STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295093	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canyon Vista Post Acute	6352 Medical Center Street Las Vegas, NV 89148

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 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** 29141 Based on interview, record review and document review, the facility failed to develop and implement baseline care plan for: 1) safety interventions for the care of 4 of 5 residents who smoke (Residents # 188, 189, 190, and 320), 2) interventions to address communication issues for 2 resident with communication deficit related to language barrier (Resident #171 and 324), and 3) interventions for the care of a peripheral intravenous (IV) catheter (Resident #325). Findings include: Resident #188 (R188) R188 was admitted on [DATE], with diagnoses including nicotine dependence and major depressive disorder. Admission Minimum Data Set (MDS) assessment dated [DATE], indicated R188 had an intact cognition with a Brief Interview for Mental Status (BIMS) score of 15. The MDS assessment documented R188 was a tobacco user. R188 medical record lacked documented evidence a baseline care plan was developed and implemented to address R188's smoking habits. Resident #189 (R189) R189 was admitted on [DATE], with diagnoses including diabetes type 2, hypertension, depression, GERD, muscle weakness. MDS assessment dated [DATE], indicated R189 had an intact cognition with a Brief Interview for Mental Status (BIMS) score of 15. The MDS assessment documented R189 was a tobacco user. Admission assessment dated [DATE], documented R189 was not a tobacco user. R189 medical record lacked documented evidence a baseline care plan was developed and implemented to address R189's smoking habits. (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/06/2025 at 9:00 AM, R189 confirmed was a tobacco user, however, R189 had refrained from smoking since admission due to the facility's smoke-free policy. Resident #190 (R190) R190 was admitted on [DATE], with diagnoses including osteoarthritis, muscle weakness, hypertension, and chronic obstructive pulmonary disease. MDS assessment dated [DATE], indicated R190 had a moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 09. The MDS assessment documented R190 was a tobacco user. R190 medical record lacked documented evidence a baseline care plan was developed and implemented to address R190's smoking habits. On 03/04/2025 at 1:29 PM, the Director of Nursing (DON) verbalized the facility did not conduct smoking care plans due to the facility being non-smoking. The DON indicated the resident's MDS should guide the care plan, and the residents should have a smoking care plan. Resident #171 (R171) R171 was admitted on [DATE], with diagnoses including cognitive communication deficit. On 02/25/2025, resident R171 was observed in bed. The inspector attempted to conduct an interview with the resident, but it was apparent that the resident did not comprehend English. A sign posted on the wall in front of the resident's bed indicated that R171's primary language was Mandarin. Furthermore, there was no communication board available in the room to facilitate translation or communication assistance. On 02/27/2025 at 3:45 PM, a Certified Nursing Assistant explained R171 did not speak English but Mandarin. The medical record lacked documented evidence a baseline care plan was developed for impaired verbal communication related to language barrier. The DON provided the comprehensive care plan dated 02/27/2025, but acknowledged the baseline care plan did not include the communication impairment. 41903 Resident 320 (R320) R320 was admitted [DATE] and readmitted [DATE], with diagnosis including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, chronic obstructive pulmonary disease unspecified, and nicotine dependence uncomplicated. On 02/25/2025 in the morning, R320 reported was a smoker and was upset could not smoke. R320 reported was not given options regarding smoking. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician History and Physical note dated 02/09/2025, documented resident was a smoker. R320's medical record lacked documented evidence of a smoking assessment. R320's medical record lacked documented evidence of a smoking care plan. On 02/26/2025 in the afternoon, the Director of Nursing (DON), acknowledged R320 was identified as a smoker upon admission to the facility. The DON confirmed R320's medical record lacked documented evidence a smoking assessment and care plan were completed for the resident. The DON explained R320 should have been assessed and smoking should have been care planned. Resident 324 (R324) R324 was admitted on [DATE] with diagnosis including enterocolitis due to clostridium difficile, unspecified dementia, mood disturbance, and anxiety and pressure ulcer of sacral region stage 3. On 02/25/2025 in the morning, three staff members entered R324's room and provided wound care. The three staff members were heard speaking to R324 in English. No verbal response was heard from R324 to the staff members. After the three staff members exited the room, R324 was observed in bed, and spoke to this surveyor in Spanish. R324 was pleasant and welcoming. R324 reported was very sad and cried when explained their spouse had passed away. R324 explained did not know why was admitted to the facility other than for wound care. R324 reported was unable to communicate with the staff because only spoke Spanish. An Admissions/Re-Admission Summary Note dated 2/23/2025, documented R324 was exclusively Spanish-Speaking and had to communicate via phone interpreter. R324's medical record lacked documented evidence of a care plan for communication or language barrier. On 02/27/2025 in the afternoon, the Director of Nursing (DON), confirmed R324 was Spanish speaking only. The DON acknowledged the language and communication barrier was not care planned for R324. The DON explained a care plan should have been created and should have included goals and interventions necessary to communicate effectively with R324. On 03/05/2025 at 8:46 AM, a Certified Nursing Assistant (CNA), reported was their first day was working with R324. The CNA was unable to answer whether or not they felt the resident understood the CNA when the CNA entered the resident's room that morning. The CNA explained if had a resident who did not speak English, the CNA would have used signs to communicate and would have looked for Spanish speaking staff to assist with communication if needed. The CNA was unable to verbalize if was aware R324 was Spanish speaking only. Resident 325 (R325) R325 was admitted [DATE] with diagnosis including bipolar disorder, acute respiratory failure, and local infection of the skin and subcutaneous tissue. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/25/2025 at 8:30 AM, R325 was sitting in bed, friendly and welcoming. The resident was observed to have a white tubular mesh bandage over left hand. The mesh bandage was intact but slightly soiled with minor discoloration. R325 pulled the mesh and exposed a peripheral intravenous (IV) access on top of the left hand. The IV access was covered by an adhesive transparent dressing dated 02/21/2025. R325 stated was unsure why the IV access was in place. A Physician order dated 02/21/2025 documented, Banana bag (an intravenous solution containing fluids, vitamins, and minerals) 50 cubic centimeters (cc) per hour times 1 liter every shift, for nutritional supplement for one day. The order status was completed. R325's medical record lacked documented evidence of a care plan for the existing IV access. On 03/05/2025 at 8:58 AM, the Infection Preventionist (IP) reported if residents were admitted with an IV access in place, they were to have been identified and assessed upon admission, a physician order had to be placed, the IV access dressing should have been changed every 3 days, and a care plan developed. On 03/05/2025 at 12:51 PM, the Director of Nursing acknowledged there was no care plan in place. The DON explained the deficiency increased the risk of infections for the resident and complications due to infections. A facility policy titled Care Plans - Baseline, undated, documented a baseline care plan should be developed for each resident within forty-eight hours (48) hours of admission. The baseline care plan should include instructions needed to provide effective, person-centered care of the resident.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50513 Based on observation, interview, record review, and document review, the facility failed to develop comprehensive care plans to reflect new interventions, specifically, a smoking care plan for 3 of 3 sampled residents (Residents 14, 34, and 116). The deficient practice had the potential to deprive residents of necessary interventions to maintain overall well-being. Findings include: Resident 14 (R14) R14 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including schizophrenia (a serious mental condition affecting thought, resulting in a mix of disorganized thinking and behavior), depression (a mental disorder resulting in loss of pleasure or interest in activities, hopelessness about the future, or thoughts of dying or suicide), and suicidal ideations (thoughts or ideas centered around death or suicide). Review of an Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/17/2025, indicated R14 was moderately impaired with a Brief Interview for Mental Status (BIMS) score of 12. The Assessment under J1300 Current Tobacco Use indicated Yes, R14 was a tobacco user. Review of the Progress Notes revealed a History and Physical from R14's Physician dated 02/13/2025 documented R14 smoked 2 packs of cigarettes per day for the last [AGE] years. Review of the Comprehensive Care Plan initiated on 02/12/2025, did not include documented evidence of a smoking care plan which would include a focus, goals, and interventions for smoking for R14. Resident 34 (R34) R34 was initially admitted on [DATE] with diagnoses including psychoactive substance dependence (a dependence on substances affecting the perception, consciousness and cognition, which include alcohol and nicotine), alcohol dependence with intoxication (a pattern of drinking which involves loss of control), and nicotine dependence (the need to use nicotine and being unable to stop). Review of an Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/26/2024, indicated R34 was moderately impaired with a Brief Interview for Mental Status (BIMS) score of 12. The Assessment under J1300 Current Tobacco Use indicated Yes, R34 was a tobacco user. Review of the Comprehensive Care Plan initiated on 12/25/2024, did not include documented evidence of a smoking care plan which would include a focus, goals, and interventions for smoking for R34. Resident 116 (R116) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R116 was initially admitted on [DATE] with diagnoses including depression (a mental disorder resulting in loss of pleasure or interest in activities, hopelessness about the future, or thoughts of dying or suicide), abnormalities of gait and mobility (changes in walking or balance), and opioid dependence (a chronic disease which involved compulsive opioid use and an inability to control it). Review of an Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/14/2025, indicated R116 was cognitive intact with a Brief Interview for Mental Status (BIMS) score of 14. The Assessment under J1300 Current Tobacco Use indicated Yes, R116 was a tobacco user. On 02/28/2025 at 11:02 AM, the Minimum Data Set (MDS) Coordinator verbalized upon admission of a new resident, an MDS assessment is conducted for the resident. The MDS Coordinator advised if questions are marked yes, a care plan should be triggered. The MDS Coordinator verbalized the Assessment under J1300 Current Tobacco Use is marked Yes if the resident is a current tobacco user or smoker, but the facility does not trigger a care plan because the resident should not be smoking in the facility. On 03/04/2025 at 1:29 PM, the Director of Nursing (DON) verbalized the facility did not conduct smoking care plans due to the facility being non-smoking. The DON indicated the resident's MDS should guide the care plan, and the residents should have a smoking care plan. The facility policy titled Care Plans, Comprehensive Person-Centered, revised on 03/2022, documented the comprehensive, person-centered care plan: a. includes measurable objectives and timeframes. b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: 1. services that would otherwise be provided for the above but are not provided due to the resident exercising his or her rights, including the right to refuse treatment. 2. any specialized services are to be provided as a result of PASARR recommendations; and 3. which professional services are responsible for each element of care. c. includes the resident's stated goals upon admission and desired outcomes. d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions.

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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** 29141 Based on observation, record review, document review, and interview, the facility failed to respond to resident call lights in a timely manner for 1 of 41 sampled residents (Resident 17), and 2 unsampled residents. The failed practice had the potential to cause delay in resident care and needs. Findings include: 02/26/25 at 8:38 AM, the call light at the door in room [ROOM NUMBER] was observed activated. At the same time a staff member was sitting at nursing station while an audible alarm from the call light system could be heard. 02/26/25 at 8:44 AM, the call light continued activated in room [ROOM NUMBER]. Two staff members wearing scrubs passed by but did not answer the call light. 02/26/25 at 9:00 AM, the resident in 220 verbalized the call light was activated to request the room temperature be adjusted since it was cold. Resident verbalize had been waiting for a long time for somebody to respond. 02/26/25 at 9:03 AM, a Certified Nursing Assistant (CNA) answered the call light and addressed resident's request. The CNA verbalized call lights were everybody's responsibility and verbalized it seemed staff expected only CNAs to answer call lights. On 02/26/2025 at 9:54 AM, a Licensed Practical Nurse LPN who was the staff member sitting at the nursing station when the call light was activated in room [ROOM NUMBER], explained could not see the call light located at the door of room [ROOM NUMBER] from the nursing station, and the audible alarm alerted the staff at the nursing station the activation of the call light. The LPN explained the call light system was malfunctioning since 02/24/2025, producing a constant alarm sound that could not be turned off, masking the real call light alarm sound. The LPN was not sure if the issue had been reported to maintenance. The LPN explained, regularly there were two different audible tones for the call light, one for regular call from the resident's bed, and another from the bathroom that had a high-pitched sound. The LPN explained if the call light system was malfunctioning, residents should have been provided with a mechanical bell, and staff should have been rounding more often. 41903 Resident 17 (R17) R17 was admitted on [DATE] with diagnosis including gout, type 2 diabetes mellitus with hyperglycemia, and spondylosis without myelopathy or radiculopathy thoracic region. A Care Plan dated 01/24/2025 documented R17 was at risk for pain or discomfort. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/26/2025 at 9:52 AM, R17 was observed in a wheelchair approaching the nursing station in the 100 hall. R17 was observed visibly distressed, face flushed, grimacing, rubbed the back of the neck with their hands, and used short broken sentences to speak. R17 told the staff at the nursing station was experiencing severe pain. The four staff at the nursing station did not acknowledge R17's presence. R17 waited for assistance and continued to report was experiencing severe pain and needed pain medication prior to leaving with transportation for an appointment outside the facility. R17 reported had activated the call light in their room over one hour prior to report pain and had requested pain medication. R17 explained a staff member answered the call light, turned it off, and said they would report the pain to a nurse; however, the nurse did not come. On 02/26/2025 at 9:57 AM, a nurse approached the resident near the 100-hall nursing station. The nurse told the resident no one had reported to the nurse the resident was in pain. The nurse administered pain medication to the resident. On 03/06/2025 in the late afternoon, a resident in room [ROOM NUMBER] across from the 200-hall nursing station was heard attempting to draw attention by emitting very loud, continuous cries, grunts and wails. The cries were heard through the walls into the conference/dining room near the 200-hall nursing station. The resident was observed in bed flat on their back, not moving, face pointing up towards the ceiling, the call light had not been activated. The resident was emitting loud cries that were indistinct and not formed into recognizable words. The cries were heard loudly throughout the 200 unit. The 200-unit hallways and the 200-hall nursing station was observed without any staff members present. A few moments later a staff member carrying a walker passed by the front of the resident's room and did not acknowledge the loud cries for help. A second staff member walked out of a nearby room and walked past the resident's room crying for help and did not check in on the resident. Approximately 15 minutes later, a staff member arrived in the unit, went into the resident's room and the resident's cries stopped. A Resident Council Log dated January 01/15/2025 documented a resident in room [ROOM NUMBER] as saying, Seems like they need more help, takes a long time when I use the call light sometimes. The Certified Nursing Assistant (CNA) would not change me, said had to pass trays and told me to eat and then would change me. I was soiled and did not want to eat like that. A Resident Council Meeting Response dated 01/17/2025 documented followed up with patient regarding call light response. Education was provided to CNAs and nurses, the importance of answering call lights on a timely manner. On 02/26/2025 at 9:29 AM, a Licensed Practical Nurse (LPN) reported call lights were to be answered as soon as possible to ensure residents were provided the care needed. ON 02/26/2025 at 11:46 AM, the Director of Nursing (DON), reported an existing QAPI Project for call lights. The DON explained call lights were to be answered in a timely manner, as soon as possible, and call light concerns were to be addressed as they were reported. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/05/2025 at 8:46 AM, A Certified Nursing Assistant (CNA) explained the goal was to answer call lights as soon as possible to assist residents and prevent accidents. The CNA reported call lights were to be answered within minutes. If the resident was in pain or needed the nurse, the CNA would not turn off the call light until the nurse came to the room. On 03/05/2025 at 1:04 PM, the Administrator reported call lights were an ongoing Quality Assurance and Performance Improvement (QAPI) project which included route cause analysis. The Administrator explained many options were tried and used to address call light concerns. The goal was to answer call lights timely. A facility policy titled Answering the Call Light dated 2001, documented the purpose was to respond to the resident's requests and needs. General guidelines included to answer the resident's call as soon as possible, listen to the residents' request, and if you had promised the resident you would return with an item or information do so promptly. Complaint #NV00072268, Complaint #NV00073330 and Complaint NV#00073352

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 50513 Based on interview, record review, and observation, the facility failed to ensure three of three residents sampled for accidents (Resident 14, 34, and 116) had interventions implemented to identify hazards and risks associated with smoking. The facility failed to ensure: 1) Resident 14 with a lighter and cigarettes did not attempt to put a used cigarette in a trash can within the resident's room, 2) Resident 34 was a documented smoker with an Oxygen Concentrator (a device delivering up to 95 percent Oxygen, Oxygen when in contact with flammable materials through heat can cause severe burns) in the resident's room, and 3) a non-smoking policy and procedure was enforced when Resident 116 (R116) took out a black lighter from the left chest pocket. The deficient practice had the potential to result in fire hazards and compromise the safety of all residents and staff in the facility. During the extended survey, the sample was expanded to include an additional four smoking residents (Resident 188, 189, 190 and 320). Findings include: Resident 14 On 02/26/2025 at 12:15 PM, the door to Resident 14's (R14) room was closed. Upon entering R14's room, a distinct odor of cigarette smoke was observed. R14 was lying in bed in the room, alert and oriented. A used cigarette, along with ash and tobacco leaves, was found on the floor next to a trash bin containing combustible materials, approximately five feet from the bed. The discarded cigarette appeared extinguished with the presence of ash and tobacco leaves. R14 stated they attempted to toss the end of the cigarette into the trash can from the bed but missed. R14 explained being permitted to smoke on facility premises until two days ago, when the survey team arrived, and indicated smoking in the courtyard with Resident 34 (R34), Resident 116 (R116), and a third resident R14 could not identify. R14 also stated having cigarettes and a lighter in the room at the time of the observation. On 02/26/2025 at 12:21 PM, two surveyors exited R14's room, one surveyor remained in the hallway directly outside R14's room to continuously observe to ensure R14 did not light another cigarette and attempt to put it in the trash can. The other surveyor went to the nurse's station in 200-hall and informed a Licensed Practical Nurse (LPN) R14 had stated to the survey team R14 was in possession of a lighter and cigarettes. The LPN revealed the facility was a non-smoking facility and followed the surveyor back to R14's room. The survey team remained in front of the door while the LPN entered R14's room. LPN was observed asking R14 if R14 was in possession of a lighter and cigarettes. R14 confirmed being in possession of a lighter and cigarettes. When LPN requested R14 to relinquish the lighter and cigarettes, R14 refused. LPN exited R14's room and stated the room smelled of cigarette smoke, and the resident was in possession of a lighter and cigarettes. At end of interview, LPN was observed returning to the nurse's station. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the admission revealed R14 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including schizophrenia (a serious mental condition affecting thought, resulting in a mix of disorganized thinking and behavior), depression (a mental disorder resulting in loss of pleasure or interest in activities, hopelessness about the future, or thoughts of dying or suicide), and suicidal ideations (thoughts or ideas centered around death or suicide). Review of an Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/17/2025, indicated R14 was moderately impaired with a Brief Interview for Mental Status (BIMS) score of 12. The Assessment under J1300 Current Tobacco Use indicated Yes, R14 was a tobacco user. Review of the Progress Notes revealed a History and Physical from R14's Physician dated 02/13/2025 documented R14 smoked 2 packs of cigarettes per day for the last [AGE] years. Review of the Comprehensive Care Plan initiated on 02/12/2025, did not include documented evidence of a smoking care plan which would include a focus, goals, and interventions for smoking for R14. On 02/26/2025 at 3:55 PM, three hours and 40 minutes after the initial observation of R14 attempting to throw a used cigarette in a trash can in the resident's room, R14's door was closed. Upon entering R14's room, a distinct odor of smoking materials was observed coming from R14. R14 verbalized going out to smoke at the main entrance over 30 minutes ago with Resident 116 (R116). R14 stated being in possession of lighter and cigarettes at the time of observation. On 02/26/2025 at 4:04 PM, an LPN stated R14, and another smoking resident, exited through the main entrance of the facility together around 3:00 PM. LPN identified the other smoking resident as a resident from 300-hall. On 02/26/2025 at 4:09 PM, an LPN in the 300-hall identified a smoking resident in the 300-hall as Resident 34 (R34). Resident 34 On 02/26/2025 at 4:16 PM, upon entering Resident 34's (R34) room, the resident was observed sitting on the bed in the room, alert and oriented. When asked if R34 had gone out to smoke, R34 explained how the resident used to smoke in the courtyard to the dining hall or the main entrance with other residents. R34 identified another smoking resident as Resident 116 (R116). An Oxygen concentrator was observed next to the bedside, two feet to the right of the resident's bed. When asked if R34 was in possession of a lighter or cigarettes, R34 stated I do not want to answer that. Review of the admission record revealed R34 was initially admitted on [DATE] with diagnoses including psychoactive substance dependence (a dependence on substances affecting the perception, consciousness and cognition, which include alcohol and nicotine), alcohol dependence with intoxication (a pattern of drinking which involves loss of control), and nicotine dependence (the need to use nicotine and being unable to stop). Review of an Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/26/2024, indicated R34 was moderately impaired with a Brief Interview for Mental Status (BIMS) score of 12. The Assessment under J1300 Current Tobacco Use indicated Yes, R34 was a tobacco user. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Comprehensive Care Plan initiated on 12/25/2024 did not include documented evidence of a smoking care plan which would include a focus, goals, and interventions for smoking for R34. Resident 116 On 02/26/2025 at 4:23 PM, upon entering Resident 116's (R116) room, R116 was observed lying in bed, alert and oriented. The resident had a distinct odor of cigarette smoke. When R116 was asked if they had recently smoked with R14, the resident said Yes. The resident stated two days ago, the facility put up non-smoking signs in the facility and no longer permitted residents to smoke in facility courtyards, urging residents to go across the street and off facility property to smoke. The resident indicated not being told upon admission the facility was non-smoking. When asked if R116 was in possession of smoking materials, R116 pulled out a black lighter from the left chest pocket of the jacket the resident was wearing. Review of the admission record revealed R116 was initially admitted on [DATE] with diagnoses including depression, abnormalities of gait and mobility (changes in walking or balance), and opioid dependence (a chronic disease which involved compulsive opioid use and an inability to control it) . Review of an Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/14/2025, indicated R116 was cognitive intact with a Brief Interview for Mental Status (BIMS) score of 14. The Assessment under J1300 Current Tobacco Use indicated Yes, R116 was a tobacco user. The Assessment under GG0115 Functional Limitation in Range of Motion indicated an impairment on one side of the upper extremity (shoulder, elbow, wrist, hand). Based on observation, facility map, and interview, a total of 4 facility courtyards were identified. On 02/27/2025 at 10:18 AM, in the 100-hall courtyard, eight extinguished cigarette butts were observed approximately two feet away from the entrance of the courtyard leading into the facility. On 02/28/22025 at 9:30 AM, LPN confirmed notifying the Director of Nursing and members of management within one hour of identification of R14 being in possession of a lighter and cigarettes, but R14 refused to give the smoking materials up. When asked what the response of the DON and members of management, the LPN did not respond except to shrug their shoulders. On 02/28/2025 at 10:14 AM, the DON stated not being informed of R14 being in possession of a lighter and cigarettes until 02/26/2025 at 6:25 PM when the Immediate Jeopardy (IJ) was presented to the DON and members of management. The DON verbalized not being aware of any actively smoking residents until the following day on 02/27/2025. The DON explained the facility was a non-smoking facility due to having residents on oxygen, and the danger of having smoking material could cause a fire within the facility and everyone would be affected. There is no evidence the staff removed the lighter and cigarettes from R14 from 02/26/2025 at 12:21 PM to 02/26/2025 at 6:25 PM. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 02/28/2025 at 10:21 AM, the Assistant Director of Nursing (ADON) stated not being aware R14 was in possession of a lighter and cigarettes until 02/26/2025 at 6:25 PM when the Immediate Jeopardy (IJ) was presented to the ADON and members of management. On 02/28/2025 at 11:21 AM, the Administrator stated the facility is a non-smoking facility for residents. The Administrator verbalized all staff are responsible to confiscate any smoking articles, if identified. When asked if the Administrator was aware the facility had smoking resident's, the Administrator confirmed receiving reports of residents smoking all the time and smoking paraphernalia being taken away from residents. Cross Reference to K741. The facility failed to enforce elements of their adopted smoking policy as it relates to employees, patients, and visitors while also ensuring the employee smoking area was properly designated and equipped with a metal can with a self-closing lid and extinguished smoking materials facility wide were disposed of within non-combustible ashtrays. 41903 On 02/26/2025 at 3:50 PM, there were greater than 30 cigarette butts observed scattered across the ground of the outdoor patio by the 100-dining room. There were two trash cans, one of which was without a plastic bag and was observed to have water at the bottom mixed with a dark matter. The contents of the trash can smelled strongly of cigarette ashes. No fire safety items were found in the area, including fire extinguishers and smoking protection gear such as aprons and gloves. On 02/26/2025 at 4:07 PM, a Receptionist reported residents that smoked went out the front entrance towards front of the building and also to the left of the entrance to smoke. Residents did not have to sign out on the facility log at the reception desk. The Receptionist explained there were no specific times designated for smoking; residents smoked anytime throughout the day. The Receptionist reported residents did not wear any protection such as smoking aprons and gloves, some wore regular street clothes. The receptionist indicated residents that needed assistance were accompanied by staff, however, could not confirm if staff remained with the residents to supervise them while smoking and residents that were physically able to go out on their own were not accompanied by staff. On 02/26/2025 at 4:10 PM, in the patio outside the 300-hall dining room, there were approximately more than 10 cigarette butts observed scattered on the floor of the patio. There was one large plastic trash can in the area, 3/4 full of dark ashes and a sand or dirt like material mixed with the ashes. On the side of the trash can there was a hole approximately the width of a finger that appeared to be burned out of the plastic which was melted, the melted and burned plastic had a strong scent of burned ashes. No fire safety items were found in the area including a fire extinguisher and no protection gear such as aprons and gloves. On 02/26/2025 at 4:16 PM, a Housekeeper reported Housekeeping routinely emptied ashtrays in the smoking area of the patio outside of the 300 hall. The Housekeeper reported the morning Housekeeping team emptied ash trays when they arrived at work, and would be emptied by the night Housekeeping team as well when they came to work. The Housekeeper explained some residents smoke in the patio outside the 300-hall dining area, however, the resident smoking area was actually by the patio outside the 100-hall dining room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility provided the Smoking Policy (undated) which documented the facility had been designated a smoke-free facility. Smoking by residents was not permitted anywhere on facility's property. All staff would be responsible for courteously informing any resident of violation of the facility's smoke-free policy. No lighting materials (matches, lighters), tobacco products, or smoking devices would be allowed to remain in the possession of the resident, either on their person or in the facility. The facility might check periodically to determine if residents had any smoking articles in violation of the smoking policies. Staff should confiscate any such articles and should notify the Charge Nurse/Unit Manager that they had done so. Non-compliance of the smoke-free policy included, but not limited to: - Giving cigarettes or lighters to residents; - Unsafe use of lighters, matches, or cigarettes; - Possession of lighting materials or smoking paraphernalia; and - Smoking in or on facility property including patios, resident rooms, and parking lot.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **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 Foley catheter was properly assessed and the correct Foley size was inserted or clarified and appropriately documented in the medical record for 1 of 41 sampled residents (Resident 104). This deficient practice had the potential to result in complications such as discomfort, urinary tract injury, bladder trauma, or obstruction. Findings include: Resident 104 (R104) R104 was admitted on [DATE] and readmitted on [DATE], with diagnoses including acute kidney failure and obstructive and reflux uropathy. On 02/25/2025 at 9:09 AM, R104 was in bed with eyes closed. R104's Foley catheter was visible from the door, uncovered, with sediments and red-tinged urine. R104's Foley catheter in place was a size 16 French by 10 milliliters (ml) water balloon. R104 indicated had been readmitted with a Foley catheter. A Licensed Practical Nurse (LPN) confirmed R104's indwelling catheter 16 French by 10 ml water balloon with a red-tinged urinary flow. The LPN indicated an indwelling catheter required a physician's order, including the catheter size; it should have been followed to prevent trauma, assessed, monitored every shift, and documented. The Daily Skilled Charting dated 01/12/2025, documented R104 had an indwelling catheter. The Admission brief interview of mental status dated 01/19/2025, documented a score of 10/15, which indicated R104's cognitive status was moderately intact, had an indwelling catheter, and had a diagnosis of obstructive neuropathy. A Physician order dated 02/08/2025, documented an indwelling urinary catheter size of 14 French by 10 milliliters (ml) water balloon for obstructive uropathy. Check every shift. A Care Plan dated 01/12/2025, documented R104 had an indwelling/Foley catheter related to obstructive uropathy with a goal R113 would remain free from catheter-related trauma through the review date. To provide catheter care every shift, monitor and record signs and symptoms of infection, including the blood-tinged urine. The Medication Administration Record from 02/08/2025 to 02/25/2025 documented R104's Foley catheter 14 French by 10 ml balloon was in place and had been checked. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/28/2025 at 10:10 AM, the Assistant Director of Nursing (ADON) indicated R104's Foley catheter required an order specifying the size and water balloon capacity. The ADON confirmed R104's Foley order was for a 14 Fr catheter with a 10 mL water balloon, while documentation consistently indicated R104 had a 14 Fr catheter in place. The ADON indicated Licensed Nurses were expected to match the order with the actual Foley catheter in place, which was 16 Fr, and document it accurately. The ADON explained failure to follow the order could have led to trauma if the Foley catheter was larger than prescribed or leakage if it was smaller. On 02/28/2025 at 10:45 AM, the Physician indicated Licensed Nurses were expected to follow the Foley size order. The Physician explained a Foley catheter larger than the prescribed size posed a risk of trauma or obstruction, while a smaller size could have led to leakage. A facility policy titled Catheter Care, Urinary revised August 2022, documented the need to prevent urinary catheter-associated complications, including urinary tract infections. The information should have been recorded in the resident's medical record, including assessment data obtained when giving the catheter care, character of urine such as color (straw-colored, dark, or red), clarity (cloudy, solid particles, or blood), and odor.

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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** 50513 Based on interview, record review, and document review, the facility failed to ensure that an impaired nutrition assessment or a comprehensive nutritional assessment was completed upon admission and failed to address the resident's severe weight loss (over 5 percent) with interventions for undesirable weight loss for 1 of 41 sampled residents (Resident 121). The deficient practice had the potential to result in continued weight loss and malnutrition, impacting Resident 121's overall health and well-being. Findings include: Resident 121 (R121) Review of the admission record revealed R121 was admitted on [DATE] and discharged on [DATE], with diagnoses including acute kidney failure, type 2 diabetes, and local infection of the skin and subcutaneous tissue. Review of an Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/04/2024, indicated R121 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. Review of the Comprehensive Care Plan did not include documented evidence of a nutritional care plan. Review of the Weight and Vitals for R121 documented: -07/08/2024 - 279.20 pounds (lbs.) -07/10/2024 - 261.20 lbs. -07/11/2024 - 267.00 lbs. -07/24/2024 - 253.00 lbs. -08/06/2024 - 243.50 lbs. -08/20/2024 - 241.00 lbs. -08/27/2024 - 241.70 lbs. On 03/04/25 at 10:21 AM, the Registered Dietician (RD) advised all residents should have an impaired nutrition assessment and a comprehensive nutritional assessment completed upon admission. Upon review of R121's electronic medical record (EMR), the RD advised R121 did not have an impaired nutrition assessment, or a comprehensive nutritional assessment completed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RD reviewed R121's weight summary and verbalized the resident experienced serve weight loss, 35.70 lbs. from 07/08/2024 to 08/06/2024, which was a 12.80 percent (%) weight loss. The RD explained anything over 5.00 % of weight loss was considered severe weight loss. The RD verbalized a registered dietician should have been consulted when the staff discovered the weight loss. The RD confirmed there were no documented evidence of interventions for the weight loss for R121. On 03/04/2025 at 12:15 PM, the Director of Nursing (DON) indicated the Restorative Nursing Assistant (RNA) who was assigned to obtain weights on all residents and was familiar with R121, was no longer employed and unavailable for interview. On 03/04/2025 at 12:15 PM, the Director of Staff Development (DSD) indicated the RNA's will report any significant or severe weight loss to the DSD to initiate a change of condition. The DSD will then report the change of condition to the DON and the resident's provider. The DSD confirmed R121 did not have documented evidence of a nutritional assessment or change of condition. On 03/04/2025 at 1:12 PM, the DON confirmed the facility did not have a nutritional assessment, change of condition, and dietary consultation conducted for R121. The DON reviewed R121's EMR and confirmed the resident lost 37.50 lbs. from 07/08/2024 to 08/27/2024, and the resident's chart lacked documented evidence of nutritional interventions. The facility policy titled Nutritional Assessment, dated 2001, documented a nutritional assessment will be conducted for each resident upon admission. The facility policy titled Weight Assessment and Intervention, revised on 03/2022, documented undesirable weight change is evaluated by the treatment team to determine if the criteria for significant weight change has been met. The evaluation included: resident target weight range, calorie, protein, and other nutrient needs compared with the resident's current intake, the relationship between current medical condition or clinical situation and recent fluctuations in weight, and whether and to what extent weight stabilization or improvement can be anticipated. The policy also documented the physician, and the multidisciplinary team will identify conditions and medications that may be causing the weight anorexia, weight loss or increased risk of weight loss. Interventions for undesirable weight loss are based on considerations like resident choice and preference, nutrition and hydration, functional factors, environmental factors, chewing and swallowing, medications, supplementation or end of life decisions and advance directives. Complaint # NV00072435

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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 the tube feeding order was followed, the actual total dose volume consumed was monitored, and the daily enteral feed and caloric intake were documented for 1 of 41 sampled residents (Resident 271). This deficient practice could have the potential to result in inadequate nutrition, dehydration, weight loss, and improper tube feeding administration. Findings include: Resident 271 (R271) R271 was admitted on [DATE], with diagnoses including dysphagia (difficulty swallowing) and gastrostomy. On 02/25/2025 at 10:24 AM, R271 was in bed, incoherent but verbally responsive. The enteral pump at the bedside with no tube feeding (TF) formula infusing. The percutaneous endoscopic gastrostomy (PEG) tube site had a dressing in place, undated. The History and Physical dated 01/09/2025 documented R271 developed aspiration pneumonia due to dysphagia, and a percutaneous endoscopic gastrostomy (PEG) tube was placed. The Nutritional Risk assessment dated [DATE] documented R271 had chewing/swallowing problems and was on enteral nutrition. R271 was at risk for malnutrition related to wound healing, and supplements were ordered to support wound healing. A Care Plan dated 01/10/2025, documented R271 had the potential for altered nutrition and/or hydration status related to wound healing and the gastrostomy tube. The interventions included administering enteral nutrition as ordered. The Dietitian Progress Notes dated 02/11/2025, documented R271's continued inadequate oral intake at meals of 8.8 pounds or 7.6% severe undesirable weight loss. The bolus feeds were discontinued, and enteral feeds via enteral pump were recommended. Formula Vital 1.5 via enteral pump at 120 mL/hr. for 10 hours/day, totaling 1200 mL/day. The formula was to run from 8:00 PM to 6:00 AM, 1797 total kilocalories (kcals), 80 grams of protein, and 905 milliliters (ml) of free water. Flush the enteral tube with 125 ml of water every 4 hours, providing 750 ml per day and 300 ml of water flush. A Physician Order dated 02/11/2025, documented every shift: Formula: Vital 1.5 via enteral pump at 120 mL/hr for 10 hours/day, totaling 1200 mL/day. The formula was to run from 8:00 PM to 6:00 AM, or until the ordered feeding was consumed. The Medication Administration Record from March 1-3, 2025, documented the enteral feed Vital 1.5 via enteral pump at 120 ml/hr x 10 hrs./day was consumed or completed and signed off by the night and day shifts. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/04/2025 at 8:58 AM, the Registered Dietitian (RD) indicated R271 had an oral diet consisting of a regular mechanical soft diet and nocturnal feed (a tube feeding administered overnight during sleep) continuously for 10 hours to meet nutritional needs. The RD explained R271 had difficulty swallowing and chewing, with only 25-50% of meal intake noted. The RD confirmed R271 had 8.8 pounds or 7.6% severe undesirable weight loss, with a goal for R271 to increase oral intake. The RD expressed uncertainty about how the total dose volume was monitored, as no documentation was available. On 03/04/2025 at 9:12 AM, R271 was observed lying in bed with the tube feeding (TF) turned off. The Licensed Practical Nurse (LPN) indicated the TF was administered at night, starting at 8:00 PM and stopping at 6:00 AM or when the complete dose had been delivered. The TF order specified administration at 120 mL/hr for 10 hours, with 125 mL water flushes every 4 hours. In the presence of the RD, the LPN verified the pump history of the TF actual dose delivered over 72 hours and confirmed a total dose of 2331 mL and 469 mL of water flushes. The RD confirmed a TF shortage of 1269 mL over 72 hours, equating to a discrepancy of 1800 calories. The RD indicated TF orders should have been followed, and the total dose volume should have been monitored daily to ensure adequate caloric intake and prevent further weight loss. The RD indicated the TF discrepancy was noted as significant for wound healing and recovery. The RD confirmed R271's TF rate had not been completely completed as ordered, and there was no documentation in place of the total dose consumed. On 03/04/2025 in the morning, the Registered Nurse (RN) indicated the resident's TF via enteral pump required the infusion rate to be programmed, including the duration and starting and stopping times, until the ordered TF was completely consumed. The RN indicated the TF should have been monitored to ensure it was completed and demonstrated how this should have been done but could not locate in the eMAR where to document the TF total consumption. On 03/04/2025 at 9:48 AM, the Director of Nursing (DON) indicated the Licensed Nurses were expected to follow the total TF order and ensure residents received the prescribed TF dose. The DON indicated R271 had significant weight loss due to multiple factors, including a history of Clostridium difficile, non-compliance, family interference with care, and unrealistic expectations. The DON confirmed the actual dose of TF consumed was not documented. On 03/04/2025 at 10:30 AM, the Nurse Practitioner (NP) indicated the Licensed Nurses were expected to follow the residents' TF complete dose to ensure daily nutritional requirements were met. The NP emphasized the importance of monitoring the total volume delivered to prevent fluid overload, malnutrition, and weight loss. A facility policy titled Enteral Nutrition, revised in November 2018, documented the adequate nutritional support through enteral nutrition was provided to residents as ordered. The nursing staff and provider were expected to monitor the resident for signs and symptoms of inadequate nutrition.

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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 obtain a physician's order for the use of an intravenous (IV) access or heplock, including assess and monitor the site, identify whether an IV was present upon admission, and document for 2 of 32 sampled residents (Residents 104 and 325). This deficient practice had the potential to cause complications such as infection, infiltration, phlebitis, or impaired venous access. Findings include: A facility policy titled Peripheral IV Catheter Insertion (undated), documented a physician's or provider's order was necessary for this procedure. The information should have been recorded in the resident's medical record, including the date and time of the procedure, the number of venipuncture attempts (with a maximum of two), the condition of the site, the location of the insertion, and the resident's response to the procedure. Resident 104 (R104) R104 was admitted on [DATE] and readmitted on [DATE], with diagnoses including anemia and malignant neoplasm of the rectum. The Admission Minimum Data Set (MDS) dated [DATE], documented the brief interview of mental status (BIMS) a score of 10/15, which indicated R104's cognitive status was moderately intact. On 02/25/2025 at 9:09 AM, R104 was in bed with eyes closed. A normal saline 0.9 percent (%) IV fluid was labeled with date of February 24, 2025, and was infusing at 60 milliliters per hour. R104's heplock on the left wrist was soiled and old, dated February 15, wrapped with elastic retention netting, and connected to the IV fluids. R104 indicated the IV heplock was inserted more than a week ago. The LPN assigned to R104 confirmed the observation the IV heplock was 10 days old. R104's medical record lacked documented evidence a physician's order had been obtained for the use of intravenous (IV) access, assessment and monitoring of the site, documentation, and transcription until 02/25/2025. On 02/25/2025 at 9:30 AM, a Charge Nurse explained the IV-certified nurses and charge nurses were responsible for IV medications. The charge nurse indicated the IV heplock should have been changed every two to three days to prevent infection, and it was unacceptable to have remained in place for 10 days, as it was prone to infection. The IV nurse showed a list of the residents on IV, and R273 was on the list. On 02/28/2025 at 10:38 AM, the Assistant Director of Nursing (ADON) confirmed there was no documentation when the IV heplock was inserted, and the order was not transcribed until 02/25/2025. The ADON confirmed previously R273 had been on IV fluids 10 or 11 days ago. The ADON indicated the IV heplock should have been discontinued and rotated in three days to prevent infection and documented the procedure. (continued on next page)

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Canyon Vista Post Acute	6352 Medical Center Street Las Vegas, NV 89148

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/28/2025 at 12:43 AM, an IV nurse indicated an IV heplock should have been changed every three days to prevent infection, rotated the site to avoid infiltration, and documented for tracking and continuity of care. 41903 Resident 325 (R325) R325 was admitted [DATE] with diagnosis including bipolar disorder, acute respiratory failure, and local infection of the skin and subcutaneous tissue. On 02/25/2025 at 8:30 AM, R325 was sitting in bed, friendly and welcoming. R325 was observed to have a white tubular mesh bandage over left hand. The mesh bandage was intact but slightly soiled with minor discoloration. R325 pulled the mesh bandage and exposed a peripheral intravenous (IV) access on top of left hand. The IV access was covered by an adhesive transparent dressing dated 02/21/2025. R325 stated was unsure why the IV access was in place. R325's medical record lacked documented evidence of whether the IV access was in place at admissions or had been inserted in the facility after admission. R325's medical record lacked documented evidence of assessments to include admissions and skin assessments regarding the IV access. R325's physician orders lacked documented evidence of an order for IV access placement, monitoring, flushing, dressing changes, and discontinuation or removal of the IV. A Physician order dated 02/21/2025 documented Banana bag (an intravenous solution containing fluids, vitamins, and minerals) 50 cubic centimeters (cc) per hour times 1 liter every shift, for nutritional supplement for one day. The order status was completed. On 03/04/2025 at 1:19 PM, an IV Nurse inspected R325's left hand. The IV Nurse confirmed the peripheral IV access was still in place, the adhesive transparent dressing was dated 02/21/2025, and both the adhesive dressing and the tubular mesh bandage were slightly soiled. The IV Nurse explained the IV access was used to administer the order for the Banana bag only and denied the IV access was used for any other purpose before or after the Banana bag administration on 02/21/2025. The IV Nurse confirmed the IV access had been in place for 11 days after the administration of the Banana bag, without documented monitoring, assessment, dressing change and use. The IV Nurse explained the IV should have been discontinued to avoid potential infection complications to the resident. On 03/05/2025 at 8:58 AM, the Infection Preventionist (IP) reported if residents were admitted with an IV access in place, the IV access was to have been identified and assessed upon admission, a physician order had to be placed, the IV access dressing should have been changed every 3 days, and a care plan developed. The tubular bandage used for protection should have also been changed every 3 days or more if soiled. Not following these procedures had the potential to result in infection. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/05/2025 at 12:51 PM, the Director of Nursing (DON) confirmed R325's medical record lacked documentation to identify if the IV access was present on admission or was inserted at the facility. The DON acknowledged there were no physician orders for placement, monitoring, flushing, use, and no care plan was in place. The DON explained the deficiency increased the risk of infections for the resident and complications due to infections. The DON explained per policy, the IV dressing should have been changed every 72 hours and the IV access should have been discontinued if no longer in use. A facility policy titled Peripheral IV Catheter Insertion dated 2001, documented steps in the procedure included a provider's order. Documentation included information that should have been recorded in the resident's medical record included the date and time of the procedure, the type, length and gauge of the catheter, the condition of the IV site, the resident's response to the procedure and the signature and title of the person recording the data. A facility policy titled Peripheral IV Catheter Removal dated 2001, documented the purpose of the procedure was to provide guidelines for safe, aseptic removal of a peripheral IV catheter. General guidelines included to remove a peripheral/midline IV catheter that was no longer in the plan of care.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interview, record review, and document review, the facility failed to ensure the resident's pain was consistently assessed or reassessed, managed, and documented in a timely manner in the Medication Administration Record (MAR) for 2 of 41 sampled residents (Residents 273 and 17). This deficient practice could have the potential for unrelieved pain, discomfort, and inadequate pain management. Findings include: Resident 273 (R273) A facility policy titled Pain Assessment and Management revised October 2022, documented acute pain should be assessed every 30-60 minutes after the onset and reassessed as indicated until relief was obtained. On 02/25/2025 at 10:54 AM, R273 was in bed, verbally alert and oriented. R273 verbalized having back surgery and feeling frustrated when requesting help for pain medication, but the request was ignored. R273 verbalized the pain scale was at 8/10, with discomfort in the hip, back, elbow, and foot. R273 verbalized the pain medication was insufficient and was changed to every four hours as needed. The Admission Minimum Data Set, dated dated dated [DATE], documented a score of 15/15, which indicated R273's cognitive status was intact. The History and Physical dated 02/21/2025, documented R273 was hospitalized due to acute-on-chronic back pain for about two days. The CT scan showed the left spine noted a burst fracture deformity and lumbar 1 vertebral fracture, acute post-trauma and infection. A Care Plan dated 02/22/2025, documented R273 was at risk for acute pain, sub-acute pain, chronic pain, or discomfort due to chronic pain syndrome, general body. A Physician Order dated 02/25/2025, documented Percocet oral tablet 5-325 milligrams (mg) to give 1 tablet by mouth every 4 hours as needed for pain scale 7-10. A review of the resident's eMAR revealed a lack of documented evidence the pain was assessed 30-60 minutes after the onset and reassessed as indicated until relief was obtained. On 02/28/2025 at 7:59 AM, a Licensed Practical Nurse (LPN) indicated if a resident was alert and oriented, was asked to verbalize the intensity of the pain on a scale of 1 to 10, and specify the location, would assess the location, and review the physician's orders. If no order was present, the physician was notified to obtain orders, administer, and document in the eMAR. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The LPN indicated after administering pain medication, a reassessment should have been conducted within 15 to 30 minutes to determine its effectiveness, ensuring the medication provided relief. The LPN demonstrated the process of pain management, including administration, reassessment, and required documentation. The LPN indicated after medication was administered, a system-generated prompt highlighted in yellow appeared, signaling that follow-up was required. The LPN indicated the prompt remained yellow until the follow-up was completed, at which point it turned green. The LPN indicated the highlight prompts for follow-up or reassessment, and the yellow prompt persisted until the task was completed, but no specific timeframe was required. On 02/28/2025 at 8:10 AM, a Registered Nurse (RN) indicated the pain evaluation should have been conducted 30 minutes after administration to assess the effectiveness of the medication, with documentation recorded in the electronic medical record. The RN emphasized the importance of administering and reassessing pain medication within 30 minutes to ensure pain relief and promote the resident's comfort. The RN explained the facility utilized the Wong-Baker Faces, Pain Rating Scale to determine the severity of a resident's pain, with the following scale: 0 - No pain / 1-2 - Least pain / 3-4 - Mild pain / 5-6 - Moderate pain / 7-8 - Severe pain / 9-10 - Very severe/horrible/worst pain On 02/27/2025 at 12:43 AM, another Registered Nurse (RN) indicated the level, location, and type of pain (such as aching or throbbing) should have been assessed. The RN explained the pain should have been reassessed within 30 minutes to an hour to determine the medication's effectiveness. The RN explained in the eMAR, the medication would have been highlighted in yellow to indicate the reassessment or follow-up was required but no specific timeframe to complete. On the afternoon of 02/27/2025, another RN indicated the resident's pain should have been reassessed 30 minutes to 1 hour after administration to evaluate its effectiveness. The RN confirmed R273's pain assessment was not consistently reassessed. The RN confirmed there was no documentation indicating R273 had received Percocet, as noted in the Controlled Medication Record book, but not documented in the eMAR. The RN indicated the administration should have been recorded in the eMAR as the official medical record and should have matched the controlled medication record. On 02/28/2025 at 8:16 AM, R273 was in bed, grimacing while repositioning self to eat breakfast. R273 reported experiencing pain in the lower back with a pain scale of 10/10, which was aggravated by movement. R273 indicated the pain assessments had not been conducted consistently to evaluate the effectiveness of the treatment. R273 mentioned informing the staff the previous day about the possibility of adding a patch to the pain medication regimen, but it had not yet been addressed. On 02/28/2025 at 9:00 AM, the Assistant Director of Nursing (ADON) indicated the pain should have been assessed and reassessed within an hour for effectiveness. The ADON verified and confirmed R273's pain was not consistently reassessed within an hour. 41903 Resident 17 (R17) R17 was admitted on [DATE] with diagnosis including gout, type 2 diabetes mellitus with hyperglycemia, and spondylosis without myelopathy or radiculopathy thoracic region. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Care Plan dated 01/24/2025 documented R17 was at risk for pain or discomfort. On 02/26/2025 at 9:52 AM, R17 was observed in a wheelchair approaching the nursing station in the 100 hall. R17 was observed visibly distressed, face flushed, grimacing, rubbed the back of the neck with their hands, and used short broken sentences to speak. R17 told the staff at the nursing station was experiencing severe pain. The four staff at the nursing station did not acknowledge R17's presence. R17 waited for assistance and continued to report was experiencing severe pain and needed pain medication prior to leaving with transportation for an appointment outside the facility. R17 reported had activated the call light in their room over one hour prior to report pain and had requested pain medication. R17 explained a staff member answered the call light, turned it off, and said would report the pain to a nurse; however, the nurse did not come. On 02/26/2025 at 9:57 AM, A nurse approached the resident near the 100-hall nursing station. The nurse told the resident no one had reported to the nurse the resident was in pain. The nurse administered pain medication to the resident. A Physician order dated 01/24/2025 documented Oxycodone Hydrochloride (HCl) Oral Tablet 15 mg (Oxycodone HCl) *Controlled Drug*. Give 1 tablet by mouth every 4 hours as needed for pain scale 7-10, hold for increased sedation or systolic blood pressure under 100. A Controlled Drug Record located at the 100-hall medication cart documented R17 was administered Oxycodone 15 milligram (mg) tablet on 02/26/2025 at 09:57 AM. The medication administration record (MAR) for February 2025 lacked documented evidence the resident received Oxycodone 15 mg tablet on 02/26/2025 at 09:57 AM. R17's medical record lacked documented evidence the resident's pain was reassessed after the administration of the pain medication. On 02/27/2025 at 3:33 PM, the Director of Nursing (DON), explained pain medication administered needed to be documented in the electronic medication administration record (EMAR) as well as the narcotics log. The DON reported residents were to be assessed for effectiveness of the pain medication 30-60 minutes following the administration. The DON acknowledged the pain medication administered to R17 was not documented in the EMAR and acknowledged no documentation was available that an assessment was completed to assess for pain relief. The DON reported the pain assessment needed to be done to confirm the effectiveness of the medication and ensure proper pain management and relief for the resident. On 02/28/2025 at 7:52 AM, a Licensed Practical Nurse, reported pain medication administration needed to be documented when administered both in the EMAR and the narcotics logbook. The LPN confirmed nurses were to assess the residents 30-59 minutes after pain medication administration to determine if the medication was effective or not. A policy titled Documentation of Medication Administration dated 2001, documented a medication administration record was used to document all medications administered. A nurse or certified medication aide (where applicable) documented all medications administered to each resident on the resident's medication administration record (MAR). Administration of medication was to be documented immediately after it was given. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy titled Pain Assessment and Management dated 2001, documented pain management was a multidisciplinary care process that included monitoring for the effectiveness of interventions. Acute pain (or significant worsening of chronic pain) should have been assessed every 30 to 60 minutes after onset and reassessed as indicated until relief was obtained.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5% during medication pass. There were 25 opportunities observed, which revealed two errors. The medication error rate was 8%. Findings include: Resident 274 (R274) On 02/27/2025 at 8:40 AM, a Licensed Practical Nurse (LPN) prepared and administered five medications, including Folic Acid 400 micrograms (mcg) (0.4 milligram), one tablet by mouth. A Physician order dated 02/24/2025, documented Folic acid oral tablet 1 milligram (mg) to give one tablet daily for a supplement. The Medication Administration Record dated 02/27/2025, documented the Folic acid 1 mg tablet was administered successfully. On 03/05/2025 at 10:39 AM, a Licensed Practical Nurse (LPN) confirmed the Folic acid order was for 1 mg or 1000 mcg, but 400 mcg had been administered. The LPN explained there were two bottles of Folic acid available. The LPN indicated the medication dosage should have been double-checked and enumerated the resident's rights, including the right to the correct dose. On 03/05/2025 at 1:59 PM, during a telephone interview, the Pharmacist indicated the Folic acid 400 mcg tablet was equivalent to 0.4 mg. The Pharmacist explained if the facility intended to use the over-the-counter Folic acid, two and a half tablets should have been administered to provide the 1 mg or 1000 mcg dose. On 03/05/2025 at 1:50 PM, the Director of Nursing (DON) indicated the Licensed Nurses were expected to observe the resident rights of the medication administration, including the right to correct dosage to prevent error. Resident 273 (R273) R273 was admitted on [DATE], with diagnoses including hypertension and overweight. A Physician order dated 02/21/2025, documented Cardizem capsule extended release 120 mg, to give 1 capsule by mouth daily for hypertension. Hold for systolic blood pressure less than 110. On 02/27/25 at 8:52 AM, the same LPN prepared nine medications and administered to R273 except the Cardizem capsule extended release. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/05/2025 at 10:39 AM, an LPN indicated the prescribed Cardizem capsule was not administered because the systolic blood pressure (SBP) was 110, and the parameter required holding the medication if the SBP was less than 110. The LPN explained did not realize the SBP parameter was less than 110 the medication could still have been given, but it was withheld. The LPN verbalized R273's blood pressure was checked again after the medication pass and was within the normal range of 110/70, however, the Cardizem was still not administered. A review of the Medication Administration Audit Report dated 02/27/2025, documented the Cardizem capsule was withheld and not administered. On 02/05/2025 11:00 AM, the Director of Nursing (DON) indicated the Licensed Nurses were expected to observe the resident rights of the medication administration including the right to correct dosage to prevent error and to follow the parameter indicated in the order or call the physician if in doubt. A facility policy titled Administering Medications revised April 2019, documented medications were administered in a safe and timely manner and as prescribed. Medications were administered in accordance with prescriber orders, including any required time. Medications were administered within one hour of their ordered time. The individual administering the medication checks the label three times to verify the resident's rights, including the right dose and right method, before giving the medication. The vital signs were checked and verified if necessary, prior to administering medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interview, and document review, the facility failed to ensure that opened items in the refrigerator and freezer were properly labeled and discarded upon expiration per policy. This deficient practice had the potential to result in the serving of expired or improperly stored food items to residents, potentially leading to foodborne illness. Findings include: On [DATE] at 7:51 AM, during an initial brief inspection of the kitchen, the surveyor, accompanied by the Director of Dietary Services, observed the following inside the walk-in refrigerator: a large bin of chopped onions dated [DATE], a half-cut large tomato wrapped in plastic wrap without a label, and a large plastic bin of canned fruits that was unlabeled. The Director of Dietary Services confirmed the observation and indicated the opened items should have been discarded within five days but had not been removed as required. An inspection of the walk-in freezer revealed an undated chocolate cream pie in a foil container had been opened and cut in half. The Director of Dietary Services confirmed the pie should have been dated and discarded, as the date of opening and partial use was unknown. The Director of Dietary Services indicated the dietary staff were responsible for ensuring the partially used or opened items should have been labeled, dated, and discarded timely. The facility's Dry Goods Storage Guideline (undated) documented canned items, including vegetables and tomatoes, should have been discarded within three days of being opened. A facility policy titled Food Receiving and Storage revised [DATE], documented all foods stored in the refrigerator or freezer were covered, labeled, and dated. Refrigerated foods were labeled, dated, and monitored.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29141 Based on observation, interview, and document review, the facility failed to ensure a safe and functional environment was provided for residents in the 200 hall by not maintaining a functioning call light system. The failed practice placed the residents at risk of not having call lights answered in a timely manner, delayed response to resident's needs and increased accidents risk. Findings include: 02/26/25 at 8:38 AM, the call light at the door in room [ROOM NUMBER] was observed activated. At the same time a staff member was sitting at nursing station while an audible alarm from the call light system could be heard. 02/26/25 at 8:44 AM, the call light continued activated at room [ROOM NUMBER]. Two staff members wearing scrubs passed by but did not answer the call light. 02/26/25 at 9:00 AM, the resident in 220 verbalized the call light was activated to request the room temperature be adjusted since it was cold. Resident verbalize had been waiting for a long time for somebody to respond. 02/26/25 at 9:03 AM and 25 minutes after the call light was activated in room [ROOM NUMBER], a Certified Nursing Assistant (CNA) answered the call and addressed resident's request. The CNA verbalized indicated call lights was everybody responsibility and verbalized it's seemed staff expected only CNAs to answer call lights. On 02/26/2025 at 9:54 AM, a Licensed Practical Nurse LPN who was the staff member sitting at the nursing station when the call light was activated in room [ROOM NUMBER] explained they could not see the call light located at the door of room [ROOM NUMBER] from the nursing station and the audible alarm alerted the staff at the nursing station the activation of the call light. The LPN explained the call light system was malfunctioning since 02/24/2025, producing a constant alarm sound that could not be turned off, masking the real call light alarm sound. The LPN was not sure if the issue was reported to maintenance. The LPN indicated regularly, there were to different audible tones for the call light, one for regular call from the resident's bed, and another from the bathroom that had a high-pitched sound. The LPN explained if the call light system was malfunctioning, residents should have been provided with a mechanical bell, and staff should have been rounding more often. (continued on next page)

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/26/2025 at 10:00 AM, an inspection of the call light system at the 200-hall nursing station, revealed the console of the call system had an error detected in room [ROOM NUMBER], giving a constant alarm sound different that the regular audible alarms. A test of call light was performed with the LPN using the activator at the bed in room [ROOM NUMBER]. The nurse confirmed when the call light was activated, the audible alarm was masked by the constant alarm sound generated by the system failure. When attempted to activate the call light from the bathroom, it was found the activator was not working. The nurse confirmed the observation and verified the malfunctioning call light in the bathroom had not been reported in the maintenance reporting log. During the observations, other two rooms were found with malfunctioning call light activators in the bathroom (room [ROOM NUMBER] and 223). room [ROOM NUMBER] was unoccupied at the time of the observation, and room [ROOM NUMBER] was occupied by an unsampled resident who was bedbound and did not use the bathroom due to health condition. The review of the maintenance reporting log located in the nursing station lacked documented evidence the malfunctioning call light system was reported to the Maintenance Department. The log documented the call issues in room [ROOM NUMBER] was included by the Maintenance Director on 02/25/2025. On 02/26/2025 at 10:41 AM, the Director of Maintenance (DOM) explained if an issue needed the attention of the Maintenance Department, the concern or problem should be documented in the maintenance reporting log located in each nursing station. DOM indicated maintenance staff revised the logs daily to address the problems and signed if resolved if the issue was fixed, or documented in process is the problem was not resolved yet. DOM indicated there were no reports of call lights malfunctioning in the 200-hall, but the problem was detected by maintenance staff on 02/25/2025 when checked an unrelated issues reported by the resident in room [ROOM NUMBER]. 41903 On 02/26/2025 at 9:29 AM, the 200-hall nursing station call light monitor system had a repetitive, beeping sound at regular intervals, continuing without cessation. The sound was loud enough to be heard throughout the nurse's station and surrounding hallways. A Licensed Practical Nurse (LPN) at the nursing station reported it was a maintenance issue; maintenance was notified, and the call light monitor system needed to be fixed. The LPN explained actual call lights that came from resident rooms made a different noise which was constant and not intermittent. The LPN acknowledged it was confusing to hear that constant noise the system was making and when a real call light came in, if the staff was not paying close attention to the sounds, they could miss a call light or find it hard to identify the difference between the constant noise the system was making and a real call light activated from a resident's room. On 02/26/2025 at 09:59 AM, the Unit Clerk at the 100-hall nursing station reported if the call light system was down, staff were to provide residents with a bell they could use to call for help as well as more frequent rounds to resident's rooms needed to be done. On 02/26/2025 at 10:06 AM, a Certified Nursing Assistant (CNA) reported call lights were to be answered as soon as possible. The CNA reported would stay near resident rooms and would round in resident's rooms more often if the call light system was not working. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295093	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canyon Vista Post Acute	6352 Medical Center Street Las Vegas, NV 89148

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/05/2025 at 1:04 PM, the Administrator, reported was not previously made aware of a call light system issue but was now aware. The Administrator reported staff may have been unplugging and plugging the call light system to reset it, which would not work because it decompensated the system and codes were needed to reset. On 03/05/2025 at 2:00 PM, the Director of Nursing, DON, reported there was not a specific policy for call system requirements. The DON reported would continue to look for a facility policy that would address call light system requirements or the maintenance of the call light system. On 03/06/2025 at 1:00 PM, the Director of Nursing, DON, reported continued to search for a facility policy regarding the call light system and or maintenance of the call light system. The facility failed to provide a policy for the call light system requirements or maintenance of the call light system.