STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wingfield Skilled Nursing and Rehabilitation Cente	2350 Wingfield Hills Rd Sparks, NV 89436

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on interview, clinical record review, and document review the facility failed to protect a resident from being kicked by another resident for 1 of 8 sampled complaint and Facility Reported Incident (FRI) residents (Resident #5). Findings include: Resident #5 Resident #5 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including cognitive communication deficit and major depressive disorder, recurrent, in partial remission. Resident #6 Resident #6 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, vascular dementia, moderate, with agitation, and schizoaffective disorder, bipolar type. FRI #NV00070234, dated 01/16/24, documented Resident #5 reported to the Licensed Social Worker (LSW) the resident was kicked in the leg by Resident #6, resulting in a bruise on Resident #5's left knee. A social services progress note dated 01/16/24, in Resident #5's clinical record, documented Resident #5 reported to the LSW the resident was kicked in the leg by another resident. An incident note dated 01/16/24, in Resident #5's clinical record, documented a circular, raised, purple, discolored site below the resident's left knee. On 02/28/24 at 1:59 PM, the Director of Nursing (DON) verbalized the DON was aware of the incident on 01/16/24 when Resident #5 reported to the LSW the resident was kicked in the leg by Resident #6. The DON verbalized Resident #6 was not exhibiting verbally or physically aggressive behaviors for a while prior to kicking Resident #5 on 01/16/24. The DON explained behavior monitoring was supposed to be included in the care plan and was documented on the task screen in a resident's electronic medical record. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2024

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Follow Up Question Report (behavior monitoring) for Resident #6 documented Resident #6 exhibited the following behaviors: -yelling out and/or at others on 12/06/23, 12/07/23, 12/08/23, 12/23/23, 12/28/23, and 01/14/24. -yelling/screaming on 12/23/23. A behavior note dated 09/19/23, documented Resident #6 screamed at another resident when the other resident accidentally bumped into Resident #6's walker. A nursing progress note dated 11/19/23, documented Resident #6 was yelling and verbally abusive toward staff. A behavior note dated 12/15/23 at 6:55 AM, documented Resident #6 was in Resident #5's room. Resident #6 was described as confused, argumentative, yelling and would not allow a Certified Nursing Assistant (CNA) to check Resident #5's vital signs. Resident #5 exited the room. Resident #5's blood pressure was noted to be elevated at 210/126. Resident #5 verbalized to nursing staff Resident #5 had a problem with Resident #6. Resident #6 was escorted back to Resident #6's room. Resident #5 was documented to have been able to calm down in the absence of Resident #6. A behavior note dated 12/31/23 at 5:26 AM, documented Resident #6 was found in room [ROOM NUMBER]. room [ROOM NUMBER] belonged to Resident #5. Resident #6 was shouting and asking staff to make Resident #5 leave the room. Resident #6 was assisted back to Resident #6's room. Resident #6 verbalized to nursing staff the two residents were arguing and it made Resident #6 angry. Resident #6's care plan documented a focus of the resident demonstrating verbally aggressive behaviors as evidenced by yelling out and at others related to dementia and anxiety, date initiated was 06/21/23. Interventions included: -Analyze key time, places, circumstances, triggers, and what de-escalates behavior and document, date initiated was 06/21/23. -Assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, etc., date initiated was 06/21/23. -Assess resident's coping skills and support system, date initiated was 06/21/23. -Assess resident's understanding of the situation. Allow time for the resident to express self and feelings towards the situation, date initiated was 06/21/23. -Give the resident as many choices as possible about care and activities, date initiated was 06/21/23. Resident #6's clinical record lacked documented evidence of revision of care planned interventions for verbally aggressive behavior following documented episodes of verbally aggressive behavior. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Wingfield Skilled Nursing and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 2350 Wingfield Hills Rd Sparks, NV 89436	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/27/24 at 2:22 PM, the LSW and the Regional Director of Social Services (RDSS) verbalized abuse was the willful intent to cause harm such as unwanted touching or physical acts, or anything causing a mark on a resident's body. The LSW explained the process if a resident reported an allegation of abuse from another resident was to separate the residents immediately and notify the Administrator. On 02/27/24 at 2:28 PM, when asked if the LSW was aware of the incident reported to have occurred between Resident #5 and Resident #6, the LSW responded which one? The LSW explained Resident #5 and Resident #6 were in a romantic relationship and Resident #6 slept in Resident #5's bed on more than one occasion. On 02/27/24 at 2:30 PM, the LSW recalled on 01/16/24, Resident #5 reported Resident #6 had kicked Resident #5 in the leg, resulting in a bruise on Resident #5's left knee. The LSW recalled during the week prior to 01/16/24, Resident #5 had asked social services for assistance in ending the relationship with Resident #6. On 02/27/24 at 3:00 PM, the Administrator verbalized abuse was the willful infliction of harm. The Administrator confirmed the Administrator was aware of the allegation of abuse reported to the LSW by Resident #5 on 01/16/24. The Administrator confirmed Resident #6 had been verbally aggressive toward staff prior to 01/16/24 however, denied any knowledge of previous altercations between Resident #5 and Resident #6. On 02/27/24 at 3:50 PM, during an interview with the DON and the Administrator, the DON and Administrator reviewed Resident #6's nursing progress note dated 12/31/23 at 5:26 AM, and confirmed Resident #6 entering another resident's room and shouting for them to be removed from the room was considered verbally aggressive behavior. On 02/27/24 at 4:04 PM, the DON verablized interventions in place for Resident #6 to prevent abuse of other residents included redirection from staff, activities, offering snacks or drinks, or something to keep the resident occupied. When asked if these interventions would have aided in preventing Resident #6 from kicking Resident #5 while the residents were in bed together, the Administrator admitted it was tough to say as it was difficult to predict Resident #6's behavior. The facility policy titled, Abuse Prevention Program, written 04/2016 and adopted by the facility on 02/01/19, documented residents had the right to be free from abuse including physical abuse. The facility policy titled, Resident-to-Resident Altercations, written 12/2016 and adopted by facility on 02/01/19, documented staff would monitor residents for aggressive/inappropriate behavior towards other residents or staff. If two residents were involved in an altercation, staff would review possibly measures to try to prevent additional incidents, make any necessary changes to the care plan approaches and document all interventions and their effectiveness. FRI #NV00070234 Cross reference with F609

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on interview, clinical record review, and document review the facility failed to report an allegation of abuse to the State Agency (SA) within the required timeframe. Findings include: Resident #5 Resident #5 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including cognitive communication deficit and major depressive disorder, recurrent, in partial remission. A social services progress note dated 01/16/24 at 9:25 AM, documented Resident #5 reported to the Licensed Social Worker (LSW) the resident was kicked in the leg by another resident. The initial Facility Reported Incident (FRI) #NV00070234 was submitted to the SA on 01/16/24 at 6:51 PM. The incident was documented as physical abuse. On 02/27/24 at approximately 3:00 PM, the Administrator verbalized all types of abuse were to be reported to the SA. The Administrator confirmed allegations of physical abuse were required to be reported to the SA within two hours of becoming aware of the allegation. The Administrator confirmed the Administrator was notified of the allegation Resident #5 was kicked by another resident in the afternoon on 01/16/24. On 02/27/24 at approximately 3:30 PM, the Administrator confirmed the initial report for FRI #NV00070234 documented the Administrator was made aware of the allegation of abuse at 4:30 PM and the initial report was submitted at 6:51 PM, later than the two hour reporting requirement. The facility policy titled, Abuse Prevention Program, written 04/2016 and adopted by the facility on 02/01/19, documented the Administrator would investigate and report any allegations of abuse within timeframes as required by federal requirements. The facility policy titled, Resident-to-Resident Altercations, written 12/2016 and adopted by facility on 02/01/19, documented resident altercations would be reported to appropriate agencies as outlined in the facility's abuse reporting policy. The facility policy titled, Abuse Investigation and Reporting, written 07/2017 and adopted by the facility on 02/01/19, documented all allegations of abuse would be reported by the facility administrator or the administrator's designee to the state licensing/certification agency responsible for surveying/licensing the facility. Allegations of abuse would be reported immediately but no later than two hours if the alleged violation involved reasonable suspicion of a crime or resulted in serious bodily injury. FRI #NV00070234 (continued on next page)

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	295088	A. Building B. Wing	02/27/2024

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cross reference with F600

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NAME OF PROVIDER OR SUPPLIER: Wingfield Skilled Nursing and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE: 2350 Wingfield Hills Rd Sparks, NV 89436	

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31739 Based on clinical record review, document review and interview, the facility failed to include in the written Notice of Transfer or Discharge provided to residents for January 2024, the reason for transfer or discharge, the effective date and/or the location of the transfer or discharge for 8 of 36 discharged residents in January 2024 (Resident #3, #9, #10, #11, #12, #13, #14, and #15). Finding include: Resident #3 Resident #3 was admitted to the facility on [DATE], with diagnoses including chronic obstructive pulmonary disease, unspecified, type II diabetes mellitus without complications, acute and chronic respiratory failure with hypoxia, chronic systolic (congestive) heart failure, unspecified asthma, uncomplicated, and paroxysmal atrial fibrillation. Resident #3's Notice of Transfer or Discharge with a notification date of 01/28/24, lacked an effective date and a reason for the transfer or discharge. Resident #9 Resident #9 was admitted to the facility on [DATE], with diagnoses including arthropathic psoriasis, unspecified, dyspnea, unspecified, cognitive communication deficit, dysphagia, oropharyngeal phase, essential (primary) hypertension, and unspecified atrial fibrillation. Resident #9's Notice of Transfer or Discharge with a notification date of 01/12/24, lacked a reason, an effective date, and the location of the transfer or discharge. Resident #10 Resident #10 was admitted to the facility on [DATE], with diagnoses including acute respiratory failure with hypoxia, atherosclerotic heart disease of native coronary artery without angina pectoris, aneurysm of heart, unspecified diastolic (congestive) heart failure, cognitive communication deficit, and essential (primary) hypertension. Resident #10's Notice of Transfer or Discharge with a notification date of 01/13/24, lacked an effective date and a reason for the transfer or discharge. Resident #11 Resident #11 was admitted to the facility on [DATE], with diagnoses including encounter for orthopedic aftercare following surgical amputation, acquired absence of left leg above knee, acute posthemorrhagic anemia, peripheral vascular disease, unspecified, and gangrene, not elsewhere classified. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Resident #11's Notice of Transfer or Discharge with a notification date of 01/13/24, lacked an effective date and a reason for the transfer or discharge. Resident #12 Resident #12 was admitted to the facility on [DATE], with diagnoses including unspecified sequelae of cerebral infarction, dysphagia, oropharyngeal phase, other vascular syndromes of brain in cerebrovascular diseases, anxiety disorder, and major depressive disorder, recurrent, unspecified. Resident #12's Notice of Transfer or Discharge with a notification date of 01/10/24, lacked a reason and the location of the transfer or discharge. Resident #13 Resident #13 was admitted to the facility on [DATE], with diagnoses including pressure ulcer of left hip, stage four, sepsis, unspecified organism, and functional quadriplegia. Resident #13's Notice of Transfer or Discharge with a notification date of 01/12/24, lacked a reason, an effective date, and the location of the transfer or discharge. Resident #14 Resident #14 was admitted to the facility on [DATE], with diagnoses including acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia, chronic obstructive pulmonary disease, unspecified, cognitive communication deficit, unspecified atrial fibrillation, generalized anxiety disorder, and depression, unspecified. Resident #14's Notice of Transfer or Discharge with a notification date of 01/23/24, lacked a reason and the location of the transfer or discharge. Resident #15 Resident #15 was admitted to the facility on [DATE], with diagnoses including encounter for surgical aftercare following surgery on the circulatory system, type II diabetes mellitus with unspecified complications, acute kidney failure, acute respiratory failure with hypoxia, and anemia, unspecified. Resident #15's Notice of Transfer or Discharge with a notification date of 01/30/24, lacked a reason, an effective date, and the location of the transfer or discharge. On 02/27/24 at 2:00 PM, the Discharge Planner, confirmed the Notice of Transfer or Discharge provided to Residents #3, #9, #10, #11, #12, #13, #14, and #15 in January 2024, had not been completed with the reason, the effective date and/or the location of the transfer or discharge. The Discharge Planner confirmed the reason, the effective date and/or the location of the transfer or discharge must be documented on the Notice of Transfer or Discharge when provided to the resident. The Discharge Planner verbalized nursing staff had completed the Notice of Transfer or Discharge provided to Residents #3, #9, #10, #11, #12, #13, #14, and #15 in January 2024. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	On 02/27/24 at 2:38 PM, the Director of Nursing (DON), confirmed nursing staff had prepared and provided the Notice of Transfer or Discharge to Residents #3, #9, #10, #11, #12, #13, #14, and #15 in January 2024, and the forms lacked the reason, the effective date and/or the location of the transfer or discharge. The DON confirmed the reason, the effective date and/or the location of the transfer or discharge should have been documented on the Notice of Transfer or Discharge when the notice was provided to the resident. The facility policy titled, Bed-Holds and Returns, with an adoption date of 02/01/19, documented prior to a transfer, written information would have been given to residents and resident representatives explaining the details of the transfer, per the Notice of Transfer. CPT #NV00070406

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46301 Based on observation, interview and document review, the facility failed to ensure kitchen equipment temperature logs were completed daily and hand hygiene supplies were available for dietary staff to wash their hands at hand washing stations with the ability to affect 119 of 119 residents. Findings include: Temperature Logs On 02/27/24 at 8:50 AM, a tour of the kitchen was conducted, and for temperature logs were hanging on the side of a reach-in refrigerator. The following logs documented the most recent temperatures of kitchen equipment: -Fridge and Freezer temperature log last completed 02/21/24 -Front fridge temperature log last completed 02/24/24 -Front fridge temperature log last completed 02/20/24 -Dishwashing and rinsing temperature log last completed 02/21/24 On 02/27/24 at 9:34 AM, the Food Services Manager (FSM) verbalized the expectation was all the logs were to be completed daily to ensure proper functioning of the kitchen equipment and ensure the residents would not become ill from faulty equipment. The FSM confirmed the logs were not up to date and was unsure if all kitchen equipment was functioning properly. The facility policy titled, Dishwashing Machine Use, adopted 02/01/19, documented the operator would check temperatures using the machine gauge with each dishwashing machine cycle and record the result in a facility approved log. Inadequate temperatures would be reported to the supervisor. The facility policy titled, Refrigerators and Freezers, adopted 02/01/19, documented Food Services Supervisors or designated employees would check and record refrigerator and freezer temperature daily and nightly. Hand Washing On 02/27/24 at 8:50 AM, a tour of the kitchen was conducted, and there were no paper towels at any of the three hand washing sinks. On 02/27/24 at 8:51 AM, the Assistant Food Services Manager explained normally being the person who ensured paper towels were stocked. The Assistant Food Services Manager confirmed all three hand washing sinks paper towel dispensers were empty and explained it was important to have paper towels to wash and dry hands appropriately. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Wingfield Skilled Nursing and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 2350 Wingfield Hills Rd Sparks, NV 89436	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled, Handwashing/Hand Hygiene, adopted 02/01/19, documented the importance of hand hygiene was to prevent the transmission of healthcare-associated infections. Hand hygiene product and supplies, such as towel, sinks and soap shall be readily accessible and convenient for staff to use to encourage compliance with hand hygiene policies. CPT# NV00070213