and required recordkeeping.The [NAME] job description (undated) described main duties included preparing and serving food including texture-modified and therapeutic diets based on facility menu. The [NAME] reviewed menus, processed diet changes, coordinated with other departments, supervised dietary aids, maintained meal schedules, prepared food conserving its nutritive value and flavor and ensured foods are palatable. Perform administrative requirements and other duties assigned by the DM.The job description of the dietary aide (undated) revealed this was an hourly position and were responsible for assisting the [NAME] during food preparation and food service. Reviewed meal tickets prior to preparing food trays, ensured appropriate equipment and utensils were provided, inspected special diets, served authorized substitute foods, transported delivery carts, cleaned food preparation area and followed cleaning schedule.On 03/27/2026 at 9:58 AM, the DM explained the facility needed one full-time DM, an assistant DM who did not double as a Cook, one full-time [NAME] and an Assistant [NAME] or food preparer, three dietary aides not counting the ones responsible for transporting food. The DM indicated there were two call-ins today and staff turnover was high, specifically, there had been 12 kitchen staff who had quit since December 2025 stating, hard work and low pay. The District Manager was present when the DM verbalized the kitchen was short-staffed and delivery times were hard to meet which impacted quality of food (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	served.On 03/27/2026 at 10:00 AM, the District Manager was aware of the DM's concerns regarding short-staffing and resident food concerns. The District Manager tried to resolve issues with the Administrator and the Director of Operations for the third-party vendor, but the agreement allocated 59 budget hours (total hours worked by all kitchen staff per day). The District Manager indicated covering six facilities in the area and stated 59 budget hours was low compared to other facilities.On 03/27/2026 at 10:41 AM, the Administrator indicated kitchen services were provided by a third-party vendor responsible for staffing the kitchen. The Administrator hired by the facility in August 2025, had been communicating with the Executive Director of the contracted vendor. The Administrator explained the former DM lacked the capacity to fulfill the role and separated from the company. The current DM was already working in the kitchen under a different role and started as DM in December 2025.On 03/27/2026 at 10:50 AM, the Administrator indicated not being made aware there had been 12 kitchen staff who resigned since the new DM started in December 2025 which the Administrator found concerning. The Administrator had expressed disappointment regarding the third-party vendor and was aware of resident food concerns which were constantly being communicated to senior leadership of the third-party vendor.On 03/27/2026 at 11:05 AM, the Administrator emphasized kitchen staffing concerns had not been brought to their attention. The Administrator expected to be informed of staffing levels and budgeted hours could be discussed. The Administrator indicated if the facility were not relying on a third-party vendor, kitchen staffing would be based on the facility assessment. For an average daily census of 170, the Administrator would staff one DM, four cooks, five aides/servers/transporters and an assistant DM who will not double as a cook. The Administrator indicated adequate staffing levels would allow meals to be delivered on time and at proper temperature.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295083	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heights of Summerlin, LLC	10550 Park Run Drive Las Vegas, NV 89144

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and document review, the facility failed to ensure food was not served late and at appropriate temperatures per facility policy. The deficient practice had the potential to negatively impact residents' quality of life.Findings include: On 03/24/2026 in the morning, the facility's census was 170.On 03/24/2026 at 7:40 AM, there were three kitchen staff members preparing meal trays for breakfast meal service. One staff member introduced themself as the Assistant Dietary Manager (DM) and indicated the other two were dietary aides.On 03/24/2026 in the morning, five residents in the 100-Hall, four residents in the 200-Hall and six residents in the 300-Hall complained about meals being served late, food was cold and often not good (unpalatable).On 03/27/2026 in the morning, the Dietary Manager (DM), cook and a dietary aide were on the service line where temperatures were taken for the following food items:Oatmeal: 197 degrees FahrenheitRegular Ham: 186 degrees FahrenheitPureed Ham: 183 degrees FahrenheitPancakes: 101 degrees FahrenheitThe Meal Delivery Times document revealed the 200-Hall was the last unit served with breakfast service scheduled from 8:10 AM to 8:35 AM.On 03/27/2026 at 8:45 AM, the last cart arrived at the 200-Hall. After the last resident was served at 9:02 AM, internal temperatures for the regular and mechanically altered test trays were taken by the District Manager with the surveyor, as follows:Regular ham: 109.9 degrees FahrenheitPureed ham: 120.5 degrees FahrenheitPancake: 101 degrees FahrenheitFresh milk: 52.0 degrees FahrenheitApple juice: 39.7 degrees FahrenheitThe facility's Food Preparation policy revised February 2025, documented all foods would be held at appropriate temperatures, greater than 135 degrees Fahrenheit for hot foods and less than 41 degrees Fahrenheit for cold foods.On 03/27/2026 at 9:48 AM, the Dietary Manager indicated the facility had nine carts with one transporter assigned to deliver carts to units. The District Manager confirmed the last cart arrived at the 200-Hall at 8:45 AM which was considered late. The Dietary Manager and District Manager indicated hot foods were ideally served at 135 degrees Fahrenheit and cold foods below 41 degrees Fahrenheit, both confirmed breakfast service was delivered late, and food was served not at appropriate temperatures per facility policy.On 03/27/2026 at 1:30 PM, a Licensed Practical Nurse (LPN) and three certified nursing assistants (CNAs) were standing by the elevator of the 200-Hall. The staff members indicated they were waiting on the lunch cart to arrive, but they were used to it being delivered late. Resident 150 was sitting outside room and overheard the discussion and interrupted stating I have been here a long time, and the food is always late and cold.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295083	A. Building B. Wing	03/27/2026

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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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure expired food items were discarded from 2 of 38 sampled resident refrigerators (Resident 151 and Resident 175). The deficient practice had the potential for expired foods to be consumed, which could lead to foodborne illness.Findings include:Resident 151 (R151) was admitted to the facility on [DATE] with diagnoses including epilepsy, pneumonia, dysphagia, type 2 diabetes mellitus, schizophrenia and dementia.On 03/24/2026 at 10:34 AM, the refrigerator in Resident 151's (R151) room contained:-one opened 1.89-liter bottle, Lucerne reduced fat milk, expired 03/19/26.-one unopened six-ounce container, Yoplait original yogurt, strawberry cheesecake flavored, expired 02/25/26. On 03/24/2026 at 10:45 AM, a Certified Nursing Assistant (CNA1) confirmed the expired findings in R151s refrigerator. CNA1 was unsure who removed expired food items from the resident refrigerators. CNA1 stated expired items would be discarded as the items were inedible and R151would get ill if the items were consumed.On 03/24/2026 at 10:50 AM, a Licensed Practical Nurse (LPN1) confirmed the expired items remained in R151's refrigerator. LPN1 explained staff on light duty were responsible for checking expiration dates and removing expired food items from residents' refrigerators. LPN1 explained expired items needed to be removed to prevent severe diarrhea, vomiting or hives in the residents. LPN1 stated if a resident consumed expired food items a change of condition form would be completed and an incident report followed.Resident 175 (R175) was admitted to the facility on [DATE] with diagnoses including spina bifida with hydrocephalus, chronic respiratory failure with hypoxia, paraplegia, type 2 diabetes mellitus and dysphagia.On 03/24/2026 at 10:56 AM, the refrigerator in Resident 175's (R175) room contained:-one opened 14 ounce bottle, French's yellow mustard, expired 02/10/2026.-two opened 12 fluid ounce bottles, [NAME] tartar sauce, expired 10/16/2024 and 10/18/2024.-one opened 16 fluid ounce bottle, [NAME] ranch dressing, expired 09/23/2025.-one opened 12 fluid ounce bottle, [NAME] real mayo, expired 02/27/2026.-two butterscotch pudding pack containers, expired 03/16/2026.On 03/24/2026 at 11:15 AM, a Certified Nursing Assistant (CNA2) confirmed the expired findings in R175's refrigerator. CNA2 explained CNAs were responsible for discarding expired items from the resident refrigerators. CNA2 stated expired items were kept in resident refrigerators if they had no odor and would not be thrown out but would instead notify a nurse.On 03/24/2026 at 11:17 AM, a Licensed Practical Nurse (LPN1) confirmed the expired items in R175's refrigerator. LPN1 explained the expired items must be discarded to prevent illness.On 03/27/2026 at 8:33 AM, the Director of Nursing (DON) was unsure of the expectation and process for expired foods in resident rooms. The facility policy titled Food Brought by Family/Visitors, revised on 03/31/2025, documented when food items were intended for later consumption, the responsible staff member labeled foods with the resident's name, and the current date and use by date. Items would be thrown out after 48 hours. Items not open followed the manufacturer's use by date.