STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295092	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health Care of Summerlin	2860 N Tenaya Way Las Vegas, NV 89128

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39418 Based on observation, interview, record review and document review, the facility failed to properly discuss and provide documentation of resident's discharge planning and appeal rights for 1 of 14 sampled residents (Resident 95). The deficient practice had a potential for a resident to not be able to exercise the right to appeal a discharge decision from the Managed Medicare (MA) Plan and have the necessary planning for discharge. Findings include: Resident 95 (R95) R95 was admitted on [DATE], with diagnoses including Parkinson's disease without dyskinesia and acute respiratory failure. On 08/21/2024 at 12:10 PM, R95 verbalized being discharged tomorrow (08/22/2024). The resident voiced concerns regarding the continuation of care proposed by the facility and the quality of care to be received with the Home Health Agency (HHA). The resident had reservations the current functional capacity might not be fitting to be downgraded to a lower level of care. The resident verbalized signing a discharge notice and was sure no option to appeal was mentioned during the discussion with the Case Manager (CM). The resident did not have a copy of the Notice of Medicare Non-Coverage (NOMNC) and confirmed signing the document and no copy was provided. Observed R95 go thru documents received from the facility and only admission documents were in possession. On 11/21/2024 at 12:31 PM, the CM indicated the resident signed the NOMNC and a copy was placed at the discharge packet to be sent home with the resident. The CM confirmed the resident was not provided a copy and the appeal option was discussed upon signing the NOMNC. The CM agreed a copy should have been left with the resident to be reviewed at a later time. The CM acknowledged having a copy would be good for the resident to have if in case a decision to appeal the discharge come into mind, the resident would have the appeals contact number. The CM agreed the resident had now passed the deadline to have an expedited independent review from the Quality Improvement Organization (QIO- an independent reviewer to ensure NOMNC was issued according to MA guidelines) and an insurance appeal was the only available option which was not expedited and could lead to a financial risk if the insurance appeal was not successful. (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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R95's MDS completed on admission had a Brief Interview for Mental Status (BIMS) score of 15. A score of 15 reflects: 13 - 15 points: Cognitively intact. R95's electronic health care records revealed one entry from Care Coordination. The documentation lacked the necessary details of discharge planning for the resident's continuation of care needs or any discussion with regards to the notice of discharge appeal rights. On 11/21/2024 at 2:41 PM, the Director of Nursing (DON) and interim DON confirmed CM and discharge planning department was under nursing services. The DONs confirmed all documents signed by a resident and the representative; a copy of the signed document should be provided for further reference. The DONs expectation for discharge documentation was to document all the necessary discharge planning provided to the resident. R95 had a BIMS of 15 and the DONs agreed the resident was capable to fully express any desire of wanting to appeal if discussed or the resident had the capacity to read and digest any information on the NOMNC if provided. The DONs acknowledged R95 had missed an opportunity to have an independent review from the QIO due to the lack of provision of document material to further reference resident rights. The facility policy titled Patient Discharge (undated), documented when the facility transfers or discharges a resident under any circumstances, the facility will ensure that the transfer or discharge is documented in the resident's medical record. #9. All other necessary information, as applicable to ensure a safe and effective transition of care. The facility policy titled Resident Rights - facility version A0717, documented the resident has the right to receive notices orally (meaning spoken) and in writing (including braille) in a format and a language he or she understands, including: 1. Required notices: The facility must furnish to each resident a written description of legal rights which includes: state and local advocacy organizations.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interview, record review, and document review, the facility failed to ensure a baseline person-centered care plan to manage a resident's edema (swelling) following admission was completed for 1 of 14 sampled residents (Resident 146). This deficient practice had the potential for delayed interventions, worsening edema, increased risk of skin breakdown or infection, and compromised resident's overall health and well-being. Findings include: R146 was admitted on [DATE], with diagnoses including cardiogenic shock, chronic obstructive pulmonary disease, cardiomyopathy, hypertensive heart disease with heart failure, acute kidney failure, lymphedema and localized edema. The Physician Progress Note dated 11/17/2024, documented R146 presented to the hospital with severe leg swelling and unable to ambulate. R146 was found to be in acute exacerbation of chronic congestive heart failure. The Nursing Progress Notes dated 11/17/2024, documented R146 had bilateral lower extremities edema. On 11/19/2024 at 11:07 AM, R146 sat in a wheelchair, alert and verbally responsive. The lower extremities showed weeping edema (water retention that occurs when fluid leaks through the skin due to swelling), legs were not elevated and had no compression stockings. The wound dressing on the left lateral lower leg was wet. R146 reported experiencing edema for a long time and mentioned multiple heart issues. R146's medical records lacked documented evidence a baseline person-centered care plan to manage R146's edema following admission was completed. On 11/20/2024 at 11:13 AM, the Wound Care Treatment Nurse (WCTN), indicated the wound dressing had been removed, it was wet, and a chuck had been placed to prevent the area from being left open due to Resident 146's severe weeping edema. On 11/20/2024 in the afternoon, the Clinical Care Manager (CCM) confirmed the edema had not been identified upon admission, no care plan had been created, the legs were not elevated, and no compression stockings were in place. The CCM acknowledged the edema was present on admission. On 11/21/2024 at 3:30 PM, the Director of Nursing (DON) confirmed the resident's edema was present but had not been identified upon admission, and a baseline care plan should have been completed within 48 hours. The DON emphasized the importance of the care plan in establishing goals and interventions to ensure timely and appropriate care. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Baseline Person-Centered Care Plan (undated), indicated the baseline care plan was developed during the admission process to guide resident care before creating the comprehensive care plan. The baseline care plan was prepared at the time of admission, including the care to be provided, goals to be achieved, and actions necessary to reach those goals. The admitting nurse was responsible for utilizing and completing the baseline person-centered care plan.

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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 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 the resident's edema (swelling) was appropriately assessed following admission and interventions implemented for 1 of 14 sampled residents (Resident 146). This deficient practice had the potential to result in delayed treatment, worsening edema, increased risk of skin breakdown or infection, and compromised overall health and well-being. Findings include: Resident 146 (R146) R146 was admitted on [DATE], with diagnoses including cardiogenic shock, chronic obstructive pulmonary disease, cardiomyopathy, hypertensive heart disease with heart failure, acute kidney failure, lymphedema and localized edema. The Observation Detail List Report dated 11/15/2024, documented a brief interview of mental status score of 15/15, which indicated R146's cognitive status was intact. The Observation Detail List Report dated 11/15/2024, documented R146 had no edema. The Admission Skin assessment dated [DATE], documented R146 had no edema. An admission Physician order dated 11/15/2024, documented to assess edema every shift and apply interventions to include the following: elevate extremities, diet, compression, diuretics and to record edema amount. The Medication Administration Record (MAR) from 11/16/2024 to 11/19/2024, showed inconsistencies in the documentation of edema, with alternating entries indicating both the presence and absence of edema on different days. The Physician Progress Note dated 11/17/2024, documented R146 presented to the hospital with severe leg swelling and unable to ambulate. R146 was found to be in acute exacerbation of chronic congestive heart failure. The Nursing Progress Notes dated 11/17/2024, documented R146 had bilateral lower extremities edema. On 11/19/2024 at 11:07 AM, R146 sat in a wheelchair, alert and verbally responsive. The lower extremities showed weeping edema (water retention that occurs when fluid leaks through the skin due to swelling), legs were not elevated and had no compression stockings. The wound dressing on the left lateral lower leg was wet. R146 reported experiencing edema for a long time and mentioned multiple heart issues. R146's medical records lacked documented evidence the edema was assessed, and interventions implemented following R146's admission. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/2024 at 11:27 AM, the wound Nurse Practitioner (NP) indicated it was the first time R146 had been seen and noted R146 had severe edema, with the left lower extremity leaking fluid. On 11/20/2024 at 11:13 AM, the Wound Care Treatment Nurse (WCTN) indicated the wound dressing had been removed, it was wet, and a chuck had been placed to prevent the area from being left open due to R146's severe weeping edema. On 11/20/2024 in the afternoon, the Clinical Care Manager (CCM) confirmed the edema was not identified upon admission, and no compression stockings were applied. The CCM indicated there was an order to assess and to implement the interventions but was not implemented except for diuretics, which were discontinued. The CCM indicated if the interventions were not appropriate, the physician should have been notified and the order clarified. The CCM confirmed the edema was present on admission based on the hospital transfer summary. On 11/21/2024 at 3:30 PM, the Director of Nursing (DON) indicated the process was to completely assess the resident upon admission, including the skin or edema. The DON confirmed the edema was present on admission, but it was not appropriately assessed, and the Licensed Nurses documented in the MAR, R146 had no edema while others documented the presence of edema. A facility policy titled Admission Skin Assessment (undated), documented upon admission, the resident would be examined to identify current issues. The physician would be contacted to initiate appropriate treatment orders if not addressed in the physician admit orders. The admission skin assessment would be uploaded into resident documents. The admitting nurse was responsible for ensuring the selected interventions were initiated, appropriate equipment was placed, and monitoring was placed on the treatment record and baseline-centered care plan as indicated.

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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, interviews, record reviews, and document reviews, the facility failed to ensure the fluid restriction was followed, or the physician's order was clarified and communicated for 1 of 14 residents (Resident 146). This deficient practice had the potential to result in fluid overload, which could lead to complications such as edema, hypertension, or congestive heart failure, compromising the resident's overall health and safety. Findings include: Resident 146 (R146) R146 was admitted on [DATE], with diagnoses including cardiogenic shock, chronic obstructive pulmonary disease, cardiomyopathy, hypertensive heart disease with heart failure, acute kidney failure, lymphedema, and localized edema. The Observation Detail List Report dated 11/15/2024, documented a brief interview of mental status score of 15/15, which indicated R146's cognitive status was intact. The physician progress note dated 11/17/2024, documented R146 presented to the hospital with severe leg swelling and was unable to ambulate. R146 was found to be in acute exacerbation of chronic congestive heart failure. A physician order dated 11/17/2024, documented low sodium (NAS) diet: texture: soft and bitesize. Liquids: thin, Fluid restriction: 1000 milliliters (ml) per day (Nursing: 640 ml; kitchen 360 ml breakfast 120 ml, lunch 10 ml, dinner 120 ml). A physician order dated 11/19/2024, documented NAS diet: texture: soft and bitesize. Liquids: thin, Fluid restriction: 1000 ml/day (Nursing: 260 ml; kitchen 840 ml breakfast 360 ml, lunch 24 ml, dinner 240 ml). The Medication Administration Record from 11/15/2024-11/20/2024, documented fluid restriction of 1000 ml/day (Nursing 640 ml; Kitchen 360 ml (breakfast-120 ml, lunch 120 ml, and dinner 120 ml). The meal tickets dated 11/19/2024 and 11/20/2024, documented R146 was on fluid restriction and the fluid or beverages being served: -Breakfast: 360 ml -Lunch: 240 ml -Dinner: 240 ml On 11/19/2024 at 11:07 AM, R146 was seated in the wheelchair, alert and verbally responsive. Severe edema on bilateral lower legs was noted and legs were not elevated. A 355 ml bottle of water was at bedside with a straw. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/2024 at 8:35 AM, R146 was in bed with eyes open. The breakfast tray was on the table, containing scrambled eggs, sausage, yogurt, and a glass of cranberry juice with a straw. The meal ticket, dated 11/20/2024, indicated breakfast included 360 ml of cranberry juice. A 355 ml bottle of water was on the table, with approximately 100 ml remaining. The Clinical Care Manager (CCM) confirmed the observation and indicated R146's fluid restrictions should have been timely communicated to staff and the kitchen to prevent fluid overdose, especially since R146 had severe edema. On 11/20/2024 in the morning, the Wound Care Treatment Nurse (WCTN) was at bedside to provide wound care treatment to R146. R146 requested water, and the 355 bottled water was provided to R146, and then the WCTN proceeded to provide the wound care. On 11/20/2024 in the afternoon, the WCTN confirmed R146 was given water as requested but was unaware R146 was on fluid restriction. The WCTN indicated previously the residents on fluid restriction had a log inside their room, but with R146, no indicator was noted the resident was on fluid restriction. On 11/20/2024, at 11:35 AM, the dietary manager indicated the fluid restrictions orders would be obtained from the matrix, or the registered dietitian would provide the information. The dietary manager confirmed the fluids were provided to R146 on 11/19/2024: breakfast-360 ml, dinner-240 ml, and dinner-240 ml. The dietary manager confirmed there was no advice or order communicated to change the order distribution. On 11/20/2024 at 11:37 AM, the Registered Dietitian (RD) indicated R146 was not evaluated yet since R146 was just admitted on [DATE]. The RD indicated the hydration was standard per policy to be distributed during breakfast-360 ml, dinner-240 ml, and dinner-240 ml. The RD verified R146 had a fluid restriction for 1000 ml due to edema. The RD confirmed the process; the fluid order restriction should have been communicated to the kitchen. The RD indicated there was a new diet order on 11/19/2024. On 11/20/2024 at 1:30 PM, R146 was seated in the wheelchair with a lunch tray with 240 ml of colored juice. R146 indicated was aware of the fluid restriction but uncertain how much fluid daily would be allowed. R146 indicated the licensed nurse administered the medication with drinking water in a cup. On 11/20/2024 at 1:41 PM, Licensed Practical Nurse (LPN) verified and confirmed R146 was on a fluid restriction of 1000 ml/day. The LPN indicated during each medication administration, R146 was given 120 ml of water and took a few sips. On 11/20/24 in the afternoon, the Director of Nursing (DON) confirmed R146 was on fluid restriction for 1000 ml/day. The DON indicated the order should have been communicated to the kitchen in writing for proper distribution as prescribed, or the order should have been clarified if needed more. The DON indicated the order should have been matched with what was provided and the fluid intake should have been documented. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Fluid Restriction (undated), documented fluid restrictions would be followed as per physician's orders and following the procedures: The amount of fluid per 24 hours would be specified in a written physician's order and sent to the food and nutrition service department in writing. The food and nutrition services department and the nursing department would determine how much fluid would be provided at meals and medication passes. Water provided at the bedside would be calculated into the daily total fluid restriction.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **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 the peripheral intravenous (IV) access was identified, flushed, and monitored, and a physician order was obtained or removed when not in use for 1 of 14 sampled residents (Resident 144). This deficient practice could have the potential to result in complications such as infection, infiltration, and phlebitis, or other adverse outcomes. Findings: Resident 144 (R144) R144 was admitted on [DATE], with diagnoses including anemia and altered mental status. On 11/19/2024 at 10:09 AM, R144 was in bed alert, verbally responsive but hard of hearing. A peripheral IV access was on the right arm; the dressing was undated, and skin redness was observed around the insertion site and had dried blood-like residue. R144 was unaware of the reason for the IV access placement and could not remember when it was inserted. R144's Admission Skin assessment dated [DATE], lacked documented evidence the peripheral IV access was identified. On 11/19/2024 at 2:42 PM, R144's family was at bedside, indicating R144's IV access was inserted in the hospital prior to admission at the facility. The family indicated R144 had been admitted 11 days ago, and the family was told by the facility staff the peripheral IV access would be removed for non-use. R144's medical records lacked documented evidence of the peripheral IV access, peripheral intravenous (IV) access was identified, flushed, monitored, and a physician order was obtained or removed when not in use. On 11/19/2024 at 2:44 PM, a Registered Nurse (RN) verified and indicated R144's peripheral IV should have been removed for non-use. The RN confirmed there was no order in place for the utilization and management of R144's peripheral IV access. The RN indicated there should have been an assessment upon R144's admission; IV should have been flushed, monitored for signs and symptoms of infection, or discontinued for non-use. The RN proceeded to remove the peripheral IV and confirmed redness surrounding the insertion site. On 11/20/2024 at 11:32 AM, the Clinical Care Manager (CCM) indicated the resident should have been assessed upon admission, and the admission Licensed Nurse should have completed the skin assessment. The CCM indicated any IV access should have been flushed, and the insertion site would be monitored for s/s of infection, and if not in use, should have been discontinued to prevent infection. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Admission Skin Assessment (undated), documented upon admission the resident would be examined to identify current issues. The physician would be contacted to initiate appropriate treatment orders if not addressed in the physician admit orders. The admission skin assessment would be uploaded into resident documents. The admitting nurse was responsible for ensuring the selected interventions were initiated, appropriate equipment was placed, and monitoring was placed on the treatment record and baseline-centered care plan as indicated. A facility policy titled Intravenous Access (undated), documented to appropriately maintain intravenous access devices.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39418 Based on observation, interview, record review and document review, the facility failed to ensure residents had physician orders and assessment for self-medicating; and medications were properly secured in the resident's room for 2 of 14 sampled residents (Resident 98 and 102). The deficient practices had a potential for a resident to improperly administer and store medications. Findings include: Resident 98 (R98) R98 was admitted on [DATE], with diagnoses including fracture of left lower leg and end stage renal disease on hemodialysis. On 11/19/2024 at 10:34 AM, observed at R98's bedside table was a Family Wellness brand Stomach Relief, Maximum Strength, bismuth subsalicylate 1050 milligram bottle. R98 indicated bringing in the medication from home just in case of needing it. R98 indicated taking the medication for upset stomach or hyperacidity. The resident confirmed placing the medication at the bedside table ever since arrival and none of the staff had questioned its presence. On 11/20/2024 at 11:45 AM, the nurse caring for R98 was not aware of the medication at the resident's bedside. The nurse confirmed all medications should be secured and if there was one, a Self-Administration assessment should be completed. The nurse confirmed R98 did not have a self-administration assessment completed. R98's progress notes had an entry from the nurse dated 11/20/2024 at 12:01 PM, The nurse's note documented: noted patient had Pepto Bismol in room that family had brought in, the patient does not have an order for this medication and states not using it, reminded patient that medication cannot be kept in room per policy, and was in agreement to take med out of the room and place in med cart to give back to the family when they visit. On 11/20/2024 at 12:59 PM, the Unit Manager (UM) indicated the nurse made an entry into the progress note indicating the presence of an unsecured medication and the resident had no self-administration assessment or physician's order. The UM confirmed a self-administration assessment should have been completed and the medication should have been secured. Resident 102 (R102) R102 was admitted on [DATE], with diagnoses including malignant neoplasm of the bronchus and open wound of the left lower leg. On 11/19/2024 at 9:41 AM, R102 indicated having lung cancer and taking supplemental medications. Observed at R102's bedside table were bottles of supplemental medications: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1) [NAME] Vegetable Supplement, 2) [NAME] Energy - Oxygen, 2) [NAME] Energy - Lungs, 3) [NAME] Energy - Colosil Plus, 4) [NAME] Energy - VirX. R102 indicated bringing the meds from home and has been taking it religiously. R102 indicated the medication was given by a friend living in Canada and was informed the medications should be good in fighting for cancer. On 11/20/2024 at 11:45 AM, the nurse caring for R102 was aware of the medication at the resident's bedside. The nurse indicated completing the self-administration assessment and confirmed not having an actual physician's order. The nurse also confirmed medications should be kept secured even when inside the resident's room. R102's electronic healthcare record had a Self-Medication Administration Assessment completed on 11/19/2024. R102's admitted was 11/12/2024. On 11/20/24 at 12:59 PM, the UM indicated the nurse should have completed the self-assessment since admission and medications should be kept secured. The UM confirmed all medications a resident will be taking should have a physician's order. The facility policy titled Self Medication Administration (Undated), documented as part of their overall evaluation, staff will assess each patient's mental and physical abilities to determine whether a patient is capable of self-administering medications. In addition to general evaluation of decision-making capacity, staff will perform a more specific skills assessment utilizing the Self-Medication Administration Assessment form. For self-administering patients, the nursing staff will be responsible for documenting that medications were taken on the eMAR. Self-administered medications must be stored in a safe and secure place, which is not accessible to other patients.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295092	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health Care of Summerlin	2860 N Tenaya Way Las Vegas, NV 89128

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **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) visitors were educated on the proper use of PPE and wore PPE inside the contact isolation precaution room (Resident 145) and 2) signage for Enhanced Barrier Precaution (EBP) was posted for a resident with a draining wound, personal protective equipment (PPE) was available, and staff used gowns when providing direct care to residents on precautions (Resident 146). The deficient practice could have the potential to increase cross-contamination and transmission of multidrug-resistant organisms (MDROs) and the spread of infectious agents, including multidrug-resistant organisms (MDROs), increasing the risk of healthcare-associated infections (HAIs) among residents, staff, and visitors. Findings include: Resident 145 (R145) R145 was admitted on [DATE], with diagnoses including surgical care aftercare following surgery on the digestive system and sepsis. A physician order dated 11/07/2024, documented R145 was on strict contact isolation for Vancomycin-Resistant Enterococci (VRE) wound. On 11/19/2024 at 10:44 AM, contact precautions signage was posted by the entrance, and PPE supplies were available. The signage indicated to perform hand hygiene and wear PPE upon room entry. R145 was in bed with eyes closed with R145's family, who had not been wearing PPE, at the bedside. A staff member was present inside the room. On 11/21/2024 in the afternoon, R145's family was at bedside with no PPE. The family indicated the staff did not say anything about wearing PPE. On 11/21/2024 at 2:37 PM, the Infection Preventionist (IP) indicated R145 was admitted with a VRE wound infection and was placed on contact isolation. The IP indicated the PPE should have been worn before entering the room, including the staff and visitors. The IP indicated the family should have been provided education regarding the importance of wearing PPE in the contact isolation room to prevent cross-contamination. Resident 146 (R146) R146 was admitted on [DATE], with diagnoses including cardiogenic shock, acute kidney failure, lymphedema, and localized edema (swelling). The Observation Detail List Report dated 11/15/2024, documented a brief interview of mental status score of 15/15, which indicated R146's cognitive status was intact. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295092	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health Care of Summerlin	2860 N Tenaya Way Las Vegas, NV 89128

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/2024 at 11:07 AM, R146 was seated in the wheelchair, alert and verbally responsive. Severe weeping edema (water retention that occurs when fluid leaks through the skin due to swelling) on the bilateral lower legs and a soiled and wet wound dressing were noted on R146's left lower leg. R146 indicated had a chronic open wound on the leg and on the thigh prior to admission. R146 indicated the peripheral IV access was placed a few days ago by the licensed nurse. There was no EBP signage posted and no PPE available by the entrance door. On 11/19/2024 at 11:27 AM, the Clinical Care Manager (CCM), the Wound Nurse Practitioner and the Wound Care Treatment Nurse (WCTN) entered R146's room, assessed, and treated the wound on the left lower leg and other parts of R146's body without wearing a gown. The wound NP indicated it was the first time R146 was seen and described the left lower lateral leg wound as non-pressure, but it was opened and draining. The NP indicated the dressing was wet and noted a scant amount of serous (clear to yellow fluid) drainage. On 11/20/24 at 11:13 AM, the WCTN confirmed there was no EBP signage posted by the door and no PPE available in R146's room. The WCTN indicated a gown should have been worn to protect self, especially during direct contact for wound treatment, regardless of whether the resident was on precautions or not. On 11/21/2024 at 8:10 AM, a Certified Nursing Assistant (CNA) provided direct care to R146 in the room without a gown, wheeled R146 to the dining room, and entered back into the room and fixed R146's bed without wearing a gown. The CNA confirmed was not wearing a gown and was aware R146 was on EBP. The CNA explained EBP protocol should have been followed to prevent contamination. On 11/21/20 at 1:28 PM, the IP indicated there should have been an EBP signage and available PPE by the door to prompt the staff and visitors due to R146's open wound. The IP indicated regardless of what kind of wound it was, EBP protocol was required. The IP explained the admission nurse and the floor nurse were responsible for initiating the precautions upon the resident's admission. The IP indicated the staff were expected to follow the protocols by putting in an order, putting up signage, performing hand hygiene, and wearing the PPE to prevent cross-contamination. A facility policy titled Enhanced Barrier Precautions (undated), documented the facility adhered to guidance by the Centers for Disease Control and Prevention (CDC) regarding the prevention of the spread of multidrug-resistant organisms through the use of Enhanced Barrier Precautions (EBP). Residents were placed on EBP for the following conditions: wounds, the presence of an indwelling medical device, or infection or colonization with a CDC-targeted multidrug-resistant organism. Staff members donned gowns and gloves during high-contact resident care activities, including changing linens, performing wound care, and providing hygiene. Signage was posted outside the resident's room indicating the type of precautions, the required personal protective equipment (PPE), and high-contact resident care activities.