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No. 0938-0391

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 12/05/2024
NAME OF PROVIDER OR SUPPLIER: Wingfield Skilled Nursing and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE: 2350 Wingfield Hills Rd Sparks, NV 89436	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34524 Based on interview, record review, and document review, the facility failed to ensure a resident was treated with dignity and respect when the staff did not provide brief changes and the resident was left wet overnight for 1 of 23 sampled residents (Resident #36). This had the potential to cause psychosocial distress to the resident. Findings include: Resident #36 Resident #36 was admitted to the facility on [DATE], with diagnoses including rhabdomyolysis, a disease which causes muscle pain and weakness and trouble moving arms and legs, repeated falls, muscle weakness, unsteadiness on feet, other reduced mobility, and pressure ulcer of sacral region, unspecified stage. On 12/02/2024 at 9:28 AM, Resident #36 verbalized the resident was ignored by the night shift staff and was only receiving a brief change once overnight. The resident explained the night shift staff should change the resident every two to three hours, however the staff only came in and changed the resident once, shortly before the morning shift came on duty. The resident would spend the night wet; the resident's linens and disposable absorbent under pad would be wet as well. The resident verbalized the staff would change the brief, but not the wet bedding, so the resident would be uncomfortable even though the brief was changed. The resident explained they were extremely stiff and weak, as well as incontinent, and was unable to get up and use the bathroom. The resident relied on the staff for incontinent care. The resident verbalized the resident had informed trusted staff the following morning, as well as the Social Worker, who responded they would look into the resident's concerns. On 12/03/2024 at 2:49 PM, a Certified Nursing Assistant (CNA) verbalized they worked with Resident #36 and the resident was incontinent, needed maximum assistance for all activities of daily living (ADLs), and required a Hoyer lift for transfers. The resident was very stiff, and staff needed to be careful and take their time when providing care. The resident was able to make their needs known and used the call light to request assistance. (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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	295088	A. Building B. Wing	12/05/2024

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The CNA recalled Resident #36 had told the CNA the resident was not changed overnight several times. The CNA explained Resident #36 was truthful and easy going about cares and if the resident stated they had not been changed frequently enough, the CNA believed the resident. The CNA felt the resident was only changed once overnight and the disposable pad under the resident was damp at times. The CNA informed the Unit Manager nurses of the resident's concerns each time the resident had complaints of care. On 12/04/2024 at 11:48 AM, Resident #36 verbalized the resident was being ignored by staff at night and was still having trouble being changed overnight. The resident explained they laid in urine all night long the previous night. Staff would change the resident once; however the resident was so soaked with urine, the disposable pads and bedding under the resident was wet. The night staff did not change the resident's bedding when they changed the residents brief, resulting in the resident laying in an uncomfortably damp bed. The resident was frustrated because they could not get up and walk to the bathroom due to paralysis and their legs not working. The night shift staff would enter the resident's room and turn off the call light, stating they would return, but did not come back. The resident felt ignored, lying in bed helpless all night. The resident verbalized the resident had told morning staff and the Social Worker of their concerns of lack of care overnight. On 12/04/2024 at 3:23 PM, the Licensed Social Worker (LSW) verbalized Resident #36 informed the LSW at least once a week they were not being changed overnight. The LSW explained the resident had made several complaints about staff not caring for them overnight and the resident thought everyone was ignoring them. On 12/04/2024 at 4:09 PM, the Director of Nursing (DON) verbalized incontinent residents should be changed every two hours and/or as needed and lack of care could impact their dignity. The facility policy titled Residents Rights, undated, documented residents had the right to be treated with consideration, respect, and dignity. The facility policy titled Urinary Continence and Incontinence - Assessment and Management, dated 02/01/2019, documented a check and change strategy involved checking the resident's continence status at regular intervals and using incontinence devices or garments. The primary goals were to maintain dignity and comfort and to protect the skin. Cross Reference Tags 585, 677, and 745

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35601 Based on interview, clinical record review and document review, the facility failed to ensure a resident gave informed consent prior to the administration of a psychotropic medication for 1 of 23 sampled residents (Resident #80). This deficient practice had the potential for a resident to experience adverse side effects of a medication without deciding if the benefit to the resident was greater than the risk. Findings include: Resident #80 Resident #80 was admitted to the facility on [DATE], with a diagnosis of depression, unspecified. The physician's order dated 10/17/2024, documented Escitalopram Oxalate oral tablet 5 milligrams, give one tablet by mouth in the morning for depression as evidence by lack of energy and feeling of sadness. The Psychoactive Medications Disclosure and Consent form signed 12/05/2023, did not indicate if the resident accepted or declined the Escitalopram. On 12/05/2024 at 8:45 AM, the Director of Nursing (DON) verbalized the consent form should have indicated if the resident accepted the medication prior to administration. The DON confirmed the resident was scheduled for administration and received it in the morning. The facility policy titled, Psychoactive Medication Use, adopted 02/01/2019, documented psychoactive substances will not be initiated until the resident or guardian's consent was received. The facility policy titled, Resident Rights, adopted 02/01/2019, documented the resident had the right to be informed in advance of the risks and benefits of proposed care.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34524 Based on interview, record review, and document review, the facility failed to ensure a grievance process was initiated, an investigation was conducted, and a verbal or written response was communicated to the resident regarding their concerns for the lack of incontinent care provided overnight for 1 of 23 sampled residents (Resident #36). This deficient practice had the potential to allow a resident's complaints of care to not be investigated and a resident provided with a resolution. Findings include: Resident #36 Resident #36 was admitted to the facility on [DATE], with diagnoses including rhabdomyolysis, a disease which causes muscle pain and weakness and trouble moving arms and legs, repeated falls, muscle weakness, unsteadiness on feet, other reduced mobility, and pressure ulcer of sacral region, unspecified stage. On 12/02/2024 at 9:28 AM, Resident #36 verbalized the resident was ignored by the night shift staff and was only receiving a brief change once overnight. The resident explained the night shift staff should change the resident every two to three hours, however the staff only came in and changed the resident once, shortly before the morning shift came on duty. The resident would spend the night wet; the resident's linens and disposable absorbent under pad would be wet as well. The resident verbalized the staff would change the brief, but not the wet bedding, so the resident would be uncomfortable even though the brief was changed. The resident explained they were extremely stiff and weak, as well as incontinent, and was unable to get up and use the bathroom. The resident relied on the staff for incontinent care. The resident verbalized the resident had informed trusted staff the following morning, as well as the Social Worker, who responded they would look into the resident's concerns. On 12/03/2024 at 2:49 PM, a Certified Nursing Assistant (CNA recalled Resident #36 had told the CNA the resident was not changed overnight several times. The CNA informed the Unit Manager nurses of the resident's concerns each time the resident had complaints of care. On 12/04/2024 at 11:48 AM, Resident #36 verbalized the resident was being ignored by staff at night and was still having trouble being changed overnight. The resident verbalized the resident had told morning staff and the Social Worker of their concerns of lack of care overnight. On 12/04/2024 at 3:23 PM, the Licensed Social Worker (LSW) verbalized when a resident had concerns about staff not providing care, the LSW would notify the nursing Unit Managers of the resident's concerns. If the complaints were habitual, the LSW would submit a grievance on behalf of the resident. An investigation into the resident's concerns would be initiated and would include interviews with the resident of concern, other residents on the hall, and the care staff assigned. The LSW clarified a resident did not have to formally request to file a grievance in order for the LSW to submit a grievance. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The LSW verbalized Resident #36 informed the LSW at least once a week they were not being changed overnight. The LSW recalled Resident #36 thought everyone was ignoring the resident. The LSW explained they were not sure if the resident had been diagnosed with delusions and the LSW did not submit a grievance on behalf of the resident because the resident was a big ball of anxiety and the LSW felt the resident's concerns were not really happening. The LSW was not sure if the care was lacking because the resident complained about day shift as well. The LSW decided it was better to work with the resident's psychosocial needs by listening, validating, and performing breathing exercises with the resident. The LSW further explained they would not submit a grievance for this resident's complaints because they would not want the investigation to be unsubstantiated and then the resident be known as the one who made complaints about their care. The LSW further explained the LSW did not feel the resident's complaints of lack of care arose to the level of a grievance. The LSW explained they verbally notified the Unit Manager nurses and the DON of the resident's concerns regarding lack of care. The LSW explained the Unit Managers would conduct an investigation. The LSW was not aware if an investigation was conducted. The LSW did not receive an outcome from the Unit Managers, nor did the LSW follow up with the Unit Managers or the Director of Nursing (DON) for their findings into the matter and did not document the resident's concerns, notification, and outcome, however the LSW thought the outcome was the concerns were unfounded. On 12/04/2024 at 4:02 PM, the Unit Manager/Licensed Practical Nurse (LPN) verbalized they were made aware of the resident concerns regarding lack of brief changes overnight just today and once in October. The Unit Manager verbalized they could not recall what actions were taken in October; however, they believe they spoke with the staff regarding the resident's complaints. The Unit Manager explained the resident was very anxious. The Unit Manager verbalized they would have notified the DON of the resident's complaints. On 12/04/2024 at 4:09 PM, the DON verbalized the DON had not been made aware of Resident #36's concerns from the LSW or the Unit Managers. The DON was not aware of the resident's complaints of lack of care overnight and if they had been notified, the DON would have started an investigation immediately, interviewing the resident, other residents in the hall, and staff involved in the resident's care. The DON confirmed the DON was not notified of the resident complaints by the Unit Managers or the LSW and the DON would expect to be notified right away. The DON confirmed the DON had not spoken with the resident regarding their complaints. The signed job description for the Licensed Social Worker, dated 12/14/2022, documented the primary purpose of the job position was to support the day-to-day needs of the residents within the facility, participated in resident care management, actively participated in care coordination, and assured social services progress notes were informative and descriptive of the services provided and of the resident's response to the service. The facility policy titled Grievances and Complaints, Filing, dated 02/01/2019, documented residents had the right to file grievances and make complaints, either orally or in writing, to the facility staff. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy defined the following: Complaint: stems from minor issues which can usually be resolved by the staff members who were present when a resident verbalized a concern. Unresolved complaints could turn into grievances. Grievance: a more serious concern with respect to care and treatment which has been furnished as well as which has not been furnished. Any resident may file a grievance or complaint concerning care or treatment. Grievances may also be voiced or filed regarding care which has not been furnished. Residents had the right to voice or file grievances without discrimination or reprisal in any form, and without fear of discrimination or reprisal. Grievances and complaints may be submitted orally or in writing. The Administrator has delegated responsibility of grievance investigation to the Grievance Coordinator, who was a member of the Social Services Staff and could be contacted by asking to speak with the Social Services Staff. Upon receipt of a grievance, the Grievance Coordinator would review and investigate the allegations and submit a written report of the findings to the Administrator within 14 working days of receiving the grievance. The resident would be informed of the findings of the investigation and the actions taken to correct any identified problems. A written or verbal summary of the investigation would be provided to the resident and a copy filed in the Grievance Complaint Log Book. Cross reference with Tag 550, 677, and 745

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35601 Based on interview, clinical record review and document review, the facility failed to ensure residents with an acquired serious mental disorder diagnosis after admission were submitted for a pre-admission screening and resident review (PASARR) level II screening for 2 of 23 sampled residents (Resident #80 and #57.) This deficient practice had the potential to not obtain additional resources for a resident with a serious mental disorder. Findings include: Resident #80 Resident #80 was admitted to the facility on [DATE], and obtained a diagnosis of delusional disorder on 12/09/2023. The resident admitted to the facility with a PASARR level I completed 07/21/2023. The Minimum Data Set 3.0 (MDS) assessment, Section I - Active Diagnoses, dated 11/30/2024, documented I5800 depression and I5950 psychotic disorder. On 12/04/2024 at 2:38 PM, the Licensed Social Worker (LSW) explained it was the LSW's responsibility to submit all PASARRs for review. The LSW reviewed the requirements for submission of a PASARR level II and confirmed Resident #80 met the requirements when the new diagnosis of delusional disorders was acquired. The LSW explained it was not the LSW's responsibility to submit the PASARRs at the time of the diagnosis (12/2023) however, it had not been submitted for review at any point in the past twelve months or since taking responsibility for the submissions. Resident #57 Resident #57 was admitted to the facility on [DATE], readmitted on [DATE], and obtained the a diagnosis of major depressive disorder on 10/17/2022. The resident admitted to the facility with a PASARR level I completed 04/07/2022. The MDS assessment, Section I - Active Diagnoses, dated 11/07/2024, documented I5800 depression and I5950 psychotic disorder. On 12/04/2024 at 2:57 PM, the LSW confirmed a PASARR level II was not submitted after Resident #57 acquired major depressive disorder as a diagnosis and did meet the criteria for submission. The LSW verbalized being familiar with the resident and explained the resident exhibited major depressive disorder when the resident was angry, was racist, or when the resident accused Certified Nursing Assistants (CNA) of talking about him. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled, Behavioral Assessment, Intervention and Monitoring, adopted 02/01/2019, documented new onset or changes in behavior indicating newly evident or possible serious mental disorder, intellectual disability, or a related disorder will be referred for a PASARR level II evaluation.

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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** 41848 Based on observation, interview, clinical record review, and document review, the facility failed to ensure 1) the activities care plan addressed a resident's visual impairment and the need for staff to support and assist the resident with personalized activities for 1 of 23 sampled residents (Resident #9). This deficient practice had the potential to prevent staff caring for the resident to be aware of the resident's personalized interests and how the staff could assist the resident to meet the resident's activity related goals. 2) A care plan was developed to address monitoring for a resident with bilateral lower extremity edema for 1 of 23 sampled residents (Resident #86). This deficient practice had the potential for the resident to suffer adverse health outcomes because of staff caring for the resident being unaware of the need to monitor for signs of leg swelling. 3) A care plan was developed for the use of bed rails for 1 of 23 sampled residents (Resident #208). This deficient practice had the potential for the resident to not receive accurate and appropriate care related to Activities of Daily Living (ADLs). Findings include: Resident #9 Resident #9 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unqualified vision loss, both eyes and depression, unspecified. On 12/02/2024 at 9:08 AM, Resident #9 verbalized the resident would participate in group activities when the activities were accessible for the resident, but the resident did not have any activities the resident could do while the resident was by themselves. An Activity Interview for Daily and Activity Preferences, dated 11/04/2024, documented it was very important to the resident to have mystery and history audiobooks and to be able to listen to oldies music. It was very important for the resident to do the resident's favorite activities including listening to music of interest and listening to books on tape. The activities care plan for Resident #9, revised on 11/20/2024, documented the resident would maintain involvement in cognitive stimulation, social activities as desired through review date. The interventions listed were to invite the resident to scheduled activities and provide a program of activities of interest to the resident by encouraging choice, self-expression, and responsibility. The position responsible for the interventions was Activities. On 12/03/2024 at 8:58 AM, Resident #9 verbalized the resident had been given a device to listen to audiobooks but no one had assisted the resident in using the device and the resident had difficulty using the device due to the resident's inability to see, so the resident had stopped attempting to listen to audiobooks. The resident verbalized the resident did not have any music or a radio in the resident's room and the facility had not offered the resident any options to listen to music in the resident's room. The resident explained the resident sometimes felt bored when in the resident's room due to not having any activities of interest available and accessible to the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/03/2024 at 2:52 PM, the Licensed Practical Nurse (LPN) for Resident #9 verbalized the LPN would offer to bring the resident to a group activity if the resident requested or was already up, but the LPN was not aware of any individual activities the resident wished to do in the resident's room. The LPN verbalized the LPN would refer to the resident's care plan if there were individual activities to provide. On 12/04/2024 at 8:57 AM, the Activities Director (AD) verbalized the AD conducted the Activity Interview for Daily and Activity Preferences to gather the necessary information to formulate a care plan for the resident. The AD verbalized individualized activities would be offered based on a resident's preferences. The AD verbalized the facility had an audiobook player, but the AD had not provided instruction to the nurses or CNAs on how to operate the player. The AD verbalized the AD had not provided a music player for the resident. The AD confirmed the activities care plan for Resident #9 did not include the individualized activities the resident had communicated as being very important for the resident and did not include the need for staff caring for the resident to offer the resident assistance with the activities. On 12/04/2024 at 10:42 AM, the Director of Nursing (DON) verbalized the AD was responsible for personalizing the resident's activities care plan. The DON verbalized the care plan should include the amount and type of assistance a resident needed and all positions responsible for assisting the resident. The facility policy titled Care Plans, Comprehensive Person-Centered, adopted 02/01/2019, documented the care plan would reflect the resident's expressed wishes and identify the professional services responsible for each element of care. Cross reference with tag F679 34524 Resident #86 Resident #86 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic kidney disease, stage 3 and acute kidney failure. On 12/03/2024 at 8:24 AM, Resident #86 verbalized the resident had swelling in both legs, especially the right leg. The resident informed the nurse and was told to put their legs up. A physician order dated 11/07/2024, documented Furosemide oral tablet 40 milligram (mg), give 40 mg by mouth in the afternoon for bilateral lower leg edema for three days. A Physician Progress Note dated 11/08/2024, documented Resident #86 had worsening bilateral lower leg edema. Resident #86's clinical record lacked documented evidence a care plan for the management and monitoring of edema had been developed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/05/2024 at 12:45 PM, the DON confirmed Resident #86's clinical record did not include a care plan for the management of the resident's edema. The DON verbalized the resident was at risk of retaining fluid and lack of monitoring could result in more symptoms of fluid retention. 30748 Resident #208 Resident #208 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unspecified sequalae of cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and muscle weakness (generalized). A physician's order dated 11/17/2024, documented upper quarter side rails on each side of the bed to promote independent bed mobility. On 12/04/2024 at 8:50 AM, Resident #208 had two quarter size bed rails, on each side of the bed. On 12/04/2024 at 10:13 AM, the resident verbalized the resident used the bed rails on a daily basis and preferred the bed rails for mobility. Resident #208's comprehensive care plan lacked documented evidence of the use of bed rails. On 12/04/2024 at 2:06 PM, the DON confirmed the resident lacked a care plan for the use of bed rails for Resident #208 and verbalized bed rails were required to be care planned so staff could coordinate proper care needs for the resident. On 12/04/2024 at 2:15 PM, the Regional MDS Registered Nurse confirmed Resident #208 did not have a care plan relating to the use of bed rails and verbalized staff referred to the care plans to determine appropriate care for the resident. The lack of the comprehensive care plan for the use of bed rails was not beneficial to the care needs of the resident. The facility policy titled Care Plans, Comprehensive Person-Centered, adopted 02/01/2019, documented comprehensive care planning included an assessment of residents strengths and needs and would include goals for care required for the resident. The purpose of the person-centered care plan was to describe services furnished to attain or maintain the residents highest practicable physical, mental and psychosocial well-being. Cross Reference with F700

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30748 Based on interview, clinical record review and document review, the facility failed to ensure a Licensed Practical Nurse (LPN) performed the duties as outlined in the State Board of Nursing Nurse Practice Act with safe medication administration when the LPN failed to check blood sugar levels prior to the administration of insulin for 1 of 23 sampled residents (Resident #212). The deficient practice had the potential to expose the resident to medication errors resulting in additional health complications. Findings include: Resident #212 Resident #212 was admitted to the facility on [DATE], with a diagnosis including type two diabetes mellitus without complications. On 12/02/2024 at 2:17 PM Resident #212 explained while waiting for lunch on 12/02/2024, the resident was sitting with the resident's daughter and a nurse approached the table to check the resident's blood sugar levels. The nurse told the resident the nurse would be back to administer the resident's insulin and the nurse walked away. The nurse came back over one hour later to administer the insulin to the resident, however, did not recheck the resident's blood sugar levels prior to administration of the insulin. On 12/02/2024 at 2:17 PM, Resident #212's daughter explained being seated in the dining room at a table waiting for lunch on 12/02/2024, and a nurse approached the table at 12:45 PM to take Resident #212's blood sugar levels. The nurse told the resident the nurse would return with the resident's insulin and walked away. Resident #212 was served lunch, ate lunch and the nurse did not return prior to the resident eating lunch to administer the insulin. The resident's daughter verbalized the nurse approached the resident at 2:00 PM, did not recheck the resident's blood sugar levels, and administered four units of insulin to the resident. A physician's order dated 11/26/2024, documented Humalog Injection Solution 100 unit/milliliter (ml) (Insulin Lispro). Inject as per sliding scale: if 131-180=2; 181-240=4; 241-300=6; 301-350=8; 351-400=10; 401+, if greater than 400, administer 12 units and notify doctor, subcutaneously before meals for diabetes mellitus. Resident #212 Blood Sugar Summary documented on 12/02/2024, the resident's blood sugar levels were checked at 8:19 AM and 12:51 PM. The December 2024 Medication Administration Records (MAR) documented Humalog Injection Solution 100 unit/ml (Insulin Lispro. Inject as per sliding scale: -If 131-180=2; 181-240=4; (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	241-300=6; 301-350=8; 351-400=10; 401 + if greater than 400, administer 12 units and notify doctor, subcutaneously before meals for diabetes Mellitus. On 12/02/2024, the MAR documented the resident received insulin at 7:00 AM, for a blood sugar level of 164, and at 12:00 PM, for a blood sugar level of 225, a code 4 was marked. The legend on the MAR defined a code 4 indicated vitals were outside of parameters for administration. On 12/05/2024 at 10:13 AM, the LPN explained when a resident was to be administered insulin, per a sliding scale, the nurse was to take blood sugar levels and based on what the blood sugar levels were and per the physician's order, insulin would be administered. The LPN verbalized it was not appropriate to take blood sugar levels and walk away from a resident without administering insulin to the resident based on the sliding scale. If a resident were to miss an administration of insulin, per the physician's order, the resident could experience an incident of shaking and confusion. The LPN recalled on 12/02/2024, it was a hectic day and remembered checking the resident's blood sugar levels during lunch, walking away from the resident, and having to tend to a different resident to take their vitals. The LPN could not recall when the LPN returned to the resident to administer insulin, however thought it may have been in the afternoon sometime and at no point in time on 12/02/2024, did the resident refuse insulin. The LPN reviewed the Blood Sugar Summary for Resident #212 and explained the blood sugar levels were documented at 225, which would require insulin to be administered to the resident. The LPN reviewed the December 2024 MAR for Resident #212 and verbalized the resident was administered insulin at 12:00 PM and believed code 4 on the MAR was defined as administering 4 units of insulin to the resident. The LPN recalled checking Resident #212's blood sugar levels around 12:00 PM on 12/02/2024, walking away from the resident for an indeterminate amount of time, returning to the resident in the afternoon, not rechecking the resident's blood sugar levels and administering insulin to the resident based off of the blood sugar levels earlier in the day. On 12/05/2024 at 10:32 AM, the Director of Nursing (DON) explained the process for administering insulin, if it was based on a sliding scale, would be to check the resident's blood sugar levels, compare the blood sugar levels with the sliding scale numbers on the physician's order and administer the amount of insulin per the physician's order. The DON verbalized blood sugar levels were to be checked every time prior to the administration of insulin because the resident could experience symptoms such as swelling, shaking or confusion if the blood sugar levels were not checked immediately preceding the administration of insulin. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON explained it was not within the nursing scope of practice to check a resident's blood sugar levels, walk away without administering the proper units of insulin, come back a few hours later and administer the resident's insulin without rechecking the blood sugar levels. The DON verbalized the LPN was trained in proper administration of insulin. The Registered Nurse (RN)/LPN Medication Pass Checklist dated 01/18/2023, documented the LPN was trained on the proper protocols and procedures for checking blood sugar levels and administering insulin. The training was checked off by the DON indicating the LPN successfully completed the training. The LPN's Job Description, signed by the LPN on 03/28/2022, documented the LPN was responsible to carry out assignments, such as administering medications per regulation and was to provide professional nursing care to assigned residents in a nursing home environment. A Competency Fair dated 04/23/2024 through 04/26/2024, attended by the LPN, documented the LPN was trained on medication administration. The facility policy titled Insulin Administration, adopted on 02/01/2019, documented the type of insulin, dosage requirements, strength, and method of administration must be verified before administration to assure the dosage corresponds with the physician's order. The proper steps for administering insulin was to check blood glucose levels per the physician's order, check the physician's order for the amount of insulin to be administered, pick a site for injection of the insulin, and administer the insulin. The facility policy titled Adverse Consequences and Medication Errors, adopted on 02/01/2019, documented a medication error was defined as the preparation or administration of drugs or biologicals which was not in accordance with physician's orders, manufacturer specifications or accepted profession standards and principles of professional (s) providing care. An example of a medication error included the wrong time and failure to follow accepted professional standards. The Nurse Practice Act Nevada Administrative Code (NAC) 632.236 Understanding and verifying orders, documented before an LPN carries out a physician order, the LPN must understand the reason for the order, verify the order was appropriate, and verify there were no documented contraindications in carrying out the order. Cross Reference F760

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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** 34524 Based on interview, clinical record review, and document review, the facility failed to ensure a resident dependent upon staff for Activities of Daily Living (ADLs) had brief changes overnight for 1 of 23 sampled residents (Resident #36). This deficient practice had the potential to compromise resident hygiene, comfort, and dignity, and increase the risk of skin breakdown and infections. Findings include: Resident #36 Resident #36 was admitted to the facility on [DATE], with diagnoses including rhabdomyolysis, a disease which causes muscle pain and weakness and trouble moving arms and legs, repeated falls, muscle weakness, unsteadiness on feet, other reduced mobility, and pressure ulcer of sacral region, unspecified stage. On 12/02/2024 at 9:28 AM, Resident #36 verbalized the resident was ignored by the night shift staff and was only receiving a brief change once overnight. The resident explained the night shift staff should change the resident every two to three hours, however the staff only came in and changed the resident once shortly before the morning shift came on duty. The resident would spend the night wet; the resident's linens and disposable absorbent under pad would be wet as well. The resident verbalized the staff would change the brief, but not the wet bedding, so the resident would be uncomfortable even though the brief was changed. The resident explained they were extremely stiff and weak, as well as incontinent, and was unable to get up and use the bathroom. The resident relied on the staff for incontinent care. The resident verbalized the resident had informed trusted staff the following morning, as well as the Social Worker, who responded they would look into the resident's concerns. On 12/03/2024 at 2:49 PM, a Certified Nursing Assistant (CNA) verbalized they worked with Resident #36 and the resident was incontinent, needed maximum assistance for all activities of daily living (ADLs), and required a Hoyer lift for transfers. The resident was very stiff, and staff needed to be careful and take their time when providing care. The resident was able to make their needs known and used the call light to request assistance. The CNA recalled Resident #36 had told the CNA the resident was not changed overnight several times. The CNA explained Resident #36 was truthful and easy going about cares and if the resident stated they had not been changed frequently enough, the CNA believed the resident. The CNA felt the resident was only changed once overnight and the disposable pad under the resident was damp at times. The CNA informed the Unit Manager nurses of the resident's concerns each time the resident had complaints of care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/04/2024 at 11:48 AM, Resident #36 verbalized the resident was being ignored by staff at night and was still having trouble being changed overnight. The resident explained they laid in urine all night long the previous night. Staff would change the resident once; however the resident was so soaked with urine, the disposable pads and bedding under the resident was wet. The night staff did not change the resident's bedding when they changed the resident's brief, resulting in the resident laying in an uncomfortably damp bed. The resident was frustrated because they could not get up and walk to the bathroom due to paralysis and their legs not working. The night shift staff would enter the resident's room and turn off the call light, stating they would return, but did not come back. The resident felt ignored, lying in bed helpless all night. The resident verbalized the resident had told morning staff and the Social Worker of their concerns of lack of care overnight. On 12/04/2024 at 11:59 AM, CNA2 verbalized incontinent residents should be checked and changed every two hours and as needed, during the day and overnight. Brief changes should be documented by the CNAs in the medical record. CNA2 explained they worked with Resident #36 and the resident was incontinent. The resident's level of care was dependent, total assist, and used Hoyer lift to get out of bed. CNA2 recalled they had been told by Resident #36 the resident was only changed once overnight. The CNA informed the day shift nurses whenever the resident had concerns about care. On 12/04/2024 at 3:23 PM, theLicensed Social Worker verbalized Resident #36 informed the social worker at least once a week they were not being changed overnight. On 12/04/2024 at 4:02 PM, the Unit Manager/Licensed Practical Nurse (LPN) verbalized they were made aware of the resident's concerns regarding lack of brief changes overnight just today and once in October. Resident #36's Comprehensive Care Plan dated 07/27/2024, documented the resident had a self-care Activity of Daily Living (ADL) performance deficit related to rhabdomyolysis and weakness. The resident needed assistance in ADLs. The resident was dependent on staff for toileting hygiene. Resident #36's Minimum Data Set 3.0 (MDS) Assessment, Section GG0130 - Self Care, dated 09/27/2024, documented toileting hygiene: substantial/maximum assistance - helper does more than half the effort. On 12/04/2024 at 4:09 PM, the Director of Nursing (DON) verbalized incontinent residents should be checked and changed every two hours and as needed during the day and overnight. The facility policy titled Activities of Daily Living, Supporting, dated 02/01/2019, documented residents who were unable to carry out ADLs independently would receive the services necessary to maintain good personal hygiene. Appropriate care and services would be provided for residents who were unable to carry out ADLs independently, including appropriate support with hygiene and elimination (toileting). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy defined substantial/maximum assistance as the helper does more than half the effort. The helper lifts or holds the trunk or limbs and provides more than half the support. The policy defined dependent assistance as the helper does all the effort. The resident performed none of the effort to complete the activity or the assistance of two or more helpers was required for the resident to complete the activity. The facility policy titled Urinary Continence and Incontinence - Assessment and Management, dated 02/01/2019, documented a check and change strategy involved checking the resident's continence status at regular intervals and using incontinence devices or garments. The primary goals were to maintain dignity and comfort and to protect the skin. Cross reference with Tag 550, 585, and 745

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848 Based on observation, interview, clinical record review, and document review, the facility failed to ensure a visually impaired resident received individualized activities based on the resident's preferences and goals for 1 of 23 sampled residents (Resident #9). This deficient practice had the potential to result in a resident feeling a loss of independence and negatively impact the resident's psychosocial well-being. Findings include: Resident #9 Resident #9 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unqualified vision loss, both eyes and depression, unspecified. On 12/02/2024 at 9:08 AM, Resident #9 verbalized the resident would participate in group activities when the activities were accessible for the resident, but the resident did not have any activities the resident could do while the resident was by themself. An Activity Interview for Daily and Activity Preferences, dated 11/04/2024, documented it was very important to the resident to have mystery and history audiobooks and to be able to listen to oldies music. It was very important for the resident to do the resident's favorite activities including listening to music of interest and listening to books on tape. The activities care plan for Resident #9, revised on 11/20/2024, documented the resident would maintain involvement in cognitive stimulation, social activities as desired through review date. The interventions listed were to invite the resident to scheduled activities and provide a program of activities of interest to the resident by encouraging choice, self-expression, and responsibility. The position responsible for the interventions was Activities. The Task: Activities for Resident #9, reviewed from 11/04/2024 through 12/04/2024, documented the resident participated in individual activities for one day in the 30-day period. On 11/18/2024, the Task documented the resident had participated in the individual activity of reading and puzzles. On 12/03/2024 at 8:58 AM, Resident #9 verbalized the resident had been given a device to listen to audiobooks but no one had assisted the resident in using the device and the resident had difficulty using the device due to the resident's inability to see, so the resident had stopped attempting to listen to audiobooks. The resident verbalized the resident did not have any music or a radio in the resident's room and the facility had not offered the resident any options to listen to music in the resident's room. The resident explained the resident sometimes felt bored when in the resident's room due to not having any activities of interest available and accessible to the resident. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/03/2024 at 2:52 PM, the Licensed Practical Nurse (LPN) for Resident #9 verbalized the LPN would offer to bring the resident to a group activity if the resident requested or was already up, but the LPN was not aware of any individual activities the resident wished to do in the resident's room. The LPN verbalized the LPN would refer to the resident's care plan if there were individual activities to provide. On 12/04/2024 at 8:57 AM, the Activities Director (AD) verbalized the AD conducted the Activity Interview for Daily and Activity Preferences to gather the necessary information to formulate a care plan for the resident. The AD verbalized individualized activities would be offered based on a resident's preferences. The AD verbalized the facility had an audiobook player, but the AD had not provided instruction to the nurses or CNAs on how to operate the player. The AD verbalized the AD had not provided a music player for the resident. The AD confirmed the activities care plan for Resident #9 did not include the individualized activities the resident had communicated as being very important for the resident and did not include the need for staff caring for the resident to offer the resident assistance with the activities. The AD verbalized the activities staff would document under the activities task when the staff assisted the resident with an individual activity. The AD confirmed the Task: Activities for Resident #9 only had documentation for one day in the 30 days look back period. On 12/04/2024 at 10:42 AM, the Director of Nursing (DON) verbalized the AD was responsible for personalizing the resident's activities care plan. The DON verbalized the care plan should include the amount and type of assistance a resident needed and all positions responsible for assisting the resident. The facility policy titled Activity Programs, adopted 02/01/2019, documented individualized activities would be provided and would reflect the interests and personal preferences of the resident. Activities would not be limited to formal activities being provided only by activities staff. Other facility staff would also provide the activities. All activities would be documented in the resident's medical record. Cross reference with tag F656

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848 Based on observation, interview, clinical record review, and document review, the facility failed to ensure a resident's medication for neuropathy (a nerve condition causing pain, numbness, tingling, swelling, or muscle weakness in different parts of the body) was refilled timely to prevent the resident from missing eight doses of the medication for 1 of 23 sampled residents (Resident #9). This deficient practice had the potential to result in a resident experiencing unrelieved nerve pain the medication was prescribed to treat. Findings include: Resident #9 Resident #9 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including other chronic pain, pain, unspecified, pain in left ankle and joints of left foot, and pain in right knee. On [DATE] at 9:18 AM, Resident #9 verbalized the resident had not received a scheduled pain medication over the weekend. The resident explained the medication was usually given three times a day to prevent the resident from having pain in the resident's feet. The resident verbalized the resident had asked the nurse about the medication because the resident was feeling a burning sensation in the resident's feet. The resident verbalized the resident had been told someone had forgotten to renew the medication and the facility had been unable to get an on-call provider to write a new order. Medication orders for Resident #9 documented the following: - pregabalin oral capsule 200 milligrams (mg), give one capsule by mouth three times a day for neuropathy for 30 days. The start date for the medication was [DATE]. - pregabalin oral capsule 200 mg, give one capsule by mouth three times a day for neuropathy for 30 days. The start date for the medication was [DATE]. The November and [DATE] Medication Administration Records for Resident #9 documented the resident did not receive the medication on [DATE] or [DATE], and only received the evening dose on [DATE]. A care plan for Resident #9, revised on [DATE], documented the resident had an alteration in comfort related to complaints of chronic pain, pain in the left ankle, pain in the right knee, and neuropathy. The interventions included to administer medications including pregabalin. On [DATE] at 2:50 PM, the Licensed Practical Nurse (LPN) for Resident #9 verbalized the facility practice was to reassess the need for narcotic medications every 30 days to ensure the medication was still effective. The LPN explained the nurse caring for the resident would be responsible for requesting a new order from the provider three days prior to the end of the order. The LPN verbalized if an order was received the nurse would be able to retrieve the medication from the facility's medication system while waiting for the pharmacy to deliver the medication. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 9:29 AM, the Director of Nursing (DON) explained the facility procedure was for a narcotic to be ordered for 30 days at a time. The DON verbalized the renewal order should have been requested two to three days prior to the order expiring. The DON confirmed the order expired on [DATE] and was not renewed until [DATE]. The DON confirmed the resident had not received the medication on [DATE], [DATE], and only received the evening dose when the medication was reordered on [DATE]. The DON verbalized the medication was not renewed because the need for a renewal order was overlooked due to a lack of communication between the staff. The DON verbalized the staff could have requested a different medication to be given until the ordering provider was able to renew the medication. The DON confirmed no medications were added to replace the pregabalin. The facility policy titled Pain Management, updated ,d+[DATE], documented the facility took a proactive approach to pain management and pain management was best achieved with scheduled medications.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30748 Based on observation, interview, clinical record review and document review the facility failed to attempt to use appropriate alternative interventions and create a comprehensive care plan prior to installation and use of bed rails for 1 of 23 sampled residents (Resident #208). This failure had the potential to increase accidental entrapment or injury when an alternate assistive device may have been effective and care planned interventions implemented. Findings include: Resident #208 Resident #208 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unspecified sequelae of cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and muscle weakness (generalized). Resident #208's five day Minimum Data Set 3.0 (MDS) assessment dated [DATE], section P0100 (Restraints and Alarms-Physical Restraints) documented the resident used bed rails daily as a physical restraint that could not be removed easily which restricted freedom of movement or normal access to one's body. On 12/04/2024 at 8:50 AM, Resident #208 had two quarter size bed rails, on each side of the bed. On 12/04/2024 at 10:13 AM, the resident verbalized the resident used the bed rails on a daily basis and preferred the bed rails for mobility. Resident #208's comprehensive care plan lacked documented evidence of the use of bed rails. A physician's order dated 11/17/2024, documented upper quarter side rails on each side of the bed to promote independent bed mobility. Resident #208's clinical record lacked documented evidence of interventions attempted prior to the installation and use of bed rails. On 12/04/2024 at 2:06 PM, the Director of Nursing (DON) explained the resident requested the bed rails and the facility was honoring the resident's wishes. The DON verbalized if a resident had requested bed rails, other interventions would be attempted prior to installing the bed rails on the resident's bed. The DON verbalized once the bed rails were in use by the resident, the bed rails would be care planned with appropriate interventions. The DON confirmed no prior interventions were attempted prior to the installation and use of bed rails for Resident #208. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/04/2024 at 2:16 PM, the Regional MDS Registered Nurse confirmed no prior interventions were attempted prior to the installation and use of bed rails for Resident #208 and verbalized alternative interventions were required to be attempted prior to the installation and use of bed rails. The bed rails were to be care planned to include interventions to ensure the safety of the resident. The facility policy titled Proper Use of Side Rails, adopted 02/01/2019, documented less restrictive interventions would be attempted prior to the use of bed rails. Documentation would be completed to indicate if the less restrictive approaches were not successful prior to considering the use of bed rails. The facility policy titled Use of Restraints, adopted 02/01/2019, documented restraints were only to be used for a specific medical symptom after other less restrictive methods had been attempted and care plans would reflect interventions to include the resident's medical symptom and underlying problems contributing to the medical symptom. Cross Reference with F656

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34524 Based on interview, record review, and document review, the facility failed to ensure a social services staff member followed up on complaints from a resident regarding lack of incontinent care overnight and provide the social services to the resident according to the job description for 1 of 23 sampled residents (Resident #36). This deficient practice had the potential for a resident to have psychosocial harm not assessed by Social Services. Findings include: Resident #36 Resident #36 was admitted to the facility on [DATE], with diagnoses including rhabdomyolysis, a disease which causes muscle pain and weakness and trouble moving arms and legs, repeated falls, muscle weakness, unsteadiness on feet, other reduced mobility, and pressure ulcer of sacral region, unspecified stage. On 12/02/2024 at 9:28 AM, Resident #36 verbalized the resident was ignored by the night shift staff and was only receiving a brief change once overnight. The resident explained the night shift staff should change the resident every two to three hours, however the staff only came in and changed the resident once shortly before the morning shift came on duty. The resident would spend the night wet; the resident's linens and disposable absorbent under pad would be wet as well. The resident verbalized the staff would change the brief, but not the wet bedding, so the resident would be uncomfortable even though the brief was changed. The resident explained they were extremely stiff and weak, as well as incontinent, and was unable to get up and use the bathroom. The resident relied on the staff for incontinent care. The resident verbalized the resident had informed trusted staff the following morning, as well as the Social Worker, who responded they would look into the resident's concerns. On 12/03/2024 at 2:49 PM, a Certified Nursing Assistant (CNA) recalled Resident #36 had told the CNA the resident was not changed overnight several times. The CNA informed the Unit Manager nurses of the resident's concerns each time the resident had complaints of care. On 12/04/2024 at 11:48 AM, Resident #36 verbalized the resident was being ignored by staff at night and was still having trouble being changed overnight. The resident verbalized the resident had told morning staff and the Social Worker of their concerns of lack of care overnight. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/04/2024 at 3:23 PM, the Licensed Social Worker (LSW) verbalized Resident #36 informed the LSW worker at least once a week they were not being changed overnight. The LSW recalled Resident #36 thought everyone was ignoring the resident. The LSW did not submit a grievance on behalf of the resident because the resident was a big ball of anxiety and the LSW felt the resident's concerns were not really happening. The LSW further explained they would not submit a grievance for this resident's complaints because they would not want the investigation to be unsubstantiated and then the resident be known as the one who made complaints about their care. The LSW continued to explain the LSW did not feel the resident's complaints of lack of care arose to the level of a grievance. The LSW clarified a resident did not have to formally request to file a grievance in order for the LSW to submit a grievance. The LSW verbalized they verbally notified the Unit Manager nurses and the DON of the resident's concerns regarding lack of care. The LSW was not aware if an investigation was conducted. The LSW did not receive an outcome from the Unit Managers, nor did the LSW follow up with the Unit Managers or the Director of Nursing (DON) for their findings into the matter and did not document the resident concerns, notification, and outcome, however the LSW thought the outcome was the concerns were unfounded. On 12/04/2024 at 4:02 PM, the Unit Manager/Licensed Practical Nurse (LPN) verbalized they were made aware of the resident's concerns regarding lack of brief changes overnight just today and once in October. The Unit Manager verbalized they could not recall what actions were taken in October; however, they believe they spoke with the staff regarding the resident's complaints. The Unit Manager verbalized they would have notified the DON of the resident's complaints. On 12/04/2024 at 4:09 PM, the DON confirmed the DON was not notified of Resident #36's complaints by the Unit Managers or the LSW and the DON would expect to be notified right away. The DON confirmed the DON had not spoken with the resident regarding their complaints. The signed job description for the Licensed Social Worker, dated 12/14/2022, documented the primary purpose of the job position was to support the day-to-day needs of the residents within the facility, participated in resident care management, actively participated in care coordination, and assured social services progress notes were informative and descriptive of the services provided and of the resident's response to the service. The facility policy titled Grievances and Complaints, Filing, dated 02/01/2019, documented residents had the right to file grievances and make complaints, either orally or in writing, to the facility staff. The policy defined the following: Complaint: stems from minor issues which can usually be resolved by the staff members who were present when a resident verbalized a concern. Unresolved complaints could turn into grievances. Grievance: a more serious concern with respect to care and treatment which has been furnished as well as which has not been furnished. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Any resident may file a grievance or complaint concerning care or treatment. Grievances may also be voiced or filed regarding care which has not been furnished. Residents had the right to voice or file grievances without discrimination or reprisal in any form, and without fear of discrimination or reprisal. Grievances and complaints may be submitted orally or in writing. The Administrator has delegated responsibility of grievance investigation to the Grievance Coordinator, who was a member of the Social Services Staff and could be contacted by asking to speak with the Social Services Staff. Upon receipt of a grievance, the Grievance Coordinator would review and investigate the allegations and submit a written report of the findings to the Administrator within 14 working days of receiving the grievance. The resident would be informed of the findings of the investigation and the actions taken to correct any identified problems. A written or verbal summary of the investigation would be provided to the resident and a copy filed in the Grievance Complaint Log Book. Cross reference with Tag 550, 585, and 677

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30748 Based on interview, clinical record review, and document review the facility failed to ensure a resident's blood sugar levels were tested timely prior to the administration of insulin for a resident with type two diabetes mellitus for 1 of 23 sampled residents (Resident #212). This deficient practice had the potential to cause the resident to experience hypoglycemia or hyperglycemia symptoms related to blood sugar levels not being regulated. Findings include: Resident #212 Resident #212 was admitted to the facility on [DATE], with a diagnosis including type two diabetes mellitus without complications. On 12/02/2024 at 2:17 PM Resident #212 explained while waiting for lunch on 12/02/2024, the resident was sitting with the resident's daughter and a nurse approached the table to check the resident's blood sugar levels. The nurse told the resident the nurse would be back to administer the resident's insulin and the nurse walked away. The nurse came back over one hour later to administer the insulin to the resident, however, did not recheck the resident's blood sugar levels prior to administration of the insulin. On 12/02/2024 at 2:17 PM, Resident #212's daughter explained being seated in the dining room at a table waiting for lunch on 12/02/2024, and a nurse approached the table at 12:45 PM to take Resident #212's blood sugar levels. The nurse told the resident the nurse would return with the resident's insulin and walked away. Resident #212 was served lunch, ate lunch and the nurse did not return prior to the resident eating lunch to administer the insulin. The resident's daughter verbalized the nurse approached the resident at 2:00 PM, did not recheck the resident's blood sugar levels, and administered four units of insulin to the resident. A physician's order dated 11/26/2024, documented Humalog Injection Solution 100 unit/milliliter (ml) (Insulin Lispro). Inject as per sliding scale: if 131-180=2; 181-240=4; 241-300=6; 301-350=8; 351-400=10; 401+, if greater than 400, administer 12 units and notify doctor, subcutaneously before meals for diabetes mellitus. Resident #212 Blood Sugar Summary documented on 12/02/2024, the resident's blood sugar levels were checked at 8:19 AM and 12:51 PM. The December 2024 Medication Administration Records (MAR) documented Humalog Injection Solution 100 unit/ml (Insulin Lispro. Inject as per sliding scale: -If 131-180=2; 181-240=4; 241-300=6; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	301-350=8; 351-400=10; 401 + if greater than 400, administer 12 units and notify doctor, subcutaneously before meals for diabetes Mellitus. On 12/02/2024, the MAR documented the resident received insulin at 7:00 AM, for a blood sugar level of 164, and at 12:00 PM, for a blood sugar level of 225, a code 4 was marked. The legend on the MAR defined a code 4 indicated vitals were outside of parameters for administration. On 12/05/2024 at 10:13 PM, the Licensed Practical Nurse (LPN) explained when a resident was to be administered insulin, per a sliding scale, the nurse was to take blood sugar levels and based on what the blood sugar levels were and per the physician's order, insulin would be administered. The LPN verbalized it was not appropriate to take blood sugar levels and walk away from a resident without administering insulin to the resident based on the sliding scale. If a resident were to miss an administration of insulin, per the physician's order, the resident could experience an incident of shaking, confusion, and shakiness. The LPN recalled on 12/02/2024, it was a hectic day and remembered checking the resident's blood sugar levels during lunch, walking away from the resident, and having to tend to a different resident to take their vitals. The LPN could not recall when the LPN returned to the resident to administer insulin, however thought it may have been in the afternoon sometime and at no point in time on 12/02/2024, did the resident refuse insulin. The LPN reviewed the Blood Sugar Summary for Resident #212 and explained the blood sugar levels were documented at 225, which would require insulin to be administered to the resident. The LPN reviewed the December 2024 MAR for Resident #212 and verbalized the resident was administered insulin at 12:00PM and believed code 4 on the MAR was defined as administering 4 units of insulin to the resident. The LPN recalled checking Resident #212's blood sugar levels around 12:00 PM on 12/02/2024, walking away from the resident for an indeterminate amount of time, returning to the resident in the afternoon, not rechecking the resident's blood sugar levels and administering insulin to the resident based off of the blood sugar levels earlier in the day. On 12/05/2024 at 10:32 AM, the Director of Nursing (DON) explained the process for administering insulin, if it was based on a sliding scale, would be to check the resident's blood sugar levels, compare the blood sugar levels with the sliding scale numbers on the physician's order and administer the amount of insulin per the physician's order. The DON verbalized blood sugar levels were to be checked every time prior to the administration of insulin because the resident could experience symptoms such as swelling, shaking or confusion if the blood sugar levels were not checked immediately preceding the administration of insulin. The DON explained it was not within the nursing scope of practice to check a resident's blood sugar levels, walk away without administering the proper units of insulin, come back a few hours later and administer the resident's insulin without rechecking the blood sugar levels. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON verbalized the LPN was trained in proper administration of insulin. The Registered Nurse (RN)/LPN Medication Pass Checklist dated 01/18/2023, documented the LPN was trained on the proper protocols and procedures for checking blood sugar levels and administering insulin. The training was checked off by the DON indicating the LPN successfully completed the training. The LPN's Job Description, signed by the LPN on 03/28/2022, documented the LPN was responsible to carry out assignments, such as administering medications per regulation and was to provide professional nursing care to assigned residents in a nursing home environment. A Competency Fair dated 04/23/2024 through 04/26/2024, attended by the LPN, documented the LPN was trained on medication administration. The facility policy titled Insulin Administration, adopted on 02/01/2019, documented the type of insulin, dosage requirements, strength, and method of administration must be verified before administration to assure the dosage corresponds with the physician's order. The proper steps for administering insulin was to check blood glucose levels per the physician's order, check the physician's order for the amount of insulin to be administered, pick a site for injection of the insulin, and administer the insulin. The facility policy titled Adverse Consequences and Medication Errors, adopted on 02/01/2019, documented a medication error was defined as the preparation or administration of drugs or biologicals which was not in accordance with physician's orders, manufacturer specifications or accepted profession standards and principles of professional (s) providing care. An example of a medication error included the wrong time and failure to follow accepted professional standards. The American Diabetes Association, issued 01/01/2021, documented hyperglycemia, hypoglycemia, and glucose variability were associated with adverse outcomes, including death. Glucose testing would align with meals, prior to eating the meal. Deviations from a physician's order for glucose testing and administration would be a medication error. Cross Reference with F658

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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** 41848 Based on observation, interview, clinical record review, and document review, the facility failed to ensure a resident did not have a bottle of over-the-counter medication unsecured on the resident's bedside table when the resident did not have an order for the medication or to keep medications at the bedside for 1 of 23 sampled residents (Resident #9). This deficient practice had the potential to result in the resident self-medicating and suffering adverse reactions or medication interactions. Findings include: Resident #9 Resident #9 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including type II diabetes mellitus with diabetic neuropathy, unspecified, type II diabetes mellitus with unspecified complications, and long term (current) use of insulin. On 12/03/2024 at 2:40 PM, a medication bottle was on the top of the bedside table to the left of the resident, in between the resident's bed and the curtain separating the resident from the resident's roommate. The label on the bottle documented glucose tablets, chewable 4-gram tablets, 50 tablets. The Order Summary for Resident #9 did not contain an order for glucose tablets and did not contain an order for the resident to keep medications at the bedside. On 12/03/2024 at 2:50 PM, the Licensed Practical Nurse for Resident #9 verbalized the medication should not have been at the bedside in case the resident decided to self-medicate and the resident could have self-administered the medication without the facilities knowledge. On 12/03/2024 at 4:14 PM, the Director of Nursing confirmed the medication had been on the resident's bedside table and verbalized medications were not supposed to be stored in a resident's room without an order for the medication and assessment of the resident to determine if the resident could safely self-administer. The facility policy titled Storage of Medications, adopted 02/01/2019, documented the facility would store all drugs and biologicals in a safe, secure, and orderly manner. Drugs would be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. The compartments containing the drug would be locked when not in use. Items would not be left unattended or otherwise potentially available to others.