STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295089	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Care at Centennial Hills	6351 N Fort Apache Rd Las Vegas, NV 89149

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50289 Based on observation, interview, record review, and document review, the facility failed to ensure an assessment for the use of bilateral mitten restraints for a resident was completed accurately and consent for the mitten restraints was obtained from the resident or the appropriate representative for 1 of 20 sampled residents (Resident #44). The deficient practice had the potential to cause physical and psychosocial harm to the resident. Findings include: Resident #44 (R44) Resident # 44 was admitted on [DATE], with diagnoses including acute respiratory failure, anxiety disorder, type 2 diabetes mellitus, dementia, nontraumatic intracerebral hemorrhage, hypoxemia, tracheostomy, and gastrostomy. Assessment: On 07/23/2024 at 3:21 PM, Resident #44 was observed wearing bilateral hand mitts (a restrictive type of mitten to prevent residents from pulling out invasive devices such as intravenous lines, feeding or airway tubes). The active care plan details Resident #44 was ventilator dependent, at risk for skin impairment/pressure ulcer related to cognitive impairment, immobility, and the vision is in question due to severe communication impairment. The Care plan also documented the hand mitts to both hands were to prevent pulling on tubing. The Physician Order dated 05/31/2024, documented bilateral hand mitts to prevent dislodgment of lifesaving medical device. Remove q (every) 2 hours for comfort and skin integrity. R44's medical record revealed a physical restraint/ assistive device assessment was performed on 06/10/2024. The assessment documented the resident's cognitive status as confused, developmentally delayed, and nonverbal. (continued on next page)

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

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The assessment documented the hand mitts were in place to prevent the resident from pulling out the gastrostomy tube (a tube inserted into the resident's stomach for feeding) and the tracheostomy tube (a tube inserted into the resident's airway through the tracheal area of the neck and connected to a ventilator for respiratory support). The assessment indicated the resident was educated on what will happen if the trach is removed, but were not sure if the resident understood. The nurse completing the assessment had checked both the attestation boxes. One box documented the resident understood the facility had determined the resident does not have an assessed need for a restrictive and/or assistive device, but the resident requested to have device/devices in place as described per the resident's right. The other box attested the resident understood the facility has determined the resident had been assessed for the need for a restrictive and/or assistive device and the resident understood the risk/benefits and alternatives that have been described and agree to the devices to be utilized. 07/25/2024 at 1:35 PM, the Resident Care Manager (E23) stated the resident could probably not request to have the devices in place. The manager was not aware if the resident could understand the risk/benefits or could agree for the devices to be used. Consent: The restraint/assistive device assessment documented verbal consent was obtained from the resident's significant other and not from the resident's next of kin. On 07/25/2024 at 03:08 PM the charge nurse indicated when calls are needed for orders or consents for R44, a primary family member is called first. The charge nurse further explained if the primary family member does not respond, will move on to the next family member, who will normally respond back to the calls. Facility policy titled Use of Restraints documented, restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor) . Should a resident not be capable of making a decision, the surrogate or sponsor may exercise the right of the use or non-use of a restraint.

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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** 50289 Based on observation, interview, record review, and document review the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) level two referral was completed for 1 of 20 sampled residents (Resident #36). The deficient practice had the potential to deprive the resident of concern and other residents of necessary behavioral health services. Resident #36 (R36) R36 was readmitted on [DATE], with diagnoses including pulmonary edema, acute respiratory failure with hypoxia, anxiety disorder, mood disorder, generalized anxiety disorder, post-traumatic stress disorder, and major depressive disorder. On 07/23/2024 in the afternoon, R36 was sitting on the bed. R36 stated had been at the facility for about 8 years and the care and services at the facility were good. A PASARR level one document dated 12/27/2016, revealed R36 did not have dementia, mental illness (MI), intellectual disability, (ID) mental retardation (MR) or any related condition (RC) and was deemed appropriate for nursing facility placement. A review of psychiatry notes revealed R36's post-traumatic stress disorder (PTSD) was first diagnosed on [DATE], generalized anxiety disorder on 03/17/2017, mood disorder on 03/15/2017, and anxiety disorder on 02/16/2018. On 07/25/2024 at 10:34 AM, the Resident Care Manager (E24) stated the PTSD is believed to be from military service. The anxiety disorder is from the PTSD, and the resident takes medicine for both. The mood disorder is from the depression, manic episodes, and refusal of cares. The psychiatrist goes to the social service director and keeps the director abreast of the patient issues. Social services were responsible for the PASARR's. On 07/25/2024 at 10:48 AM, the Social Services Director (SSD)(E22) and the Social Worker (SW)(E25) explained the SSD was responsible for completing the online PASARR requests. The SSD indicated not being aware of social services' involvement with identifying and referring residents who met criteria for PASARR two referrals, unless the mental disorder was interfering with their daily living, they were suicidal, or were sent out to the hospital for psych issues. The Assistant Administrator confirmed social services' involvement with identifying and referring residents who met criteria for PASARR two referral, was to be completed in their morning meeting. When asked if the resident's diagnoses of anxiety disorder, mood disorder, generalized anxiety disorder, post-traumatic stress disorder, and major depressive disorder would be representative of mental illness, intellectual disability, or a related condition that the Medicaid Service Manual documents a PASARR II must be completed for, both the SSD and the SW stated these diagnoses would be an indication. The medical record lacked documented evidence R36 was referred for a PASARR level two screening. (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's document titled, The Division of Health Care Financing and Policy- Medicaid Services Manual- for Nursing Facilities Policy dated 05/01/2015, documented when an individual has been identified with possible indicators of mental illness, intellectual disabilities or related condition, a PASARR Level II screening must be completed to evaluate the individual and determine if nursing facility services and/or specialized services are needed and can be provided in the nursing facility. Examples include: a resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting a presence of a mental disorder (where dementia is not the primary diagnoses), or an intellectual disability or related condition was not previously identified and evaluated through PASARR. Social services would be responsible for keeping track of each resident's PASARR screening status and referring to appropriate authority.

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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** 40131 Based on observations, interviews, record reviews, and document reviews, the facility failed to ensure documentation accurately reflected medications and treatment services were provided. Specifically, this pertained to 1) wound care treatment; 2) ACE wrap (elastic bandage); 3) Oxygen (O2) therapy; and 4) diuretic medication . This deficient practice could potentially have led to severe harm, including ineffective wound management, an increased risk of respiratory complications, inadequate compression therapy, and compromised medication management. Findings include: A facility policy titled Administering Medications dated 04/08/2019, medications should be administered in a safe and timely manner and as prescribed. Medications or treatments must be administered in accordance with the orders, including any required time frame. Resident 48 (R48) R48 was admitted on [DATE], and readmitted on [DATE], with diagnoses including edema, anemia, congestive heart failure, effusion, chronic obstructive pulmonary disease (COPD), and heart failure. The Brief Interview of Mental Status documented a score of 15/15, which indicated R48's cognitive status was intact. 1) Wound Care Treatment: A physician order dated 07/09/2027, documented to cleanse skin tear to right forearm with normal saline, pat dry, apply no sting barrier film to peri wound, apply xeroform, and clear acrylic dressing every three days and as needed (PRN) on day shift for skin impairment. On 07/23/2024 at 1:19 PM, R48 was alert, oriented, and verbally responsive. R48's right forearm had a clear dressing dated 07/18/2024, which was peeling off. R48 indicated was admitted to the facility with the wound, which occurred when it got caught in the bed rail while in the hospital. R48 was uncertain about the frequency of the wound treatment but indicated it was treated when the Wound Care Treatment Nurse (WCTN) came for treatment. R48 indicated the last treatment occurred last week and did not refuse any wound care treatment. The Treatment Administration Record (TAR) dated 07/21/2024 documented the wound care treatment was provided to R48's right forearm, with Wound Care Treatment Nurse 1 (WCTN 1) signing off to indicate completion, despite the dressing being dated 07/18/2024. On 07/23/2024 at 1:41 PM, a Licensed Practical Nurse (LPN) confirmed the observation the clear wound dressing on R48's right forearm was dated 07/18/2024, old and peeling off. The LPN indicated the TAR was signed off or checked by WCTN 1 indicating the wound care treatment was successfully provided. The LPN indicated WCTN 1 was unavailable for interview and had already left the building. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/25/2024 at 11:56 AM, Wound Care Treatment Nurse 2 (WCTN 2) explained the process involved obtaining orders for wound care treatment, providing the treatment as scheduled, and documenting completion. WCTN 2 verified WCTN 1 had modified the TAR dated 07/21/2024 to reflect R48's refusal of treatment and the absence of treatment. WCTN 2 explained if a resident refused treatment, it should have been reoffered, and if treatment could not be provided, the physician should have been notified. WCTN 2 further explained while the wound care team could edit documentation, accurate recording of whether treatment was completed was expected on the same day as the scheduled treatment. On 07/25/2024 at 12:09 PM, WCTN 1 confirmed the treatment scheduled for 07/21/2024 was not provided but was inaccurately documented as successfully administered in the TAR. WCTN 1 explained was off the following day (07/22/2024) and had forgotten to correct the record. On 07/24/2024, WCTN 1 clarified had edited the documentation to reflect R48's refusal and verbalized R48 was asleep at the time and did not refuse the treatment. WCTN 1 confirmed the physician was not notified about the missed treatment on 07/21/2024, and accurate documentation was not maintained. On 07/25/2024 at 12:46 PM, the Director of Nursing (DON) indicated WCTNs were expected to provide wound treatment as ordered and maintain accurate documentation. 2) ACE wrap (elastic bandage): A Physician order dated 07/21/2024, documented to apply ACE wrap to bilateral lower extremities in the morning at 8:00 AM for edema and remove per schedule at 8:00 PM. On 07/23/2024 at 2:01 PM, R48 was in bed with both lower extremities edematous (swollen). The ACE wrap, ordered to treat the edema, was on the bedside table and not applied. R48 indicated taking medications with a recently increased dosage and indicated the ACE wrap was helping reduce the swelling, but were applied inconsistently. The Medication Administration Record (MAR) dated 07/23/2024 documented R48's ACE wrap was applied and in place. The ACE wrap was observed lying on the resident's bedside table. On 07/23/2024 at 2:50 PM, the ACE wrap was lying on top of R48's bedside table. The LPN confirmed R48's edema and an order for a diuretic and ACE wrap as treatment. The LPN confirmed the ACE wrap was not applied despite being documented as successfully applied. The LPN indicated the CNAs were responsible for the application of the ACE wrap. The LPN explained the Licensed Nurses oversee resident care, including the application of the ACE wrap, but failed to ensure the wrap was in place before signing off the TAR or documenting it was applied when the wrap had not been applied. The LPN confirmed the TAR was inaccurately documented. On 07/23/2024 at 1:55 PM, a Certified Nursing Assistant (CNA) indicated the Licensed Nurses or the wound nurses were responsible for putting on the ACE wrap not the CNAs. The CNA indicated being unaware of which residents should have ACE wraps and had no access to physician orders unless instructed by the Licensed Nurses. On 07/25/2024 at 10:37 AM, the Assistant Director of Nursing (ADON) indicated the nursing staff was responsible for applying the ACE wraps and ensuring were applied as ordered. The ADON verbalized the staff were expected to document or sign the MAR or TAR only after the task had been completed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) Oxygen (O2): A physician order dated 07/08/2024, documented O2 at 2-4 liters per minute (LPM) via nasal cannula. May titrate to keep O2 saturation greater than 90 percent (%) related to chronic obstructive pulmonary disease (COPD) with exacerbation. On 07/23/2024 at 10:06 AM, R48 was in the therapy session, O2 via concentrator was left on at bedside and flowing at 5 LPM, the nasal cannula was on the chair, O2 tubing was dated 07/24/2024. On 07/23/2024 at 2:50 PM, R48 was in bed, alert and oriented. R48's O2 was flowing at 5 LPM via nasal cannula. R48 reported the therapy had been completed before lunch. R48 indicated had received O2 at 3 LPM continuously at home and the same flow rate at the facility. R48 did not exhibit any signs or symptoms of shortness of breath. The MAR dated 07/23/2024, documented R48's O2 was flowing and administered at 3 LPM continuously via nasal cannula. On 07/23/2024 at 2:50 PM, the LPN confirmed R48's O2 was flowing at 5 LPM continuously via nasal cannula. The LPN verified and confirmed R48's O2 order was for 2-4 LPM. The LPN explained the O2 flow meter had not been checked but had been documented in the MAR as 3 LPM. The LPN indicated the O2 flow meter should have been verified and documented accurately, but the O2 order had been inaccurately administered and documented. On 07/24/2024 in the morning, the Charge Registered Nurse (CRN) indicated the staff were expected to document accurately after the order was verified and completed. On 07/25/2024 at 10:25 AM, the ADON indicated the documentation accuracy was crucial to the resident's care. Staff were expected to verify and administer medications and treatments as ordered. On 07/25/2024 at 3:32 PM, the Director of Respiratory Services explained if a resident with a diagnosis of COPD received too much oxygen when it was not needed, it could potentially suppress the resident's respiratory drive. A facility policy titled Oxygen Administration dated March 2015, indicated the need to verify a physician's order. The policy instructed staff to review the physician's order or facility protocol for O2 administration. An assessment was required before administering O2 and while the resident was receiving it. Cross reference to Tag F684 41903 4) Diuretic Medication: Resident 56 (R56) R56 was admitted on [DATE] and readmitted on [DATE], with diagnosis including Parkinson's disease with dyskinesia and fluctuations, atrial fibrillation, and major depressive disorder. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Order Summary Report documented a physician order for Lasix (a medication used to remove excess fluid in the body) Oral Tablet 40 milligrams (mg), give one tablet by mouth one time a day for edema (swelling). On 07/25/2024 at 8:55 AM, during medication administration observation, a nurse pulled out of the medication cart an empty medication packet labeled Lasix Oral Tablet 40 mg. The nurse explained the Lasix was not available in the cart and would order it from the pharmacy. The nurse reported did not know how long it would take the pharmacy to deliver the Lasix. The nurse confirmed the Lasix was not administered to R56 along with the rest of R56's medication. On 07/26/2024 in the morning, review of R56's medication administration record revealed the nurse had documented administered Lasix Oral Tablet 40 mg on 07/25/2024 at 9:24 AM. The medical record lacked documented evidence of where the nurse had obtained the administered medication from. On 07/26/2024 at 12:30 PM, the Director of Nursing (DON), explained Lasix was a medication available in the Pyxis (an automated medication dispensing system) which the nurse could have accessed. The DON further explained the Nurse could have also requested medication from the pharmacy, however, the Pyxis was the first choice to best administer medication to residents in a timely manner as ordered. On 07/26/2024 at 2:05 PM, the DON confirmed the Lasix administered to R56 had not been removed from the Pyxis and also confirmed the pharmacy did not provide the medication to the Nurse. The DON further explained had contacted the nurse who admitted to the DON the Lasix administered to R56 was borrowed from another nurse and belonged to another resident. The DON acknowledged the Lasix belonging to another resident should not have been borrowed from another nurse, both for safety reasons and it created a shortage of medication for another resident. A policy titled Medication Administration General Guidelines revised 01/01/2023, documented medications were to be administered as prescribed in accordance with good nursing principles and practices. Medications supplied for one resident were never to be administered to another resident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interview, record review, and document review, the facility failed to ensure: 1) the wound care treatment was provided as ordered to treat impaired skin; 2) the ACE wrap (elastic bandage) was applied as ordered to treat edema; and 3) the Oxygen flow meter rate was administered as ordered to treat chronic obstructive pulmonary disease (COPD) for 1 of 20 sampled residents (Resident 48). These deficient practices had the potential to cause delayed wound healing, increased risk of complications related to poor circulation and compromised respiratory function. Findings include: Resident 48 (R48) R48 was admitted on [DATE], and readmitted on [DATE], with diagnoses including edema, anemia, congestive heart failure, effusion, COPD, atrial fibrillation and heart failure. The Brief Interview of Mental Status dated 07/13/2024, documented a score of 15/15, which indicated R48's cognitive status was intact. 1) Wound Care Treatment The admission Skin Integrity Report dated 07/07/2024 documented R48 had a skin tear on the right forearm measuring 1.5 centimeters by 1.0 centimeters, which was well approximated. The surrounding tissue was fragile, intact. A Physician order dated 07/09/2027, documented to cleanse skin tear to right forearm with normal saline, pat dry, apply no sting barrier film to peri wound, apply xeroform and clear acrylic dressing every three days and as needed (PRN) on day shift for skin impairment. A Care plan revised 07/19/2024, documented to provide treatment as ordered. On 07/23/2024 at 1:19 PM, R48 was alert, oriented, and verbally responsive. R48's right forearm had a clear dressing dated 07/18/2024, which was peeling off. R48 indicated was admitted to the facility with the wound, which occurred when it got caught in the bed rail while in the hospital. R48 was uncertain about the frequency of the wound treatment but indicate it was treated when the Wound Care Treatment Nurse (WCTN) came for treatment. R48 indicated the last treatment was last week and did not refuse any wound care treatment. The Treatment Administration Record (TAR) dated 07/21/2024, documented the wound care treatment was provided to R48's right forearm. Wound Care Treatment Nurse 1 (WCTN 1) signed off the TAR to indicate completion. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/23/2024 at 1:41 PM, a Licensed Practical Nurse (LPN) confirmed the observation the clear wound dressing on R48's right forearm was dated 07/18/2024, old and peeling off. The LPN indicated the TAR was signed off or checked by WCTN 1 indicating the wound care treatment was successfully provided. The LPN indicated WCTN 1 was unavailable for interview and had already left the building. On 07/25/2024 at 11:56 AM, Wound Care Treatment Nurse 2 (WCTN 2) explained the process involved obtaining orders for wound care treatment, providing the treatment as scheduled, and documenting completion. WCTN 2 confirmed the treatment administration record dated 07/21/2024 had been edited by WCTN 1 to indicate R48 refused the treatment. WCTN 2 explained if a resident refused treatment, it should have been reoffered, and if treatment could not be provided, the physician should have been notified. On 07/25/2024 at 12:09 PM, WCTN 1 confirmed the treatment scheduled for 07/21/2024 was not provided, but was inaccurately documented as successfully administered in the TAR. WCTN 1 explained was off the following day and forgot to correct the record. WCTN 1 indicated on 07/24/2024, the documentation was edited to indicate R48 refused the wound treatment, but WCTN 1 clarified R48 was asleep at the time and did not refuse the treatment. WCTN 1 confirmed the physician was not notified about the missed treatment on 07/21/2024, and accurate documentation was not maintained. On 07/25/2024 at 12:46 PM, the Director of Nursing (DON) indicated that WCTNs were expected to provide wound treatment as ordered and maintain accurate documentation. 2) ACE wrap (elastic bandage) The Nursing Admission assessment dated [DATE], documented R48 had present edema (swelling) on right and left lower extremities of 1 + pitting, capillary refill of less than 3 seconds. A physician order dated 07/21/2024, documented to apply ACE wrap to bilateral lower extremities in the morning at 8:00 AM for edema and remove per schedule at 8:00 PM. On 07/23/2024 at 2:01 PM, R48 was in bed with both lower extremities edematous (swollen). The ACE wrap, ordered to treat the edema, was on the bedside table, but not applied. R48 indicated taking medications with a recently increased dosage and indicated the ACE wrap was helping reduce the swelling, but was applied inconsistently. The Medication Administration Record (MAR) dated 07/23/2024 documented R48's ACE wrap was applied and in place. The ACE wrap had been observed lying on the resident's bedside table. On 07/23/2024 at 2:50 PM, the ACE wrap was lying on top of R48's bedside table. The LPN confirmed R48's edema and an order for a diuretic and ACE wrap as treatment. The LPN confirmed the ACE wrap was not applied despite being documented as successfully applied. The LPN indicated the CNAs were responsible for the application of the ACE wrap. The LPN explained the Licensed Nurses oversee resident care, including the application of the ACE wrap, but failed to ensure the wrap was in place before signing off the TAR or documenting it was applied when it was not. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/23/2024 at 1:55 PM, a Certified Nursing Assistant (CNA) indicated the Licensed Nurses or the wound nurses were responsible for putting on the ACE wrap, not the CNAs. The CNA indicated being unaware of which residents should have ACE wrap and had no access to physician orders unless instructed by the Licensed Nurses. On 07/25/2024 at 10:37 AM, the Assistant Director of Nursing (ADON) indicated the nursing staff was responsible for applying the ACE wraps and ensuring the wraps were applied as ordered. The ADON verbalized the staff were expected to document or sign the MAR or TAR only after the task had been completed. A facility policy titled Administering Medications dated 04/08/2019, medications should be administered in a safe and timely manner and as prescribed. Medications or treatments must be administered in accordance with the orders, including any required time frame. 3) Oxygen (O2) A physician order dated 07/08/2024, documented O2 at 2-4 liters per minute (LPM) via nasal cannula. May titrate to keep O2 saturation greater than 90 percent (%) related to chronic obstructive pulmonary disease (COPD) with exacerbation. A Care plan dated 07/08/2024, documented R48 had inadequate/ compromised respiratory function due to respiratory failure, congestive heart failure and COPD/ The interventions included was to administer the medications and O2 use as ordered. On 07/23/2024 at 10:06 AM, R48 was in the therapy session, O2 via concentrator was left on at bedside and flowing at 5 LPM, the nasal cannula was on the chair, and O2 tubing was dated 07/24/2024. On 07/23/2024 at 2:50 PM, R48 was in bed, alert and oriented. R48's O2 was flowing at 5 LPM via nasal cannula. R48 reported finishing the therapy before lunch. R48 indicated had received O2 at 3 LPM continuously at home and the same flow rate at the facility. R48 did not exhibit any signs or symptoms of shortness of breath. The MAR dated 07/23/2024, documented R48's O2 was flowing and administered at 3 LPM continuously via nasal cannula. On 07/23/2024 at 2:50 PM, the LPN confirmed R48's O2 was flowing continuously at 5 LPM via nasal cannula. The LPN verified and confirmed R48's O2 order was for 2-4 LPM. The LPN explained had not checked the O2 flow rate, but had documented it in the MAR as 3 LPM. The LPN further explained accurate verification and documentation of the O2 flow meter were necessary, but the administration and documentation of the O2 order were inaccurate. On 07/24/2024 in the morning, the Charge Registered Nurse (CRN) indicated the staff were expected to document accurately after the order was verified and completed. On 07/25/2024 at 10:25 AM, the ADON indicated the documentation accuracy was crucial to the resident's care. The ADON expected staff to verify and administer medications and treatments as prescribed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/25/2024 at 3:32 PM, the Director of Respiratory Services explained if a resident with a diagnosis of COPD received too much oxygen when it was not needed, it could potentially suppress the resident's respiratory drive. A facility policy titled Oxygen Administration, dated March 2015, indicated the need to verify a physician's order. The policy instructed staff to review the physician's order or facility protocol for O2 administration. Before administering O2 or while the resident was receiving it, an assessment was required.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29141 Based on observation, interview, record review, and document review, the facility failed to implement floating heels to prevent pressure ulcers for 1 of 20 sample residents (Resident #11). The deficient practice had the potential to expose the resident to an avoidable skin injury. Findings included: Resident #11 (R11) R11 was admitted on [DATE], with diagnoses including hypertension, diabetes, epilepsy, CVA, and chronic hypoxia. A physician order dated 04/26/2024 documented floating heels while in bed for skin integrity. A Braden Scale for predicting pressure sore risk assessment dated [DATE] indicated R11 had moderate risk for pressure sore. On 07/23/24, at 10:00 AM, R11 was in bed without any heel protectors, and the heels were not floating. A registered nurse confirmed the observation and explained the bed should have been in a position to allow heels to float. The bed was in a flat position, which did not prevent the heels from coming into direct contact with the mattress. On 07/25/2024 at 2:00 PM, R11 was in bed and was not wearing heel protectors, and the heels were not floating. The RN confirmed the observation and, after reviewing the medical record, acknowledged R11's heels should have been floating to prevent pressure ulcers. A care plan dated 05/24/2024 revealed R11 was at risk for skin impairment related to friction, incontinence, bruises, diabetes, chronic progressive diseases, and decreased mobility. The care plan's approaches included float heels with pillows to relieve pressure on bony prominence and heel and foot drop protector boots on both feet while in bed. On 07/25/2024 in the afternoon, the Director of Nursing explained the floating heels procedure was a nursing intervention and should have been implemented following the plan of care. The facility policy titled Prevention of Pressure Injury-Level II, dated 05/15/2019, stipulated when a resident is in bed, any attempt should be made to keep heels off of the bed by placing a pillow or a Keen Heel Float device.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41903 Based on observation, interview, record review, and document review, the facility failed to complete a post fall assessment and neurological checks after an unwitnessed fall for 1 of 20 residents (Resident 38). The failed practice could have contributed to increased pain and a delay of necessary medical interventions. Findings include: Resident 38 (R38) R38 was admitted on [DATE] with diagnosis including polyneuropathy, unilateral primary osteoarthritis of right hip, dizziness and giddiness. A Care Plan initiated 02/11/2024, documented R38 was at risk for falls due to muscle weakness and history of falls. A Fall/Post Fall assessment dated [DATE] documented a history of falls, and R38 remained at risk for falls related to unsteady gait with poor safety awareness. On 07/23/2024 at 9:51 AM, R38 reported fell asleep sitting on bed and fell on the floor approximately one week before. R38 reported had right hip pain after the fall. A Fall Note dated 07/09/2024, documented R38 reported fell asleep while lying down on edge of bed and fell on the floor on right side. R38 reported right hip and right leg were slightly sore. R38's medical record lacked documented evidence a post fall assessment and neurological checks were completed for the fall R38 reported on 07/09/2024. On 07/24/2024 at 2:02 PM, the Director of Nursing (DON) reported had spoken to the nurse R38 had reported the fall to. The nurse had acknowledged to the DON fall protocol was not followed due to the resident reporting the fall two days after it happened. The DON explained the post fall assessment and neurological checks should have been completed regardless of when R38 reported the fall. The DON further acknowledged the recent increased pain reported by R38 could have been related to the fall. On 07/24/2024 at 3:52 PM, a Charge Nurse (CN), reported a post fall assessment and neurological checks had to be completed regardless of whether the fall was identified immediately or reported by a resident later and whether or not it was a witnessed or unwitnessed fall. The CN explained the benefits to the resident of a post fall assessment and neurological checks completed included identification of injuries and correct care provided. On 07/25/2024 at 8:16 AM, a Registered Nurse (RN) reported the pain on right hip R38 complained about, may have been related to the recent fall. The RN explained even if R38 reported the fall days later, an assessment and neurological checks should have been completed as part of the fall protocol. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy titled Accidents and Incidents Investigating and Reporting revised 05/2018, documented date and time the accident or injury took place, nature of the injury/illness (e.g. fall), circumstances surrounding the accident or injury, the condition of the injured resident including vital signs, and other pertinent data as necessary or required should have been included in the resident's clinical record. A policy titled Falls and Fall Risk Managing revised 11/2022, documented if falls recurred despite initial interventions, staff would implement additional or different interventions, or indicate why the current approach remains relevant.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interview, record review, and document review, the facility failed to ensure: 1) water flushes were provided following the admission of a tube feeding-dependent resident, or the physician was notified when the hydration needs were not successfully met for 1 of 20 sampled residents (Resident 188), and 2) the resident's weight was obtained in a timely manner for 1 of 20 sampled residents (Resident 39). These deficient practices could have potentially resulted in severe dehydration, compromised nutritional status, increased risk of medical complications, and delayed recovery. Findings include: 1) Resident 188 (R188) R188 was admitted on [DATE], with diagnoses including dysphagia (difficulty swallowing), gastrostomy (tube inserted into the stomach for nutrition and hydration) status and malignant neoplasm of lip, oral cavity and pharynx. The Nursing Admission assessment dated [DATE], documented an initial Brief Interview of Mental Status score of 15/15, indicating R188's cognitive status was intact. On 07/23/2024 at 10:08 AM, R188 was lying in bed, alert and verbally oriented. The water bag (part of the tube feeding equipment) was full at 1000 milliliters (ml), labeled with a date and time (07/22/2024, 7:30 PM) and R188's name. A Licensed Practical Nurse (LPN) indicated R188 had been admitted on [DATE] around 6:00 PM, was dependent on tube feeding (TF), and was NPO (nothing per Orem or nothing by mouth). The LPN explained R188 had requested water, but due to swallowing difficulties, R188 could not drink. The LPN further explained the TF solution had caused R188 stomach discomfort, leading to a hold on the TF while awaiting instructions. On 07/23/2024 at 10:11 AM, R188 expressed the tube feeding (TF) and water flushes had not been administered immediately upon admission because the TF pumps were not working properly and had to be changed three times. R188 verbalized upon receiving a small amount of TF infusion, R188 experienced stomach discomfort, leading to the TF being held and no water flushes being given. R188 indicated the following day after admission had requested a sip of water because R188's mouth was very dry and uncomfortable, making it hard to cough out the phlegm but the LPN had declined to honor the request. The Dietitian assessment dated [DATE], documented R188's hydration needs as follows: -1080 ml of free water. -Flush order: 250 ml every 6 hours (1000 ml/day). -Flush the enteral tube with 30 ml of water before and after each medication administration. -5-10 ml between each medication. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Dilute/dissolve each non-liquid medication with 15 ml of fluid. -Free water in TF: 1080 ml. -Fluids given with enteral flushes: 1000 ml/day. -Total fluids given by tube: 2080 ml/day. R188's medical records lacked documented evidence the water flushes were administered as ordered. On 07/24/2024 at 12:07 PM, the Registered Dietitian (RD) indicated the assessment was the estimated fluids R188 should have received if successfully administered based on R188's needs. The RD indicated since the water flushes via enteral pump were not administered R188's fluid needs had not been met. The RD verified and confirmed the same water bag prepared upon R188's admission on 07/22/2024, was not being infused and the water bag was still full. The Speech Therapy Treatment Encounter dated 07/23/2024, documented R188 was referred to speech therapy services for nothing per Orem (NPO) or nothing by mouth with gastrostomy tube. R188 expressed taking small sips of water to moisten mouth and also assist with cough reflex. R188 edentulous (lacking teeth) and was limited to no movement of tongue upon commands. R188 able to articulate speech 75-80%. Trialed thin liquids via very small sips, was able to initiate swallow without overt signs and symptoms of aspiration. Discussed/educated with med nurse and Director of Rehabilitation Services, R188 may have the small sips of water as requested and supervised by spouse or nursing. On 07/24/2024 at 11:04 AM, same water bag was at bedside hung in the pole, not infused. R188's family was at bedside expressed R188 had not received any hydration for almost 24 hours, resulting in a dry mouth and throat. R188 requested water to sip to moisten the mouth or loosen phlegm. R188 had a history of lip and lymph node cancer, which affects saliva production. The family indicated the Speech Therapist assessed R188 and indicated R188 could sip water, but the LPN did not provide the request or at least to moisten the mouth with a swab. On 07/24/2024 at 11:04 AM, the attending physician indicated the staff were expected to administer the water flushes as scheduled and if not carried out timely, should notify the physician or the RD to obtain new orders. The Physician indicated the prolonged deprivation of the hydration was unacceptable. On 07/24/2024 at 11:26 AM, a Registered Nurse (RN) explained the process was to obtain TF orders upon resident's admission and administer immediately. The RN indicated if the TF was not successfully administered the physician or RD should have been notified for new orders. The RN indicated if the resident refused or was unable to successfully provide water flushes, the physician or RD should have been notified immediately to keep the resident hydrated. On 07/24/2024 at 11:47 AM, the Charge RN indicated the Licensed Nurses were expected to administer the TF and water flushes timely as ordered. The Charge RN confirmed the water flushes had not been provided as ordered since the bag of water prepared on 07/22/2024, was still full and not being infused. The Charge RN indicated the Licensed Nurses were expected to provide the water flushes to R188 timely as ordered or notify the physician if unable to carry out the orders. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/24/2024 at 12:07 PM, the RD removed the TF formula and water bag from R188's bedside. The RD indicated was unaware the TF formula and fluids had not been successfully provided to R188. The RD explained the LPN could have administered the water through the percutaneous endoscopic gastrostomy (PEG) tube using a syringe to meet R188's hydration. The RD indicated the Licensed Nurses were expected to notify either the RD or the physician of any concerns related to the TF or the resident's hydration to prevent delays in administration. The RD confirmed lacked documented evidence R188's hydration needs had been met. On 07/24/2024 at 1:33 PM, the Director of Nursing (DON) indicated the resident's hydration source was expected to be administered timely as ordered or the physician should be notified if there were any interruptions. On 07/26/2024 at 9:19 AM, the Speech Therapist (ST) indicated R188 was evaluated on 07/23/2024, in the early afternoon. The ST indicated R188 was alert and oriented, answering questions with limited lingual and tongue movement. The ST allowed R188 to sip water, observing no coughing and easy initiation of swallowing. The ST confirmed it was safe for R188 to swallow the water, which helped moisten the mouth and enabled R188 to cough out the phlegm. The ST discussed the assessment with the assigned LPN. The ST indicated had not been notified earlier of R188 ' s and the family's request. On 07/26/24 at 9:29 AM, the Director of Rehabilitation Services (DORS) indicated R188 was evaluated following day of admission. The DORS indicated R188 had undergone a mandible replacement, which caused limitations in lingual ability, but R188 was very alert and oriented. The DORS verbalized R188's family expressed frustration over not receiving timely hydration. R188 appeared tired and quiet at the time. The DORS indicated the family was involved in and familiar with R188's care. The DORS recounted a discussion with the family about the concentrated urine color during the first hours of admission, which improved after water flushes were administered the following day. The DORS indicated the assigned LPN should have reached out to the physician or Rehabilitation Services for assistance if R188 had concerns with swallowing. The DORS verbalized it was unacceptable for R188 not to receive hydration for almost 24 hours following admission. The DORS indicated the LPN should not have argued with R188's family, but instead R188's hydration needs should have been timely communicated or addressed timely. A facility policy titled Resident Hydration and Prevention of Dehydration dated 05/12/2021, documented the facility would endeavor to provide adequate hydration and to prevent and treat dehydration. If potential inadequate intake and or signs and symptoms of dehydration, individual preferences, physician would be informed. Nursing would monitor and document fluid intake and the dietitian would be kept informed of the status. 50289 2) Resident 39 (R39) R39 was admitted to the facility on [DATE], with diagnoses including infection of tracheostomy stoma, chronic pain, nontraumatic intracerebral hemorrhage, unspecified intestinal obstruction, acute embolism and thrombosis, and bed confinement. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R39's Weight Summary report, documented a January weight of 218.7 pounds (lbs.) on 01/12/2024. No weights were tracked or monitored for April 2024. According to the weight task history, R39 was on monthly weights from 01/10/2024 until 05/15/2024 when the resident was switched to weekly weights due to weight loss. R39's Weight Report documented weights from January 2024 through July 2024 as follows: -07/22/2024: 198.4 lbs. -07/15/2024: 197.0 lbs. -07/08/2024: 196.8 lbs. -07/01/2024: 196.2 lbs. -06/17/2024: 198.4 lbs. -06/10/2024: 196.4 lbs. -06/03/2024: 196.0 lbs. -05/27/2024: 196.4 lbs. -05/13/2024: 195.8 lbs. -05/12/2024: 194.0 lbs. -03/12/2024: 220.0 lbs. -02/12/2024: 216.8 lbs. -01/12/2024: 218.7 lbs. On 07/24/2024 at 10:43 AM, the Dietician (E14) revealed the patient had had a 26 lb. weight loss from March 12, 2024, to May 12, 2024. According to the dietician, they would have liked to have caught this in April, but because no weights were taken and no report was run to follow up on the need for reweights, this resident's weight was missed. The dietitian stated that R39 was on the list to have the weight taken, however, there was no documentation from the Restorative Nursing Assistants (RNAs) on why they missed taking R39's weight. The dietician added the RNAs may have been pulled to work the floor that day, but the dietician stated could not be 100% sure this was the reason. On 07/24/2024 at 4:55 PM, R39's physician assistant (E17) revealed that the patient had been put on diuretics to reduce edema, had infections, and wounds. The physician also stated that R39's weight loss was a desirable loss. R39's active care plan documented the resident should be monitored for signs and symptoms of fluid overload, edema, respiratory distress, weight gain, vital signs changes and venous distention. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Dietician assessment dated [DATE], documented R39's BMI indicates extreme obesity and the patient's nutritional needs were to be based on an adjusted desired weight since a slow weight loss would be appropriate. A facility policy titled Weight Assessment and Intervention documented the nursing staff is to measure resident weights on admission (within first 24 hours), and weekly for four weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter. Weights will be recorded through POC, EMAR or directly in Weights/Vitals tab of the resident record. The facility will review monthly weight variances to follow individual weight trends over time.

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F 0693 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interview, record review, and document review, the facility failed to ensure adequate tube feeding (TF) formula was provided as ordered to a resident who was TF-dependent or to notify the physician when it could not be carried out in a timely manner for 1 of 20 sampled residents (Resident 188). This deficient practice had the potential to compromise the resident's nutritional status and overall health, leading to malnutrition, dehydration, and an increased risk of infection. Findings includes: Resident 188 (R188) R188 was admitted on [DATE], with diagnoses including dysphagia (difficulty swallowing) and gastrostomy. The Nursing Admission assessment dated [DATE], documented R188's short and long memory as intact. R188 had a gastric feeding tube in place. A Care Plan dated 07/23/2024, documented R188 required TF in maintaining or improving nutritional status related to chewing problems and swallowing impairment. The goal included providing the TF as ordered, monitoring, and reporting formula intolerance to a physician or Registered Dietitian. On 07/23/2024 at 10:08 AM, R188 was lying in bed, alert and verbally oriented. The unhooked TF Glucerna 1.2 formula was at the bedside at approximately 1000 milliliters (ml), labeled with a date and time (07/22/2024, 7:30 PM) and R188's name. A Licensed Practical Nurse (LPN) indicated R188 had been admitted on [DATE] around 6:00 PM, was dependent on TF, and was nothing per Orem (NPO) or nothing by mouth. The LPN explained the Glucerna TF had caused R188's stomach discomfort, leading to hold the TF while waiting for instructions. On 07/23/2024 at 10:11 AM, R188 expressed the tube feeding (TF) had not been administered immediately upon admission because the TF pumps were not working properly and had to be changed three times. R188 had experienced stomach discomfort, leading to the holding of the TF Glucerna. R188's medical records lacked documented evidence a physician order was obtained for Glucerna through a gastrostomy tube. The Nursing Progress Notes dated 07/23/2024 at 1:20 AM, documented R188 refused the TF Glucerna and the stomach was hurting. The Dietitian assessment dated [DATE], documented Diabetisource 55 milliliters per hour (ml/hr.) via PEG tube. Total volume per 24 hours: 1320 (1584 kilo/calories, 79 gram protein, 1080 ml free water). (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Scheduling Details dated 07/23/2024, documented to administer Diabetisource at a rate of 55 ml/hr. through the PEG tube. Total volume of 1320 ml per 24 hours. To start at 6:00 PM. A Physician order dated 07/23/2024 at 2:38 PM, documented to administer Diabetisource for 500 ml at 8:00 AM, 12:00 PM, and 5:00 PM with a total of 1500 ml via PEG tube using a syringe. The Medication Administration Record (MAR), documented the Diabetisource bolus of 500 ml was administered only once on 07/23/2024 and on 07/24/2024 at 8:00 AM. On 07/24/2024 at 10:45 AM, the same TF Glucerna formula bag was observed at the bedside with approximately 1000 ml, labeled with the date and time 07/22/2024, 7:30 PM. R188's family was present and indicated had spoken to the Licensed Nurse regarding R188 taking Diabetisource at home before hospitalization instead of Glucerna. The family reported R188 had taken a bolus of Diabetisource, two cartons (500 ml), in the afternoon on 07/23/2024, after 4:00 PM, after reminding the Licensed Nurse about R188's feeding, and again at 8:00 AM on 07/24/2024. The family expressed concerns about the inadequacy of R188's nutrition for almost 24 hours following admission. On 07/24/2024 at 11:04 AM the attending physician indicated the staff were expected to administer the TF as scheduled and if not carried out timely should notify the physician or the RD to obtain new orders. The Physician indicated it was not acceptable to delay the administration of the R188's nutrition. On 07/24/2024 at 11:26 AM, the Registered Nurse (RN) confirmed the TF formula had not been administered upon admission on 07/22/2024 and was only administered once on 07/23/2024 in the afternoon and again on 07/24/2024 at 8:00 AM. The RN explained the process was to obtain TF orders upon the resident's admission and administer immediately. The RN indicated if the TF was not successfully administered, the physician or RD should have been notified for new orders. The RN confirmed there was no documented evidence the physician or RD was notified when the TF was not administered or when the TF was inadequate for almost 24 hours following R188's admission. On 07/24/2024 at 11:47 AM, the Charge RN indicated the Licensed Nurses were expected to administer the TF formula timely as ordered to meet the resident's nutritional needs or notify the physician if there were any interruptions. On 07/24/2024 at 12:07 PM, the Registered Dietitian (RD) indicated had not been notified R188 was not tolerating the TF Glucerna and had assumed it was infusing overnight since it was hung at the bedside, but observed the TF bag was still full at 1000 ml. The RD indicated the Licensed Nurses were expected to notify the physician or the RD to obtain new orders. The RD confirmed R188's adequate nutritional needs had not been met in a timely manner. On 07/24/2024 at 1:33 PM, the Director of Nursing (DON) explained if the resident refused the TF formula for any reason, it should have been reoffered or the physician should have been notified to obtain new orders to ensure timely and adequate nutritional delivery. A facility policy titled Enteral Nutrition dated 04/29/2019, documented adequate nutritional support through enteral feeding would be provided to residents as ordered. Enteral feeding orders would be written to ensure consistent volume infusion. The following information would be included to ensure the full volume would be infused, regardless of any interruption of feeding.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295089	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Care at Centennial Hills	6351 N Fort Apache Rd Las Vegas, NV 89149

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 29141 Based on observation, interview, and document review, the facility failed to ensure food products were labeled with the date when they were opened, and failed to dispose of fruits showing signs of spoilage. The deficient practice could have exposed the residents to potential health risk associated with contaminated food. Findings included: 07/23/24 08:19 AM, inspection was conducted in the kitchen with the Kitchen Manager. The following issues in the walk-in refrigerator were identified: - A 1 Lb. container of beef base open and not dated. - Staff beverage stored in the walk-in refrigerator - 1 gallon container of coleslaw dressing open and not dated. - 5 Lb. container of low fat cottage cheese open and not dated. - 8.44 Lb. container of mild chunky salsa open and not dated - 1 gallon container of golden Italian dressing open and not dated - 11 Cantaloupes and one watermelon with black spots and white patches on the skin, showing signs of spoilage, with softness and mushiness at the touch. The Kitchen Manager confirmed the observation and indicated open containers of food products should have been dated. The Kitchen Manager was not aware of the conditions of cantaloupes and the watermelon and stated the fruits should have been discarded. The facility policy titled Storage of Frozen and Refrigerated Foods dated 01/05/2024, stipulated food needs to be labeled with the name of the product and the expiration or discard date.