| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295088 | A. Building<br>B. Wing | 02/12/2026 |

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

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and document review, the facility failed to ensure 1) a resident's drinking water placed on the floor was not in close proximity to a urinal holding the resident's bodily fluids for 1 of 23 sampled residents (Resident #17), 2) clean linens were kept covered during transport and delivery, 3) a Licensed Practical Nurse (LPN) cleaned a tablet splitter before and after use during medication administration, 4) hand hygiene supplies were readily available to staff and staff performed hand hygiene as required when performing wound care for 1 of 23 sampled residents (Resident #4), 5) Enhanced Barrier Precautions (EBP) were implemented appropriately for 1 of 23 sampled residents (Resident 13), and 6) Transmission-Based Precautions (TBP) were implemented according to facility policy and Centers for Disease Control and Prevention (CDC) recommendations for 1 of 23 sampled residents (Resident #100). This deficient practice had the potential to spread infectious organisms throughout the facility. Findings Include: Urinal<br><br>Resident #17<br><br>Resident #17 was admitted to the facility on [DATE], with diagnoses including pneumonia, unspecified organism, methicillin resistant staphylococcus aureus infection, unspecified site, and cognitive communication deficit.<br><br>On 02/09/2026 at 11:19 AM, Resident #17 had a portable urinal approximately 1/10 full of dark brown urine. The urinal was on the ground at the resident's feet, next to the resident's bed. Next to the urinal was the resident's gray pitcher of water. The urinal and the pitcher were approximately 2 inches apart.<br><br>On 02/09/2026 at 11:35 AM, a Certified Nursing Assistant (CNA1) verbalized the CNAs were responsible for rounding on the resident every two hours to take care of the resident's urinal. The urinal was to be emptied and only stored on hooks of the bed or on the side of the resident's trash can. CNA1 explained the resident's urinal should not be stored on the ground nor stored on the ground next to the resident's cup of water. The urinal could spread bacteria into the resident's drinking water creating an infection control issue.<br><br>On 02/11/2026 at 8:31 AM, the Director of Nursing (DON) verbalized the expectation was for CNAs to empty, clean, and return urinals to the resident's bedside during rounds or when the resident called after use. The urinals could be placed on the side of the bed rail if needed, but most of the time they were kept at the bedside. The DON explained urinals were not to be kept on the ground because they might not be accessible for the resident and created an infection control issue due to bodily fluids. Urinals placed on the ground could spill and create an environmental hazard for staff and residents. The DON confirmed it would not be appropriate to keep a water pitcher and urinal approximately 2 inches apart for health and safety reasons.<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The facility policy titled Standard Precautions, adopted 02/01/2019 and reviewed annually, documented standard precautions were used in the care of all residents regardless of diagnoses, suspected, or confirmed infection status. Standard precautions presume all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents. Standard precautions included resident care equipment. Resident care equipment soiled with blood, body fluids, secretions, and excretions were handled in a manner preventing skin and mucous membrane exposure, contamination of clothing, and transfer of microorganisms to other residents or environments.<br><br>Linen<br><br>On 02/10/2026 at 4:16 PM, a blue laundry cart was outside room [ROOM NUMBER], uncovered. The cart contained nine folded white bed sheets and one folded beige blanket.<br><br>On 02/10/2026 at 4:19 PM, the Unit Manager Registered Nurse (RN) confirmed the cart contained clean linens and was left uncovered. The Unit Manager RN verbalized the CNAs usually delivered the linens to the residents' rooms.<br><br>On 02/10/2026 at 4:24 PM, the DON, confirmed the laundry was left uncovered and unattended, and should have been covered to maintain infection control practices and to prevent potential cross contamination.<br><br>The facility policy titled, Linen and Laundry, updated 05/2020, documented clean linen would be transported and stored according to best practices for infection prevention and control, and placed in a cart with a cover for transport.<br><br>Cleaning of tablet-splitter<br><br>Resident #43<br><br>Resident #43 was admitted to the facility on [DATE], with diagnoses including chronic atrial fibrillation, unspecified and localized edema.<br><br>On 02/11/2026 at 8:43 AM, LPN1 began preparing medications for Resident #43. LPN1 retrieved one tablet of Potassium Chloride extended release 10 milliequivalents (meq) from the medication cart. LPN1 verbalized Resident #43 liked the Potassium Chloride broken in half as the tablet was large and hard to swallow if left whole. LPN1 retrieved a tablet splitter from the top drawer of the medication cart, placed the Potassium Chloride tablet inside the tablet splitter, cut the tablet in half, and returned the tablet splitter to the drawer. LPN1 did not clean the tablet-splitter prior to and after use.<br><br>On 02/11/2026 at 3:20 PM, LPN1 verbalized if a medication tablet needed to be cut/broken, staff were to use a tablet splitter and explained staff should clean the tablet splitter before and after each use to help prevent the potential spread of infection. Sanitizing cloths were used to clean the tablet splitter. LPN1 confirmed LPN1 did not clean the tablet splitter before and after use for Resident #43 during the morning medication administration pass.<br><br>On 02/12/2026 at 10:55 AM, the DON verbalized staff could use a tablet splitter to cut medication tablets in half, if necessary, when preparing medications for administration. Tablet splitters were to be cleaned after each use. The DON explained it was important for tablet splitters to be cleaned<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | before and after each use as it was an infection control concern and could result in cross contamination.<br><br>The facility policy titled Preparation and General Guidelines, Equipment and Supplies for Administering Medications, dated 05/2024, documented if breaking tablets was necessary to administer the proper dose, hands were to be washed with soap and water or alcohol gel and examination gloves worn prior to handling tablets. A tablet-splitter was to be used to ensure accuracy and to minimize contact with the tablet. The splitter blade and surfaces contacting the tablet were to be cleaned before and after each use.<br><br>Hand hygiene supplies readily available and performance of hand hygiene during wound care<br><br>Resident #4<br><br>Resident #4 was admitted to the facility on [DATE], with diagnoses including unspecified atrial fibrillation and hypertensive heart disease with heart failure.<br><br>A Physician's Order dated 02/02/2026, documented left lower leg vascular wound: cleanse with Normal Saline (NS), apply zinc oxide to peri-wound, apply collagen particles to wound bed, cover with foam dressing. Every day shift, every other day.<br><br>On 02/12/2026, LPN2 performed wound care for Resident #4. The following was observed:<br><br>-At 1:17 PM, LPN2 entered Resident #4's room, donned a pair of gloves, wiped the resident's bedside table with a sanitizing cloth, doffed the pair of gloves, donned a new pair of gloves, opened and placed a clean drape on the bedside table, doffed the pair gloves and discarded the gloves in a garbage can, touched the resident's foot, exited the resident's room, unlocked a wound care cart, grabbed the handle of the bottom drawer of the cart and opened the drawer, retrieved a bottle of Alcohol-Based Handrub (ABH) and applied the ABH to LPN2's hands. LPN2 did not perform hand hygiene after removing the second pair of gloves, before touching the resident, after touching the resident, prior to/upon exiting the resident's room, and before touching the wound care cart.<br><br>-At 1:22 PM, LPN2 entered Resident #4's room, explained the procedure to the resident, entered the resident's bathroom and washed LPN2's hands with soap and water. The paper towel dispenser in the bathroom was empty, and the bathroom lacked any additional supply of paper towels or clean towels. LPN2 used LPN2's elbow to open the bathroom door, walked to the resident's doorway and asked another staff member to retrieve paper towels so LPN2 could dry LPN2's hands.<br><br>-At 1:36 PM, after completing the wound care for Resident #4, LPN2 entered the resident's bathroom and washed LPN2's hands with soap and water. LPN2 verbalized LPN2 kept forgetting there were no towels in the bathroom, exited the resident's room, knocked on the door of another resident's room, entered the room and retrieved paper towels from the resident's bathroom.<br><br>On 02/12/2026 at 1:43 PM, LPN2 verbalized staff were supposed to perform hand hygiene before and after contact with residents. ABH was appropriate to use unless LPN2 was performing wound care, then LPN2 would wash LPN2's hands with soap and water. LPN2 confirmed paper towels were not available in Resident #4's bathroom and confirmed towels were a necessary supply to complete hand hygiene when washing with soap and water. LPN2 acknowledged LPN2 did not perform hand hygiene after touching Resident #4 and before unlocking and opening the wound care cart.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 02/12/2026 at 1:48 PM, the DON verbalized staff were expected to perform hand hygiene before and after resident care. Hand hygiene was important in controlling infections due to the potential for cross contamination. The DON explained housekeeping staff were responsible to keep the paper towel dispensers in resident bathrooms stocked and clinical staff were expected to communicate with housekeeping when the clinical staff ran out of paper towels. The DON confirmed the DON would expect staff to perform hand hygiene when exiting a resident's room and prior to touching a wound care cart. The DON confirmed paper towels were considered an essential supply necessary for hand hygiene, however; verbalized a clean hand towel could be used in an emergency.<br><br>The facility policy titled Handwashing/Hand Hygiene, dated 02/01/2019, documented all personnel were to follow handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) were to be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. Supplies necessary for hand hygiene were alcohol-based hand rub containing at least 62 percent alcohol, running water, soap, paper towels, a trash can, lotion and non-sterile gloves. Alcohol-based hand rub or soap and water were to be used for the following situations: before and after contact with residents, before handling clean or soiled dressings or gauze pads, after contact with objects in the immediate vicinity of the resident, and after removing gloves. The procedure for washing hands included drying hands thoroughly with paper towels and turning off the faucet with a clean, dry paper towel.<br><br>EBP Implementation<br><br>Resident #13<br><br>Resident#13 was admitted on [DATE] with diagnoses of hemiplegia and hemiparesis, dysphagia, and contractures.<br><br>A physician's order dated 09/17/2025, documented EBP for G-tub every shift.<br><br>On 02/11/2026 at 1:30 PM, LPN3 was changing the feeding of Resident #13 G-tube wearing gloves and no gown.<br><br>On 02/11/2026 at 2:00PM, the LPN3 verbalized the LPN3 believed neither the LPN3 nor staff were required to don a gown when changing the feeding on a Gˆtube for Resident #13.<br><br>On 02/12/2026 at 2:19 PM, the DON verbalized the EBP should have included hand hygiene, gloves, and gowns. The DON stated staff should have donned gloves and a gown when placing the new feeding for Resident #13's G-tube.<br><br>The facility policy titled, Enhanced Barrier Precautions (EBP), updated 03/21/2024, documented EBP were infection control intervention designed to reduced transmission of resistant organisms that employs targeted gown and glove use during contact resident care activities.<br><br>TBP Implementation<br><br>Resident #100<br><br>Resident #100 was admitted to the facility on [DATE], with a diagnosis of methicillin resistant<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | staphylococcus aureus (MRSA) infection as the cause of diseases classified elsewhere.<br><br>An aerobic bacterial urine culture report dated 12/02/2025, documented heavy growth of MRSA.<br><br>A physician's order dated 12/24/2025, documented the resident was on single room contact isolation for MRSA to the left heel wound every shift.<br><br>A care plan focus initiated 12/26/2025, documented Resident #100 had MRSA and was on contact isolation for MRSA to the resident's left heel. An intervention initiated 04/06/2025, documented to instruct family, visitors, and caregivers to wear a disposable gown and gloves during physical contact with the resident. An intervention initiated 07/18/2025, documented contact precautions would be followed when providing treatment to the resident's wound.<br><br>On 02/09/2026 at 10:39 AM, TBP signage was posted at the entrance of Resident #100's room. The sign documented contact precautions. Everyone must clean hands before entering and when exiting the room. Staff must also don gloves and gowns prior to room entry and upon exit.<br><br>On 02/09/2026 at 10:39 AM, a CNA2 entered Resident #100's room. The CNA did not use an alcohol-based hand rub (ABHR) and did not don gloves or a gown.<br><br>On 02/09/2026 at 10:44 AM, CNA2 explained the CNA believed Resident #100 was on contact precautions for an infection related to the resident's stool. CNA2 confirmed the signage on the resident's entryway documented contact precautions required staff use ABHR and wear gowns and gloves prior to entering the resident's room. CNA2 verbalized the CNA only donned a gown and gloves when assisting the resident to the restroom. The CNA confirmed the CNA did not use and ABHR nor did the CNA don a gown and gloves. CNA2 explained the CNA was in the resident's room to assist the resident to the restroom. The CNA kept a gown inside the resident's bathroom to reuse each time the resident required assistance.<br><br>On 02/12/2026 at 9:05 AM, LPN4 verbalized contact precautions required all staff to use ABHR and don gloves and a gown prior to entering the resident's room. LPN4 verbalized Resident #100 required contact precautions due to an active diagnosis of MRSA.<br><br>On 02/12/2026 at 9:56 AM, the Infection Preventionist (IP) verbalized contact precautions were used to prevent the transmission of infectious diseases among residents and staff. Contact precautions required staff use ABHR and don new gloves and gowns prior to entering the resident's room because surfaces in the room could be contaminated. The IP explained Resident #100 was admitted to the facility with an active diagnosis of MRSA and should be on contact precautions.<br><br>The facility policy titled Isolation-Transmission Based Precautions, adopted 02/01/2019, documented TBP were additional measures to protect staff, visitors and other residents from becoming infected. The CDC maintained a list of diseases, modes of transmission recommended precautions and recommendations for discontinuation. Contact precautions required staff and visitors to wear clean gloves and disposable gowns when entering the room.<br><br>The CDC document titled 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, updated 09/2024, documented Multidrug Resistant Organisms (MDROs) were generally defined as microorganisms which were resistant to one or more classes of antimicrobial agents. MDROs of concern included MRSA. Documented outbreaks in<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | long-term care facilities were caused by various viruses and bacteria and could lead to substantial morbidity and mortality and increased medical costs. Prompt detection and implementation of effective control measures were required. Placement of a resident in a single room was preferred when there was concern about transmission of an infectious agent, including residents on contact and droplet precautions. Recommendations for residents infected or colonized with an MDRO judged as clinically important by the infection control program included contact in addition to standard precautions. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review, the facility failed to ensure a resident's care plan related to oxygen administration was revised when the resident's oxygen order was discontinued for 1 of 23 sampled residents (Resident #70). This deficient practice had the potential to result in staff being unaware of the services required by the resident to reach and maintain their highest practicable level of functioning.Findings include:Resident #70Resident #70 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), and emphysema.A physician's order dated 11/13/2026, and discontinued on 01/29/2026, documented to administer oxygen at 3 liters per minute (lpm) via nasal cannula continuously every shift for emphysema.Resident #70's clinical record lacked documentation of an active physician's order for oxygen therapy.A care plan focus, initiated 01/14/2026, documented Resident #70 had emphysema and COPD. A goal, initiated 01/14/2026, documented the resident would have no signs and symptoms of respiratory difficulty with use of supplemental oxygen through the review date.An alert progress note dated 01/29/2026, documented Resident #70's oxygen saturation was 95 percent (%) on room air. The resident did not use their oxygen in the previous 24 hours. The oxygen order would be discontinued.Resident #70 verbalized the resident did not require oxygen therapy.On 02/09/2026 at 3:23 PM, a Registered Nurse (RN) verbalized Resident #70's physician's order for oxygen therapy was discontinued on 01/29/2026.On 02/12/2026 at 9:03 AM, a Licensed Practical Nurse (LPN) explained Resident #70 previously received oxygen therapy. However, the resident was stable on room air, so the facility requested to titrate the oxygen and the physician's order was discontinued. The LPN recalled the LPN was the nurse to discontinue the oxygen order in the resident's electronic health record.02/12/2026 1:26 PM, the Unit Manager RN verbalized both the nursing staff, and the Minimum Data Set 3.0 (MDS) staff were responsible for care plan implementation and revision. If a change was made to a resident's treatment plan, the Unit Manager would document the change in an interdisciplinary team (IDT) note and the MDS staff would revise the care plan.On 02/12/2026 at 2:33 PM, the MDS Coordinator explained the MDS Coordinator received a daily 24-hour report comprised of changes made to resident treatment for all residents in the facility. The MDS Coordinator used the report to guide Care Plan implementation and revision. All staff were responsible for ensuring the care plan was complete and accurate. A care plan focus would be removed from the care plan when the related treatment ceased. The MDS Coordinator verbalized Resident #70's oxygen order was discontinued; however, the care plan documented the resident received oxygen therapy.The facility policy titled Care Plans, Comprehensive Person-Centered, adopted 02/01/2019, documented the comprehensive, person-centered care plan would describe services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Assessments of residents were ongoing, and care plans were revised as information about the residents and the residents' conditions changed.Cross reference with tag F0757. |

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| F 0691<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and document review, the facility failed to ensure a resident with an ileostomy received care consistent with professional standards of practice and the resident's care plan for 1 of 23 residents (Resident #32), by not conducting and documenting a formal assessment of the residents ability to safely perform ileostomy self-care before allowing independent management of the pouch, not providing and documenting education on safe infection control, when to report problems; and, not ensuring staff provided and accurately documented ileostomy care and monitoring in accordance with physician orders and the care plan. This deficient practice had the potential to result in improper ostomy management, leakage, skin breakdown, infection, and inaccurate documentation of care.Findings include:Resident #32Resident #32 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including ileostomy status, cognitive communication deficit, and myoclonus.A Hospital Discharge summary dated [DATE], documented the resident emptied the ostomy; however, often made a mess.Physician's orders dated 01/26/2026, directed staff to change the ileostomy bag/wafer and to cleanse the ileostomy nag/wafer as need for leaking or accidental removal.A Care Plan initiated on 02/27/2026, identified alteration in bowel function related to neurogenic bowel and documented the resident had an ileostomy. The interventions included the following: Ostomy remained patent and functional daily. Resident remained clean and free from unpleasant odor. Assess stoma characteristics. Change ostomy bag/wafer every other shower day and as needed. Cleanse ostomy site daily and as needed. Monitor output and stoma condition. Provide ostomy care per facility protocol.Staff were to complete the interventions listed in the resident's care plan.The care plan lacked goals and interventions related to ostomy self-care, including assessment, education, supervision, and monitoring of Resident #32 performing independent ostomy care.On 02/09/2026 at 1:16 PM, Resident #32 explained the resident and the resident's spouse managed the ileostomy pouch because staff did not know how to properly change it. Resident #32 verbalized the Certified Nursing Assistants (CNA) had changed the pouch after admission; however, the CNAs were not properly trained which caused the ileostomy to leak fecal matter. As a result, Resident #32 and the resident's spouse initiated taking over the resident's own care of changing the ileostomy pouch.On 02/12/2026 at 10:42 AM, a CNA confirmed the resident was independent with changing the ileostomy and had been managing it. The CNA verbalized the CNAs were to ensure the wafer site looked clean, change the ileostomy bag if soiled or if gas accumulated, and notify a nurse if anything appeared abnormal with the wafer.On 02/12/2026 at 10:46 AM, a Licensed Practical Nurse (LPN) explained nurses supervised the resident while the resident emptied the ileostomy bag and changed the bag only on an as needed basis while monitoring the stoma site for signs of infection. The LPN was unsure if an assessment existed to determine whether the resident could safely perform the resident's own ostomy care.On 02/12/2026 at approximately 10:55 AM, a Registered Nurse (RN) explored the resident's clinical record and confirmed there was no assessment to determine the resident's ability to perform ileostomy self-care.On 02/12/2026 at 11:16 AM, the Director of Nursing (DON) explained CNAs were to empty the ileostomy bag and nurses were to clean the site. The nurses would change the bag as needed or at least weekly per physician's order. The DON verbalized in order for residents to perform self-care and change their own ostomy bag, the residents would need to be assessed for safety before being permitted to perform self-care. The DON confirmed Resident #32 had not been educated or assessed for safe self˜care and was unaware the resident was changing the ostomy bag themselves. The DON verbalized this posed a risk for improper supply use, incorrect sizing, and potential skin issues.On 02/12/2026 at 1:28 PM, the Regional Minimum Data Set (MDS) RN explained staff were signing off on the resident's ostomy care daily, which indicated staff performed the care, even though Resident #32 had been changing the ostomy<br>(continued on next page) |

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| F 0691<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | bag on their own. The Regional MDS RN verbalized an assessment should have been completed prior to letting the resident change the ostomy bag and the assessment would determine cognitive safety and infection control understanding. The Regional MDS RN explained Occupational Therapy (OT) had conducted an assessment, which was sufficient. The OT assessment reviewed the dexterity of the resident's movements to determine if the resident could change the ileostomy pouch independently. The Regional MDS RN confirmed OT could not assess the resident further to include education to the resident related to infection control, concerns to watch for, when to report concerns to staff, or any other nursing concern. The Regional MDS RN confirmed Resident #32 lacked a formal assessment and education for ostomy self-care, and verbalized the facility lacked a formal assessment process for residents performing ostomy self-care.The facility policy titled Changing an Ostomy Bag, undated, described steps to measure the stoma, prepare, and apply the pouch system, cleanse and protect the peristomal skin, ensure the closure clamp was secure, and document the reason for the change, skin condition, and client teaching or participation. The facility was unable to provide a policy for assessing a resident's ability to perform self-care of an ileostomy pouch. |

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| | 295088 | A. Building<br>B. Wing | 02/12/2026 |

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| Wingfield Skilled Nursing and Rehabilitation Cente | 2350 Wingfield Hills Rd<br>Sparks, NV 89436 |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and document review, the facility failed to identify, report, and address signs and symptoms of dehydration for 1 of 23 sampled residents (Resident #13) by not ensuring staff assessed, documented, or implemented required careˆplan interventions and physician orders related to hydration needs. The deficient practice had the potential for worsening dehydration, electrolyte imbalance, delayed treatment, and compromised physical wellˆbeing.Findings include: Resident #13 Resident#13 was admitted to the facility on [DATE], with diagnoses of hemiplegia and hemiparesis, dysphagia, and contractures. On 02/10/2026 at 8:26 AM, Resident#13 was observed lying in bed with dry, cracked lips. On 02/11/2026 at 1:30 PM, Resident #13 was observed with dry, cracked lips and sunken eyes. A Licensed Practical Nurse (LPN) assigned to Resident #13's care, confirmed the resident had dry, cracked lips, signs, and symptoms consistent with dehydration. The LPN stated the Certified Nursing Assistants (CNAs) had not reported the resident's condition to the nursing staff and acknowledged there was no documentation regarding the resident's current condition. On 02/11/2026 at 3:33 PM, Resident #13 was observed with dry, cracked lips and sunken eyes. A CNA stated that signs and symptoms of dehydration include cracked lips, sunken eyes, and a dry mouth. The CNA was brought to Resident #13's room and confirmed the resident was showing signs of dehydration. The CNA stated this condition should have been reported to the nursing staff. Resident #13's Dehydration Risk Evaluation dated 01/09/2026, documented the resident did not show any signs or symptoms of dehydration. A physician's order dated 04/07/2025, directed staff to assess and provide oral and nasal care every shift. Resident #13's care plan dated 04/07/2025, identified the resident was at risk for dehydration and electrolyte imbalance. The care plan indicated the resident had a history of dehydration, weight loss, and poor appetite related to stroke side effects. Resident #13's care plan goals included maintaining adequate hydration as evidenced by stable vital signs, good skin turgor within normal limits, and moist mucous membranes.Care plan interventions included the following: Observed, documented, and reported as needed any signs or symptoms of dehydration, such as decreased or no urine output. The resident received staff assistance with fluid intake to meet daily requirements. Monitored vital signs per protocol and reported significant abnormalities to the physician. Checked tube placement. Monitored and recorded weights. Observed for signs or symptoms of significant weight loss and dehydration and reported to the physician as needed. Observed, documented, and notified the physician as needed for symptoms of dehydration such as dry mucous membranes, poor skin turgor, increased lethargy, and increased confusion. On 02/12/2026 2:19 PM, the Director of Nursing (DON) explained the signs of dehydration included dry, cracked lips; sunken eyes; and dry, flaking skin on both lower extremities. The DON verbalized the CNAs were expected to provide oral care and complete a dehydration risk evaluation when a resident exhibited symptoms of dehydration. The facility policy titled Hydration-Clinical Protocol, dated 09/2017, documented the staff would provide supportive measures. The staff would identify and report to the physician individuals with signs and symptoms of existing fluid or electrolyte imbalance. physicians would manage significant fluid and electrolyte imbalance, and staff would provide support measures. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and document review, the facility failed to ensure the enteral nutrition was administered in accordance with physician orders and facility policy for 1 of 23 sampled residents (Resident #13). This deficient practice had the potential to place the resident at risk for aspiration and inadequate nutritional intake.Findings include: Resident #13 Resident #13 was admitted to the facility on [DATE], with diagnoses including hemiplegia and hemiparesis, dysphagia, and contractures. A physician order dated 04/08/2025, documented Jevity 1.5 continuous feeding at 65 milliliters (ml) per hour, to be turned off at 10:00 AM for four hours and restarted at 2:00 PM. On 02/10/2026 at 8:56 AM, Resident #13 had a tube feeding (a surgically placed device that delivers nutrition, fluids, and medicine directly into the stomach) running at a rate of 60 ml per hour. A physician order, dated 04/07/2025, documented to have the head of bed up 30-45 degrees during feeding and for one hour after gravity or bolus feeding. On 02/10/2026 at 8:58 AM, Resident #13 was observed in bed lying in a fetal position on the flat portion of the mattress near the lower part of the head of the bed. On 02/10/2026 at 9:00 AM, a Licensed Practical Nurse (LPN) verbalized Resident #13's head of bed was at approximately thirty degrees and should have been elevated higher. Resident #13 continued to be observed in a fetal position on the flat portion of the mattress near the lower part of the head of the bed. The LPN verbalized Resident #13 should have been repositioned due to aspiration risks.The LPN confirmed the feeding rate was set at 60 mL per hour and stated it should have been set at 65 mL per hour. The LPN verbalized that not setting the correct rate could result in the resident receiving an insufficient amount of nutrition. On 01/06/2022 at 10:26 AM, the Director of Nursing (DON) verbalized staff were expected to follow physician orders for the Gˆtube (gastrostomy tube). The DON verbalized Resident #13's head of bed should have been elevated due to the risk of aspiration during feeding, and the resident should have been repositioned to reduce aspiration risk. The facility's policy titled Enteral Feedings - Safety Precautions, updated 02/01/2019, documented staff were to check the enteral nutrition label against the physician order before administration, including method (pump, gravity, syringe) and rate (milliliters per hour) and required elevating the head of bed at least thirty degrees during feeding and for at least one hour afterward to prevent aspiration. If headˆofˆbed elevation was medically contraindicated, the reverse Trendelenburg position was to be used. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and document review, the facility failed to ensure 1) a safety sign was posted on the outside of a resident door related to oxygen (O2) therapy for 1 of 23 sampled residents (Resident #50) and 2) a resident requiring oxygen therapy was assessed timely when the resident complained of shortness of breath for 1 of 23 sampled residents (Resident #113). These deficient practices had the potential to result in improper handling of oxygen equipment increasing the risk of fire and compromising resident safety as well as the potential to result in physical and emotional distress.Findings include:<br><br>Resident #50<br><br>Resident #50 was admitted to the facility on [DATE] with diagnoses including chronic pulmonary hypertension, and congestive heart failure.<br><br>A physician's order dated 01/29/2026, documented to administer oxygen (O2) @ 4 liters/minute via nasal cannula continuously.<br><br>A care plan dated 01/30/2026, documented monitor peripheral capillary oxygen saturation (SPO2) every hour may titrate O2 to 5-6 liters via mask. Notify provider for any significant changes. O2 SETTINGS: O2 4 liters via nasal cannula as ordered. every shift.<br><br>A Medication Administration Record (MAR) documented change nasal cannula and O2 tubing one time per week every night shift, every Tuesday. Start date 02/03/2026.<br><br>On 02/09/2026 10:50 AM, observed no O2 sign postage at entry door.<br><br>On 02/09/2026 10:50 AM, Resident #50 wearing O2 with a concentrator next to bed. Resident #50 confirmed wearing O2 at all times and checked O2 levels to keep the saturations between 92 and 95 percent.<br><br>On 02/10/2026 8:53 AM, a Registered Nurse (RN) confirmed the facility has a schedule to check O2 every Tuesday night by checking tubing, and bottles, as well as checking as needed. The facility had physician orders and sheets to show how many liters to administer. RN confirmed the expectation of staff was to always have a sign on the resident room door when there was O2 in the room. The sign stated O2 in use and was posted outside the resident room door. It was intended to notify staff for safety purposes, like fire hazards.<br><br>On 02/12/2026 2:12 PM, the Director of Nursing (DON) confirmed when residents admit with O2, facility staff was expected to place a sign stating O2 in use outside the resident room entrance door as soon as the facility received a physician's order for O2. The DON confirmed not placing an O2 sign outside the resident room door could result in a resident getting hurt, which could become a safety hazard.<br><br>The facility policy titled, Oxygen Administration, dated 02/01/2019, documented the facility would post an Oxygen in Use sign on the outside of the room entrance door.<br><br>Resident #113<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #113 was admitted to the facility on [DATE], with diagnoses including chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease with acute exacerbation, other nonspecific abnormal finding of lung field, cognitive communication deficit, and anxiety disorder, unspecified.<br><br>A physician's order, dated 08/18/2025, documented to administer oxygen at three liters per minute via nasal cannula continuously every shift for chronic obstructive pulmonary disease (COPD) with acute exacerbation.<br><br>A care plan focus, initiated 07/29/2025, documented Resident #113 had oxygen therapy related to ineffective gas exchange and COPD with acute exacerbation. An intervention initiated 07/29/2025, documented to monitor the resident for signs and symptoms of respiratory distress to include restlessness.<br><br>On 02/09/2026 at 2:37 PM, Resident #113 sat in the resident's wheelchair wearing oxygen via nasal cannula at the nurse's station and verbalized I can't breathe. A Certified Nursing Assistant (CNA1) and a Support Aide were present. The resident was not acknowledged.<br><br>On 02/09/2026 at 2:40 PM, Resident #113 sat in the resident's wheelchair wearing oxygen via nasal cannula at the nurse's station and verbalized I can't breathe. CNA1 and a Support Aide were present. The resident was not acknowledged.<br><br>On 02/09/2026 at 2:46 PM, Resident #113 sat in the resident's wheelchair wearing oxygen via nasal cannula at the nurse's station and verbalized I can't breathe, I can't breathe. The resident became tearful. Resident #113's oxygen tank gauge read refill. CNA1 and a Support Aide were present. The resident was not acknowledged.<br><br>On 02/09/2026 at 2:51 PM, CNA1 verbalized the CNA1 did not respond to Resident #113 because the CNA1 was recently hired at the facility and was unfamiliar with Resident #113's care needs.<br><br>On 02/09/2026 at approximately 2:53 PM, the Support Aide confirmed hearing Resident #113 verbalize the resident could not breathe and explained the Support Aide was new to the facility and was not familiar with Resident #113's care needs.<br><br>On 02/09/2026 at approximately 2:55 PM, the following events occurred:<br><br>-A CNA2 approached the nurse's station.<br><br>-The CNA2 explained Resident #113 required continuous oxygen via nasal cannula.<br><br>-The CNA2 checked Resident #113's oxygen tank.<br><br>-The CNA2 verbalized the oxygen was low and needed to be replaced. The CNA2 verbalized the CNA2 would replace the oxygen tank.<br><br>On 02/09/2026 at 3:00 PM, the CNA1 verbalized the CNA1 received training from the facility on oxygen use to include observing nasal cannula placement, replacing the tank before the oxygen was low, observing the chest rise, and measuring oxygen saturations using a pulse oximeter. Should a resident complain of shortness of breath, the CNA1 would monitor the resident's oxygen saturations (continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | and locate a nurse to assess the resident.<br><br>On 02/12/2026 at 8:47 AM, a CNA3 explained Resident #113 required continuous oxygen therapy. When Resident #113 verbalized being unable to breathe, staff would check the resident's oxygen flow and tubing to confirm the resident received oxygen.<br><br>On 02/12/2026 at 8:50 AM, a Licensed Practical Nurse (LPN) verbalized Resident #113 previously expressed anxiety surrounding the resident's oxygen. When the resident complained of shortness of breath, staff would measure the resident's oxygen saturations and administer an Albuterol inhaler. The LPN verbalized Resident #113 required continuous oxygen therapy at 3 liters per minute per physician's order.<br><br>On 02/12/2026 at 9:28 AM, the Director of Nursing (DON) explained when a resident complained of shortness of breath, staff were expected to assess the resident's oxygen saturation levels and provide assurances to the resident. Staff should always address a resident's complaint of shortness of breath as an emergency.<br><br>On 02/12/2026 at 1:02 PM, the Administrator explained any staff member present would be responsible for assisting a resident complaining of shortness of breath. If the staff member available was unfamiliar with the resident's care needs, the staff would be expected to find a CNA, notify a nurse, or refer to the resident's chart.<br><br>The facility policy titled Oxygen Administration, adopted 02/01/2019, documented before administering oxygen and while the resident received oxygen therapy, staff were to assess for signs or symptoms of cyanosis, hypoxia, and oxygen toxicity to include difficulty breathing or slow shallow breath, as well as vital signs and oxygen saturation. Staff were to check the mask, tank, and humidifying jar to ensure all were in working order. Staff would observe the resident upon oxygen setup and periodically thereafter to ensure oxygen was tolerated. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and document review, the facility failed to ensure an oxygen administration was stopped and the concentrator removed from the resident's room when the physician's order for oxygen was discontinued for 1 of 23 sampled residents (Resident #70). The deficient practices had the potential to cause residents to use an unnecessary medication with possible adverse effects.Findings include:Resident #70Resident #70 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), and emphysema.A physician's order dated 11/13/2026, and discontinued on 01/29/2026, documented to administer oxygen at 3 liters per minute (lpm) via nasal cannula continuously every shift for emphysema.Resident #70's clinical record lacked documentation of an active physician's order for oxygen therapy.An alert progress note dated 01/29/2026, documented Resident #70's oxygen saturation was 95 percent (%) on room air. The resident did not use their oxygen in the previous 24 hours. The oxygen order would be discontinued.An oxygen saturations summary documented the following:-On 01/30/2026 at 8:33 AM oxygen saturation was 90%. Oxygen administered via nasal cannula.-On 01/31/2026 at 12:37 AM oxygen saturation was 90%. Oxygen administered via nasal cannula.-On 02/06/2026 at 10:56 PM oxygen saturation was 90%. Oxygen administered via nasal cannula.-On 02/08/2026 at 7:11 PM oxygen saturation was 91%. Oxygen administered via nasal cannula.On 02/09/2026 at 3:11 PM, Resident #70 was in bed in the resident's room. An oxygen concentrator was placed next to the bed and was set to an oxygen flow of 3 liters per minute. The nasal cannula and oxygen tubing were on the floor.Resident #70 verbalized the resident did not require oxygen therapy and was unsure why the oxygen concentrator was present in the resident's room.On 02/09/2026 at 3:20 PM, a Registered Nurse (RN) verbalized believing Resident #70 required continuous oxygen therapy at two liters per minute via nasal cannula.The RN was informed Resident #70's oxygen was not being used by the resident, and the nasal cannula was on the floor. The RN entered the resident's room and encouraged the resident to wear the nasal cannula. The resident replied no, I don't need it. The RN exited the resident's room.On 02/09/2026 at 3:23 PM, the RN confirmed Resident #70 was not wearing the nasal cannula and the nasal cannula was on the floor. The RN verbalized the RN educated the resident and resident refused to wear the nasal cannula. The RN verbalized the RN would monitor the resident's oxygen saturation and left to retrieve a pulse oximeter. Upon return, the RN verbalized the RN was mistaken and the physician's order for oxygen therapy was discontinued on 01/29/2026.On 02/12/2026 at 9:03 AM, a Licensed Practical Nurse (LPN) explained Resident #70 previously received oxygen therapy. However, the resident was stable on room air so the facility requested to titrate the oxygen and the physician's order was discontinued. The LPN recalled the LPN was the nurse to discontinue the oxygen order in the resident's electronic health record. The LPN explained when an oxygen order was discontinued, the LPN would immediately remove the concentrator from the resident's room to ensure the oxygen therapy was not administered without a physician's order.02/12/2026 1:26 PM, the Unit Manager RN verbalized staff were expected to round on residents every two hours to ensure the nasal cannula was placed properly on the resident's face, oxygen tubing was not on the floor, and the humidifier and the tubing were properly labeled with the date changed. The Unit Manager RN explained when oxygen therapy was discontinued, the oxygen concentrator would immediately be removed from the room, and the oxygen safety sign would be removed from the resident's entryway.The Unit Manager RN defined an unnecessary medication as one administered without a physician's order. The Unit Manager RN would consider oxygen to be a medication. The Unit Manager RN explained unnecessary oxygen therapy administered to residents with COPD could result in embolism and other complications.On 02/12/2026 at 3:20 PM, the Director of Nursing (DON) defined an unnecessary medication as one administered without an order prescribed by the physician. If a medication was administered after the<br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | medication order was discontinued, the DON would consider it unnecessary medication. When a physician's order for oxygen was discontinued, the concentrator would need to be removed from the resident's room, cleaned, and placed into the storage area.The facility policy titled Storage of Medications, adopted 02/01/2019, documented the facility would not use discontinued drugs or biologicals. All such drugs would be returned to the dispensing pharmacy or destroyed.The facility policy titled Adverse Consequences and Medication Errors, adopted 02/01/2019, documented an example of a medication error included an unauthorized drug, or a drug administered without a physician's order.Cross reference with tag F0657. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure 1) medications were secured in a locked cart and inaccessible to residents, visitors, and unauthorized staff when two medication carts and a treatment cart were left unlocked and unattended by a nurse, and 2) expired medications were removed from 1 of 2 medication carts inspected for medication storage. This deficient practice had the potential for residents, visitors, and unauthorized staff to have access to medications not prescribed or intended for the individual and for expired medications with diminished efficacy to be administered to residents. Findings include: Medication carts and treatment cart:<br><br>On 02/09/2026 at 12:03 PM, the medication cart located at the entrance to the 100 Hall was unlocked and unattended. The top left drawer was pulled open approximately six inches.<br><br>On 02/09/2026 at 12:04 PM, the Registered Nurse (RN) walked out of the Cafe room, walked up to cart and closed the top left drawer. The RN verbalized having stepped away from the medication cart to take blood sugar readings and confirmed the medication cart was left unlocked, unattended and out of site. The RN verbalized the medication cart should have been locked when the cart was not within view of the nurse.<br><br>On 02/12/2026 at 3:17 PM, the DON verbalized having expected all medication carts to be locked at all times when not in view.<br><br>On 02/10/2026 at 8:40 AM, a medication cart was against the wall on the second floor, next to room [ROOM NUMBER], with the drawers facing the hallway. The medication cart was unlocked, and there were no staff members in sight of the cart.<br><br>On 02/10/2026 at 8:46 AM, a Licensed Practical Nurse (LPN) came out of room [ROOM NUMBER] and confirmed the medication cart had been left unlocked with the keys in the LPN's pocket while the cart was unattended and out of sight.<br><br>On 02/12/2026 at 2:19 PM, the Director of Nursing (DON) verbalized the procedure for leaving a medication cart unattended was for the medication cart to be locked and the medication cart keys would always be with the nurse.<br><br>On 02/09/2026 at 11:01 AM, a treatment cart was against the wall in the 100 hallway, next to room [ROOM NUMBER], with the drawers facing out into the hallway. An RN walked up to the treatment cart, opened a drawer without the use of keys, retrieved medication from the cart, closed the drawer, and walked away, without locking the cart. The treatment cart was not within view of any other staff members.<br><br>On 02/09/2026 at 11:01 AM, the RN verbalized the RN was passing medications or something like that.<br><br>On 02/09/2026 at 11:04 AM, RN2, opened the door from the inside of room [ROOM NUMBER], exited the room, performed hand hygiene, and walked past the treatment cart.<br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 02/09/2026 at 11:04, RN2 explained the treatment and medication carts could remain unlocked, without staff present, if the carts were pushed against the wall. RN2 confirmed the treatment cart was unlocked, unsecured, and contained resident medications used to treat wounds. RN2 explained residents had access to medications not prescribed to them, should a resident access the treatment cart.<br><br>Inside of the treatment cart were the following unsecured items:<br><br>Zinc<br><br>Oxide Ointment<br><br>Therahoney Gel<br><br>Hydro Amorphous Dressing<br><br>Curad Triple Antibiotic Ointment<br><br>Collagenase Santyl Ointment 250 unit/gram<br><br>Triamcinolone Acetonide Ointment USL 0.1%<br><br>1% Silver Sulfadiazine Cream (SSD)<br><br>Two boxes of Therahoney HD Sheet Honey Impregnated Wound Dressing<br><br>Several Zinc Ointment Oxide Skin Protectant Aquaphor packets<br><br>Several Thera Moisturizing Body Sheild packets<br><br>Several Dermafungal Antifungal Cream packets, 2% Miconazole Nitrate<br><br>Several Vitamin A & D Ointment Powder Stimulant Enhance Collogen Powder packets<br><br>At the bottom of the treatment cart were all resident specific medications. The unsecured medications were the following:<br><br>Two bottles of Ammonium Lactate 12% Moisturizing Lotion<br><br>Aspercreme 4% Lidocaine Pain Relief Spray, 4 ounces<br><br>Lidocaine<br><br>Diclofenac Sodium Topical Gel 3%<br><br>Antifungal Cream, 2% Miconazole Nitrate<br><br>Two bottles of Nystatin Powder 100,000<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295088 | A. Building<br>B. Wing | 02/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Wingfield Skilled Nursing and Rehabilitation Cente | 2350 Wingfield Hills Rd<br>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.

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Remedy Antifungal Powder<br><br>Four tubes of Clobetasol Propionate USP 0.05%<br><br>Diclofenac Sodium Topical Gel 1%<br><br>Triamcinolone 0.1% Lubricant, 454 grams<br><br>Two tubes of Ketoconazole Cream 2%<br><br>Two tubes of Hydrocortisone Cream 2.5%<br><br>Two packages of Epsom Salt Magnesium Sulfate Saline Laxative<br><br>Triamcinolone Acetonide Ointment USP 0.1%<br><br>Cetaphil Moisturizing Cream 20 ounces<br><br>On 02/11/2026 at 8:36 AM, the Director of Nursing (DON) explained the facility had two kinds of carts. One cart was a treatment cart containing necessary supplies to address resident wounds. The second cart was a medication cart containing all resident medications used for daily administration to the residents. If the carts were not in use, the carts were to have the drawers facing the wall and locked at all times. If the carts were in use, the carts could face away from the wall; however, the carts must be locked at all times. The DON verbalized if the treatment carts or the medication carts were left unlocked, it could be a safety concern for the residents because any resident could access the medications contained in the carts. If the residents accessed the medications, the residents could use or ingest the medications themselves. The DON explained staff were not trained to leave the treatment or medications carts against the wall, unlocked if the drawers were facing the wall. The carts could still be maneuvered and would need to be locked at all times.<br><br>On 02/11/2026 at 9:09 AM, the DON provided the in-service training dated 10/13/2025, related to the security of treatment and medication carts. The DON verbalized all licensed staff were trained on the security of treatment and medications carts upon hire at the facility, and during the monthly facility meetings.<br><br>The training titled Nurses Monthly Meeting, dated 10/13/2025, documented 28 staff members were present for the training. The topics covered during the training were:<br><br>Missing medications/unavailable<br><br>Hospital Lab Specimen Pick up<br><br>Liberalized Medications<br><br>Medication at Bedside; and,<br><br>Medication Carts<br><br>Should always be locked when out of vision.<br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility policy titled Security of Treatment Cart, adopted 02/01/2019, documented the nurse must secure the treatment cart during usage and non-usage to prevent unauthorized entry. When it was not possible to face the cart toward the resident room, the cart had to be pushed against the wall, with the drawers facing the wall, and the cart must be locked before the nurse entered a resident's room. Treatment carts were to be securely locked at all times when out of the nurse's view and when the cart was not being used, it must be locked and parked either at the nurses' station or inside of a medication room.<br><br>Expired medications in a medication cart<br><br>On 02/12/2026 at 2:08 PM, the following medications were found in a medication cart on the second floor of the facility:<br><br>-A bubble pack containing 32 tablets of Hydroxyzine Hydrochloride (HCl). The expiration date printed on the bubble pack was 01/30/2026.<br><br>-A box of Allegra 60 milligram (mg) tablets, with 25 tablets remaining inside. The expiration date printed on the box was 07/2025.<br><br>On 02/12/2026 at 2:21 PM, LPN2 confirmed the expiration dates printed on the medication containers had passed and the medications were expired. LPN2 verbalized medications should be removed from carts no later than the expiration date printed on the container.<br><br>On 02/12/2026 at 2:23 PM, the DON verbalized nurses were expected to remove discontinued and expired medications from medication carts and place the medications in the medication storage room pending destruction. The DON explained it was important to remove medications from the cart as soon as the medications expired to prevent an expired medication from being administered to a resident.<br><br>The facility policy titled Storage of Medications, dated 02/01/2019, documented the facility would not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs were to be returned to the dispensing pharmacy or destroyed. |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>Based on observation, interview, and document review, the facility failed to enforce its nonˆsmoking policy and failed to ensure staff refrained from smoking on facility property. The deficient practice created potential fire hazards and compromised the safety of residents, staff, and visitors.Findings include:On 02/09/2026 at 7:45 AM, two staff members were observed standing outside the front entryway near the handicap parking spaces next to the facility van, while smoking. Both employees extinguished the cigarettes and reˆentered the front entrance at 7:51 AM. The area was within the main entrance zone of the facility.On 02/09/2026 at 8:41 AM, there was an open ash tray with cigarette butts outside of the back entrance to the kitchen area of the facility.On 02/09/2026 at 9:41 AM, the Administrator verbalized the facility was a non-smoking campus. Residents and staff who smoke cigarettes, were to smoke off of the property. The Administrator confirmed the facility followed the facility smoking policy.On 02/11/2026 at 11:04 AM, there was an ashtray with two cigarette buts outside of the back door near the kitchen area of the facility and one staff member was observed smoking a cigarette while seated on the curb in the same area. On 02/11/2026 at 11:11 AM, the Housekeeper smoking on the property verbalized smoking every day, a few times a day, in the same area in the back of the facility, outside of the kitchen. When the Housekeeper was finished smoking a cigarette, the cigarette butt would be extinguished in the ash tray and left for someone to clean out the ashtray. The Housekeeper believed Maintenance was responsible for emptying the ashtray, had been slacking in the past few weeks, and was allowing the ashtray to overflow with cigarette butts.On 02/11/2026 at 11:12 AM, the Kitchen Manager explained the ashtray was always outside of the backdoor to the kitchen and was used for staff to dispose of the cigarette butts when the staff were finished smoking. The Kitchen Manager was not sure who was responsible for emptying the ashtray but the cigarette butts would be taken to the trash dumpster a few feet away for disposal. The Kitchen Manager confirmed an employee was smoking on the facility property and verbalized all staff were supposed to be smoking off of the property on the sidewalk, behind the Housekeeper actively smoking on the property.On 02/11/2026 at 2:28 PM, the Regional Minimum Data Set (MDS) Registered Nurse (RN) and the Owner of the facility both confirmed the facility was a non-smoking campus. Residents were able to smoke outside of the facility parking lot and employees could smoke on the pathway, behind the facility; however, staff and residents were not allowed to smoke on the property.The facility policy titled Smoking Policy-Residents and Employees, last updated March 2022, documented the facility was committed to providing a safe, orderly and productive environment for the residents, employees, and visitors who come to the facility. The facility was a smoke free environment, prohibiting smoking in all indoor and outdoor areas. |

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| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>Based on observation, document review and interview, the facility failed to ensure nursing hours were posted daily in the facility.This deficient practice had the potential to prevent residents and visitors from being informed of the total number of nursing staff and the actual hours worked each day.Findings include: On 02/09/2026 at 8:02 AM, the daily nursing hours posted behind the front desk reception area was dated 02/06/2026. On 02/09/2026 at 8:09 AM, the Administrator confirmed the posting at the front desk was dated 02/06/2026 and should have been changed to the current date. The Administrator verbalized the Certified Nursing Assistant (CNA), Nursing Aide Staffing Coordinator, was responsible for updating the postings daily. On 02/09/2026 at 8:26 AM, the nursing hours posted at the first-floor nurses' station was dated 02/06/2026. On 02/09/2026 at 8:29 AM, the nursing hours posted at the second-floor nurses' station was dated 01/31/2026. On 02/09/2026 at 10:30 AM, the CNA, Nursing Aide Staffing Coordinator, responsible for updating the postings, confirmed all three of the postings in the facility had not been updated but should have been. The facility policy titled, Posting Direct Care Daily Staffing Numbers, dated 08/02/2019, documented the facility would post on a daily basis in a prominent location, the number of nurses and aides directly responsible for resident care. |