STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295094	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spanish Hills Wellness Suites	5351 Montessouri Street Las Vegas, NV 89113

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41903 Based on observation, document review, record review, and interview, the facility failed to provide a working over the bed light for 1 of 24 residents (Resident 125). The failed practice had the potential to deprive the resident of using a urinal bottle independently overnight. Findings include: Resident 125 (R125) R125 was admitted on [DATE], with diagnosis including hemiplegia affecting left nondominant side, hereditary and idiopathic neuropathy, and cerebrovascular disease. On 01/07/2025 at 10:07 AM, R125 was observed in bed with a urinal bottle hung on the bedside nightstand. R125 reported had moved into the room two weeks prior and was not provided a remote control for the over the bed light. R125 was informed the remote control was sent out for repair. R125 explained was able to use the urinal bottle independently, however, had not been able to use the urinal bottle at night due to not being able to see in the dark. R125 explained needed the light on to position the urinal bottle correctly. R125 stated wanted to continue to use the urinal bottle independently, but instead had to call staff for help at night. The Resident Census dated 12/27/2024, documented a room change to room [ROOM NUMBER] Bed B. On 01/08/2025 at 12:42 PM, a Nurse reported was not aware R125 did not have a remote control to turn on the light above the bed and was unable to use the urinal bottle at night. On 01/08/2025 at 1:21 PM, the Maintenance Director, confirmed the remote control for the over the bed light had been sent for repair. The Maintenance Director stated did not have an expected date for completion of the repair. The Maintenance Director acknowledged a remote control could have been removed from an empty room or the resident moved to another room, to prevent disruption of care to the resident. On 01/09/2025 at 11:16 AM, the Assistant Director of Nursing (ADON), acknowledged R125 should have been provided a light to be able to continue to use the urinal bottle at night independently while repairs were done, both to preserve R125's independence, and continue to encourage self-care. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy titled Resident Room Environmental revised 11/01/2017, documented promoting and preserving resident independence and self-sufficiency should be considered when arranging the resident living space.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29141 Based on observation, interview and document review, the facility failed to provide a clean and sanitary homelike environment by ensuring proper floor cleaning procedures were performed in 16 of 90 residents' rooms (rooms 406 to 422). The deficient practice had the potential to increase infection risk and denied the residents the right to a safe and clean homelike environment. Findings include: 1) Residents' room cleanness: On 01/07/2025 at 9:30 AM, Resident #28 (R28) verbalized concerns related to the cleanness of the resident's room. R28 indicated the room had been cleaned on a daily basis but dust and debris remained on the edges between the wall and the floor at the baseboard. On 01/07/2025 at 10:00 AM, a housekeeping staff confirmed room [ROOM NUMBER] had been cleaned. The housekeeping staff acknowledged the edges between the wall and the floor at the baseboard were not cleaned. On 01/07/2025 at 10:12 AM, the housekeeping supervisor confirmed the observation and verbalized all the surfaces of the room should have been cleaned. On 01/07/2025 during the inspection of rooms 406 to 422, it was corroborated dust and debris remained at the edges between the wall and the floor after the rooms were cleaned. The housekeeping supervisor confirmed the observations. The facility policy titled General Cleaning dated March 2006, documented the routine cleaning and disinfection procedures would be performed in a way to provide a clean, safe decontaminated environment for the residents. The policy indicated staff should check areas above eye levels and dust as needed and move furniture weekly to clean underneath and behind.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50289 Based on observation, interview, record review, and document review, the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) level two referral was completed for 1 of 24 sampled residents (Resident 69). The deficient practice had the potential to deprive the residents of concern and other residents of necessary behavioral health services. Findings include: Resident 69 (R69) R69 was readmitted on [DATE], with diagnoses including schizoaffective disorder, anxiety disorder, depression, and post-traumatic stress disorder. On 01/07/2025 in the afternoon, R69 stated was on the Resident Council and had been at the facility for about three years. The resident related had been in a bad accident, had post-traumatic stress disorder (PTSD) from it, and also has bipolar illness. A PASARR level one document dated 08/06/2021, revealed R69 did not have dementia, mental illness (MI), intellectual disability, (ID) mental retardation (MR) or any related condition (RC) and was deemed appropriate for nursing facility placement. A review of the resident's medical notes revealed R69's schizoaffective disorder was diagnosed on [DATE], the post-traumatic stress disorder was diagnosed on [DATE], the anxiety disorder was diagnosed on [DATE], and the resident's depression was diagnosed on [DATE]. On 01/09/2025 in the morning, the Social Services Director (SSD) explained the SSD was responsible for referring residents who met criteria for PASARR two by completing the online PASARR request. When asked if a residents' diagnoses of schizoaffective disorder and post-traumatic stress disorder would be representative of a mental illness, intellectual disability, or a related condition which the Medicaid Service Manual documents a PASARR II must be completed for, SSD agreed these diagnoses would be an indication. The Division of Health Care Financing and Policy- Medicaid Services Manual- for Nursing Facilities Policy dated 05/01/2015, documented when an individual has been identified with possible indicators of mental illness, intellectual disabilities or related condition, a PASARR Level II screening must be completed to evaluate the individual and determine if nursing facility services and/or specialized services are needed and can be provided in the nursing facility. Examples include: a resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting a presence of a mental disorder (where dementia is not the primary diagnoses), or an intellectual disability or related condition was not previously identified and evaluated through PASARR. Social services would be responsible for keeping track of each resident's PASARR screening status and referring to appropriate authority. The medical record lacked documented evidence a referral for a PASARR level two screening was completed.

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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 care plan was formulated to manage the resident's care with a nephrostomy tube for 1 of 24 sampled residents (Resident 98). This deficient practice could have led to an increased risk of complications related to improper management and a lack of continuity in care. Findings include: Resident 98 (R98) R98 was admitted on [DATE] and readmitted on [DATE] with diagnoses including palliative care, dysuria (painful or difficult urination), and malignant neoplasm of the prostate. On 01/07/2025 at 12:48 PM, R98 verbalized a complaint to a Registered Nurse (RN) about a peeling dressing. An RN checked the resident's back and confirmed the nephrostomy dressing had peeled off, appeared old and undated, and was soiled. R98 indicated a shower had caused the dressing to become wet, but it had not been changed. Complaints of itchiness on the surrounding skin were noted. The RN acknowledged R98 was receiving hospice services but was unsure if the hospice nurse was responsible for changing the dressing. R98's medical records lacked documented evidence a baseline care plan was formulated for the management of R98's nephrostomy. The RN confirmed no care plan was in place. On 01/08/2025 at 12:16 PM, the Charge Nurse indicated the nephrostomy tube required a baseline care plan with management instructions on proper care for the nephrostomy. On 01/09/2025 at 1:39 PM, the Director of Nursing (DON) confirmed the absence of a baseline care plan. The DON indicated licensed nurses were responsible for formulating the care plan, which should have been followed through by nursing leadership. The DON indicated a baseline care plan should have been developed to monitor the insertion site for signs of infection and address dressing changes. The DON indicated there should have been a baseline care plan following R98's admission. A facility policy titled Care Plan Process, Person-Centered Care, dated 05/05/2023, documented the facility's commitment to developing and implementing a baseline and comprehensive care plan for each resident, including instructions to provide effective, person-centered care meeting professional standards of quality care. The baseline person-centered care plan was to be developed and implemented within 48 hours of the resident's admission.

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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** 29141 Based on observation, record review, interviews and document review, the facility failed to: 1) implement a care plan for restorative hand splinting services to prevent contractures for 1 of 24 sampled residents (Resident 44), and 2) develop care plans for side rails, weight loss and pressure ulcer for 3 of 24 sampled residents (Residents 62, 87, and 129). The deficient practice placed the residents at risk for worsening health conditions related to contractures, injuries, malnutrition and pressure ulcers. Findings include: The facility policy titled Care Plan Process, Person-Centered Care dated 05/30/2023, documented the facility would develop and implement baseline and comprehensive care plan for each resident that include instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. 1) Implementation of a Care Plan: Resident 44 (R44) R44 was admitted on [DATE], with diagnoses including cerebrovascular accident (CVA) with weakness right side of the body. On 01/07/2025 in the morning, R44 was lying on the bed clutching the right hand with the left hand. The resident indicated could not move the right hand, and a splint was previously used but was not sure why the splint was no longer applied. A care plan developed on 04/20/2023 and updated on 12/18/2024, documented R44 should have received restorative nursing program (RNP) (a set of nursing interventions that help residents maintain or improve their ability to function independently) for right resting hand splint due to the increased risk to acquire a contracture. The care plan indicated R44 should have been wearing a resting hand splint in the right hand up to eight hours a day to prevent contracture. The minimum date set (MDS) quarterly assessment dated [DATE] and the last annual MDS assessment dated [DATE], revealed the restorative program was not performed including splint or brace assistance. Physician order dated 05/13/2024 documented right-hand splint and left ankle foot orthosis to be worn daily up to 8 hours a day as tolerated. The order was discontinued on 10/21/2024 because R44 was discharged (transfer to hospital). The medical record lacked documented evidence a new physician order for splinting was obtained when R44 was readmitted to the facility. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/09/2025 at 3:45 PM, a Licensed Practical Nurse (LPN) reviewed R44's physician orders and confirmed there was no orders for splinting. The LPN indicated R44 went to the hospital back in October 2024 and it is possible the order was not carried on. The LPN confirmed a care plan was developed for the hand splint and acknowledged a physician order should have been obtained to ensure the implementation of the care plan. On 01/10/2025 at 8:15 AM, the Director of Nursing (DON) explained R44 had been transferred several times to a hospital and the order for splint was not carried on. The DON indicated R44 was in the process to be re-evaluated for physical therapy (PT) but could not explain why the resident was not assessed upon re-admission. On 01/10/2025 at 9:30 AM, the PT Director explained R44's last PT assessment was performed March 2024 and discharged from the skilled program on 04/15/2024 since the resident attained the maximal potential for their condition. The PT Director indicated R44 was referred to restorative program for home exercise. The PT Director indicated R44 was not re-assessed after being discharged and readmitted because there were no significant changes. The PT Director explained a person having a stroke that affect a side of the body could benefit from the use of splint and orthosis for limb positioning, joint alignment, and to prevent contractures. On 01/10/2025 at 10:45 AM, a restorative aid explained R44 was receiving restorative services for transfers but not for splinting since there was no physician order for splints. 41903 2) Development of a Care Plan: Resident 62 (R62) R62 was admitted on [DATE], with diagnosis including Parkinson's disease without dyskinesia, chest pain, and syncope and collapse. On 01/07/2025 at 3:27 PM, R62 was observed sitting in a wheelchair at the bedside. Bed side rails were observed up on bilateral sides of the bed. R62 reported side rails were put up to facilitate movement. On 01/10/2025 at 8:37 AM, a Nurse confirmed side rails were up and in use for R62 to hold on to, for bed mobility. A Side Rail Review and Consent dated 12/06/2024, documented the use of side rails was considered for syncope, status post fall, hypertension, and hypothyroidism to aid with repositioning, bed mobility and transfers. The medical record lacked documented evidence a comprehensive care plan was developed for the use of side rails. On 01/10/2025 at 9:53 AM, the Director of Nursing (DON) acknowledged a comprehensive care plan was not developed for R62's side rails use. The DON confirmed a comprehensive care plan should have been developed when the side rails consent was completed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 87 (R87) R87 was admitted on [DATE], with diagnosis including encephalopathy, nausea with vomiting, and drug induced subacute dyskinesia. A Malnutrition Screening Tool dated 09/09/2024, documented R87 was eating poorly due to decreased appetite. R87 scored positive for nutritional risk. R87's Vitals Report dated 09/07/2024, documented an initial resident weight of 150 pounds (lbs.) upon admission. The Vitals Report documented resident weight of 120.1 lbs. on 10/09/2024. R87 sustained weight loss of 29.99 lbs. or 19.93% of R87's total body weight between 09/07/2024 and 10/09/2024. A Nutritional Assessment at Admissions dated 09/11/2024, under the Estimated Nutritional Needs section, calories per day, protein grams per day, and fluid milliliters per day was observed blank. The Evaluation of Nutritional Needs section of the form was observed blank and lacked information for nutritional diagnosis, interventions, goals, monitoring and evaluation. A Nutritional Review dated 12/10/2024, documented resident weight of 117.2 lbs. and significant weight loss had occurred. A Care Plan edited 12/12/2024, documented R87 was at nutrition and/or dehydration risk related to dysphagia, anxiety, and recent weight loss. The Care Plan documented the problem start date as 11/13/2024. The medical record lacked documented evidence a comprehensive care plan was developed for R87 to address the significant weight loss sustained between 09/07/2024 and 10/09/2024, until 11/13/2024. On 01/08/2025 at 1:31 PM, the Director of Nursing (DON) confirmed a comprehensive care plan for nutrition and weight loss had not been developed for R87 during the period of substantial weight loss. The DON explained the lack of a care plan, goals, and interventions could have been detrimental to resident care and may have contributed to exacerbation of wounds and comorbidities. Resident 129 (R129) R129 was admitted on [DATE], with diagnosis including spinal stenosis site unspecified, cellulitis, and polyneuropathy. On 01/07/2025 at 10:07 AM, R129 reported had a wound on right heel that was not present during admission to the facility. A Progress Note dated 12/21/2024, documented R129 had a bedside wound consult for the heels. R129's right heel had an open area 1.6 centimeters (cm) x 1.2 cm, depth 0.2 cm from trauma. R129 stated possibly hit foot while at therapy. A Physician Order dated 12/21/2024, documented weekly wound treatment: Cleanse right heel trauma with normal saline/wound cleanser, apply Silvasorb (a gel used to treat wounds), three times weekly for 30 days. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Wound Care Progress Note dated 01/06/2025, documented R129 was seen for follow up of the right heel wound. Notification received of right heel wound culture done showed positive for Methicillin Resistant Staphylococcus Aureus (MRSA). The medical record lacked documented evidence a comprehensive care plan was developed for R129's right heel wound. On 12/09/2025 at 8:53 AM, the Director of Nursing (DON), acknowledged the medical record lacked a comprehensive care plan for R129's heel wound. The DON reported a comprehensive plan should have been developed including goals and interventions.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50289 Based on observation, interview, record review, and document review, the facility failed to provide an ongoing program of activities designed to meet the interests of the residents for 2 of 24 sampled residents (Residents 26 and 117) and 7 unsampled residents. The deficient practice had the potential risk to cause psychosocial distress to the residents. Findings include: Resident #26 (R26) R26 was admitted to the facility on [DATE], with diagnoses including erythematous condition (unspecified), anxiety disorder (unspecified), and secondary hyperparathyroidism of renal origin. On 01/07/2025 in the morning, R26 explained had been at the facility for about 6 years and liked to come to activities and do single solitary activities like reading newspapers and magazines. R26 explained R26 would like to see more trips out of the facility to events and shopping places. R26 had an Activity Evaluation dated 04/09/2024 which documented the resident had identified needs where programming should be focused on community outings, large groups, independent activities, and outdoor activities. Resident #117 (R117) R117 was admitted to the facility on [DATE], with diagnoses including acute embolism and thrombosis of right femoral vein, pain (unspecified), and edema (unspecified). On 01/07/2025 in the morning, R117 explained had been at the facility for about 2 months. R117 stated participated in the activities which were of interest as long as was not in pain. R117 explained if was able to change one thing about the facility to make it better would change the transportation to get the residents out to shop again. R117 stated the facility used to take the residents out to places but hadn't in a while. R117's medical record lacked documented evidence of an Activity Evaluation to document the resident's identified needs as to where programming should be focused. Activity calendars lacked documentation of any outdoor activities or outings for December or January. Previous months activity calendars were unable to be found. On 01/08/2025 at 01:55 PM, the Administrator verbalized the facility had two buses/vans and two drivers. The Administrator also explained the facility utilized outside transportation company contractors for transports which conflict with their own facility transports or when they have a bus/van down for mechanical reasons. The administrator went on to explain only two buses/vans have been down due to mechanical issues for about a week or less in the last four months. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/10/2025 at 12:38 PM, the Activity Director explained the activity department sometimes gets ideas for activities from Resident Council. Sometimes the activity department also gets ideas from upcoming holidays or special events. The Activity Director explained the outings are not put on the schedule due to them having to schedule the buses/vans with their in-house transportation. When they do schedule an outing, the activity department will put up signs to notify the residents of the upcoming outing. The Activity Director stated the facility tries to make a shopping trip for the residents once a month. The Activity Director also explained was off in mid-August and came back to work in November Unsampled Residents (Residents 72, 76, 51, 66, 09, 58, 02) Resident Council Minutes dated 12/18/2024, docoumented residents had asked for an outing to a specific shopping center be added to the January Activity Calendar schedule. The Activity Director agreed to add it to the January Activity Calendar schedule. During a Resident Council meeting on 01/09/2025 in the afternoon, the Unsampled Residents acknowledged there had not been a trip to a specific shopping center since August 2024. The facility policy and procedure titled, Activity/Recreation Programming, last revised 11/04/2024, documented the facility will implement an ongoing resident centered activities program that incorporates the resident's needs, interests, hobbies, and cultural preferences which are integral to maintaining and/or improving physical, intellectual, psychosocial, emotional, spiritual wellbeing and independence as well as to create opportunities for each resident to have a meaningful life by supporting the domains of wellness (security, autonomy, growth, connectedness, identity, joy, and meaning).

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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** 50289 Based on observation, interview, record review, and document review, the facility failed to ensure an expired medication was not administered to 1 of 7 unsampled residents (Unsampled Resident 02). The deficient practice had a potential for a non-viable medication to be administered to the resident. Findings include: Unsampled Resident 02 (UR2) UR2 was admitted to the facility on [DATE] with diagnoses of other sequelae of cerebral infarction, anxiety disorder (unspecified), chronic kidney disease stage 3 (unspecified), and dementia with mood disturbance (unspecified). On [DATE] at 09:45 AM, a punch card of Hydralazine HCL 10 milligram (mg) tablets for UR2 was observed expired on [DATE], in the 400-hall medication cart. On [DATE] at 09:46 AM, a Licensed Practical Nurse, confirmed the Hydralazine HCL 10mg tablets were expired and should have been discarded for resident safety. On [DATE] at 09:47 AM, the Assistant Director of Nursing, also verified the Hydralazine HCL 10mg tablets were expired and should have been discarded for resident safety. On [DATE] at 09:48 AM, the Licensed Practical Nurse stated the expired Hydralazine HCL 10mg tablets were documented to have been administered to UR2 on [DATE] at 9:01pm for elevated Blood Pressure (BP) of ,d+[DATE] mmHg by the Registered Nurse working that night. UR2's vitals were taken on [DATE] at 11:45pm indicating the resident's blood pressure was ,d+[DATE] mmHg per the facilities vitals report. A physician order for UR2 on [DATE] was for one Hydralazine HCL 10mg tablet to be administered orally every 4 hours, as needed (PRN), for systolic blood pressure greater than 160. A care plan for UR2's blood pressure medication related to hypertension was created on [DATE] for medication administration, monitoring blood pressure, and observing for signs and symptoms of elevated blood pressure. A facility policy titled Medication Management Program: Administering the Medication Pass revised [DATE], documented prior to administering the medications, the nurse is responsible for checking for expiration dates and removing any expired products.

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29141 Based on observation, record review, and interviews, the facility failed to place hand splint for contracture management for 1 of 24 sampled residents (Resident 44). The deficient practice placed the resident at risk to develop contractures, decrease hand functionality, and cause pain and discomfort. Findings include: Resident 44 (R44) R44 was admitted on [DATE], with diagnoses including cerebrovascular accident (CVA) with weakness right side of the body. On 01/07/2025 in the morning, R44 was lying on the bed clutching the right hand with the left hand. The resident indicated they could not move the right hand, and a splint was previously used but was not sure why the splint was no longer applied. A care plan developed on 04/20/2023 and updated on 12/18/2024, documented R44 should have received restorative nursing program (RNP) (a set of nursing interventions that help residents maintain or improve their ability to function independently) for right resting hand splint due to the increased risk to acquire a contracture. The care plan indicated R44 should have been wearing a resting hand splint in the right hand up to eight hours a day to prevent contracture. The minimum date set (MDS) quarterly assessment dated [DATE] and the last annual MDS assessment dated [DATE], revealed the restorative program was not performed including splint or brace assistance. Physician order dated 05/13/2024 documented right-hand splint and left ankle foot orthosis to be worn daily up to 8 hours a day as tolerated. The order was discontinued on 10/21/2024 because R44 was discharged (transfer to hospital). The medical record lacked documented evidence a new physician order for splinting was obtained when R44 was readmitted to the facility. The physical therapy discharge summary dated 04/16/2024, revealed R44 was discharged for skilled therapy services since had attained the highest practical level of function for their condition, and recommended a referral to the clinical team for restorative program review. On 01/09/2025 at 3:45 PM, a Licensed Practical Nurse (LPN) reviewed R44's physician orders and confirmed there was no orders for splinting. The LPN indicated R44 went to the hospital back in October 2024 and it is possible the order was not carried on. The LPN confirmed a care plan was developed for the hand splint and acknowledged a physician order should have been obtained to ensure the implementation of the care plan. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/10/2025 at 8:15 AM, the Director of Nursing (DON) explained R44 had been transferred several times to a hospital and the order for splint was not carried on. The DON indicated R44 was in the process to be re-evaluated for physical therapy (PT) but could not explain why the resident was not assessed upon re-admission. On 01/10/2025 at 9:30 AM, the PT Director explained R44's last PT assessment was performed March 2024 and discharged from the skilled program on 04/15/2024 since the resident attained the maximal potential for their condition. The PT Director indicated R44 was referred to restorative program for home exercise. The PT Director indicated R44 was not re-assessed after being discharged and readmitted because there were no significant changes. The PT Director explained a person having a stroke that affect a side of the body could benefit from the use of splint and orthosis for limb positioning, joint alignment, and to prevent contractures. On 01/10/2025 at 10:45 AM, a restorative aid explained R44 was receiving restorative services for transfers but not for splinting since there was no physician order for splints. The facility policy titled Joint Mobility/Range of Motion Program and Splinting dated 10/25/2024, documented residents would be assessed for joint mobility upon admission, re-admission, quarterly, annually, and with significant changes through the comprehensive nursing assessment. The policy indicated a restorative program would be implemented through the care plan to increase, maintain, or prevent deterioration of joint mobility and to maximize physical function when referral to therapy was not indicated or upon discharge from skilled therapy, and orthotics, assistive or prosthetic devices would be provided if indicated.

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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 a physician's order had been obtained for the presence of the nephrostomy tube, the insertion site had been monitored, and dressing changes had been scheduled for 1 of 24 sampled residents (Resident 98). This deficient practice increased the risk of infection, complications from improper management, and a lack of continuity in care. Findings include: Resident 98 (R98) R98 was admitted on [DATE], and readmitted on [DATE], with diagnoses including palliative care, dysuria (painful or difficult urination) and malignant neoplasm of the prostate. On 01/07/2025 at 12:48 PM, R98 voiced a complaint to a Registered Nurse (RN) about a peeling dressing. The RN checked the resident's back and confirmed placement of a capped nephrostomy tube, with the nephrostomy dressing soiled, peeled off, and appearing old and undated. R98 indicated a shower had caused the dressing to become wet, but it had not been changed. The RN acknowledged R98 had been receiving hospice services but was unsure if the hospice nurse had been responsible for changing the dressing. R98's medical records lacked documented evidence a physician's order had been obtained for the presence of the nephrostomy tube, the insertion site had been monitored, and dressing changes had been scheduled. The RN confirmed no order for R98's nephrostomy and no care or monitoring orders had been in place. On 01/08/2025 at 12:16 PM, RN Charge Nurse indicated the nephrostomy tube required an order, the insertion site should have been monitored for signs and symptoms of infection, and the dressing change should have been scheduled. On 01/09/2025 at 1:39 PM, the Director of Nursing (DON) indicated R98 was on hospice services and had been visited by hospice staff. The DON confirmed the absence of a physician's order for the presence of the nephrostomy tube, monitoring, and care orders. The DON indicated despite R98 being on hospice, orders should have been documented in the resident's electronic records to ensure continuity of care and shared responsibility between hospice and facility staff. The DON indicated monitoring of the insertion site for signs and symptoms of infection should have been conducted, with the tube discontinued if no longer needed. The DON confirmed R98's nephrostomy tube had not been monitored for signs and symptoms of infection, and the dressing had been changed inconsistently. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Physician Orders, revised 05/05/2023, documented a qualified licensed nurse was required to obtain and transcribe orders following facility practice guidelines. Upon a resident's admission, the physician's orders, including routine care orders, were obtained. The orders were communicated in writing, either through paper medical records or electronically in facilities using electronic medical records.

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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 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** 41903 Based on observation, record review, document review, and interview, the facility failed to assess a resident's nutritional status during a period of substantial weight loss for 1 of 24 residents (Resident 87). The deficient practice had the potential to place the resident at risk of malnutrition and dehydration, compromising the residents' health and increasing susceptibility to further medical complications. Findings include: Resident 87 (R87) R87 was admitted on [DATE], with diagnosis including encephalopathy, nausea with vomiting, and drug induced subacute dyskinesia. A Malnutrition Screening Tool dated 09/09/2024, documented R87 was eating poorly due to decreased appetite. R87 scored positive for nutritional risk. R87's Vitals Report dated 09/07/2024, documented an initial resident weight of 150 pounds (lbs.) upon admission. The Vitals Report documented resident weight of 120.1 lbs. on 10/09/2024. R87 sustained weight loss of 29.99 lbs. or 19.93% of R87's total body weight between 09/07/2024 and 10/09/2024. A Nutritional Assessment at Admissions dated 09/11/2024, under the Estimated Nutritional Needs section, calories per day, protein grams per day, and fluid milliliters per day were observed blank. The Evaluation of Nutritional Needs section of the form was blank and lacked information for nutritional diagnosis, interventions, goals, monitoring, and evaluation. A Nutritional Review dated 12/10/2024, documented resident weight of 117.2 lbs. and significant weight loss had occurred. The medical record lacked documented evidence a nutritional assessment or review was performed from 09/11/2024 until 12/10/2024. On 01/08/2025 at 1:31 PM, the Director of Nursing (DON) acknowledged R87's medical record lacked documented evidence of nutritional assessments during the time R87 sustained significant weight loss. The DON reported the Registered Dietitian (RD) was on medical leave. The DON explained the lack of nutritional assessments and interventions could have been detrimental to resident care and may have contributed to exacerbation of wounds and comorbidities. On 01/10/2025 at 11:00 AM, the Administrator acknowledged the facility had identified concerns with weight loss not addressed timely. The Administrator explained excessive weight loss needed to be addressed including dietary needs, food preferences, percentage of intake, supplements, and include close collaboration with the physician. (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 Nutritional Assessment/Evaluation revised 06/20/2023, documented a comprehensive nutritional assessment was to be completed upon the resident's admission, annually, and whenever a significant change in status occurred. The assessment/evaluation was to include an assessment of the overall nutritional status of the resident.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services 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 Dialysis Communication Record were completed, shunt or dialysis access assessments were conducted, and vital signs were obtained pre- and post-dialysis for 1 of 24 sampled residents (Resident 16). The deficient practice increased the risk of complications, including delayed detection of shunt malfunction, inadequate dialysis, hemodynamic instability, bleeding, and potential infection. Findings include: Resident 16 (R16) R16 was admitted on [DATE], with diagnoses including chronic kidney disease, hypertension, and dependence on renal dialysis. The Quarterly Minimum Data Set, dated dated dated [DATE], documented the brief interview of mental status with a score of 14/15, which indicated R16's cognitive status was intact and R16 was receiving dialysis treatment. A Physician Order dated 08/28/2024, documented dialysis on Monday, Wednesday, and Friday. A Care Plan dated 09/06/2024, and revised 12/05/2024, documented R16 was on hemodialysis for kidney ureter stones, acute kidney injury, and sepsis. The interventions included monitoring the patency of the shunt by assessing the presence of a thrill and bruit and monitoring vital signs as ordered. On 01/07/2025 at 12:25 PM, R16 was in bed, alert and oriented, with a white bandage (Kerlix) observed wrapped around the left upper arm. R16 indicated it was a dialysis access and reported receiving dialysis three times a week. R16 indicated the dialysis center wrapped the dialysis access and recorded vital signs post-dialysis; however, vital signs were inconsistently taken upon arrival at the facility, sometimes not taken at all. The Medication Administration Record documented R16 had dialysis treatments: -October 2024: 13 times -November 2024: 13 times -December 2024: 13 times -January 2025: five times The Hemodialysis Communication Record lacked documented evidence the Hemodialysis Communication Records were completed; shunt or dialysis access assessments were consistently conducted, and vital signs were obtained pre- and post-dialysis from October 2024 to January 2025. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/09/2025 at 1:03 PM, the Director of Nursing (DON) indicated R16 received hemodialysis three times weekly. The DON explained the process, where pre- and post-dialysis procedures included obtaining vital signs and assessing the shunt or dialysis access for intactness, bleeding, or complications. The DON indicated the hemodialysis communication record was used to document assessments, including pre-dialysis vital signs, and was returned to the facility with completed documentation by the dialysis center. Upon arrival at the facility, shunt assessment and vital signs were obtained and documented on the same dialysis form. The DON confirmed R16's records lacked documented evidence showing shunt assessments and vital signs were consistently obtained and recorded. The DON indicated the staff were aware of the protocol and were expected to assess, obtain vital signs, and document accordingly. On 01/10/2025 at 11:47 AM, the physician indicated it was vital to assess the resident's shunt or IV access before dialysis treatment to ensure patency of the dialysis access, evaluate any signs and symptoms of infection, and assess the bruit and thrill. The physician indicated post-dialysis the dialysis access should have been monitored for bleeding. The physician emphasized the importance of promptly assessing the resident's dialysis access pre- and post-dialysis and obtaining vital signs to monitor for potential hypotension.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41903 Based on observation, record review, document review, and interview, the facility failed to obtain a physician order for the use of bed side rails for 1 of 24 residents (Resident 62). The failed practice had the potential to place the resident at risk of injury such as falls, entrapment, and broken bones. Findings include: Resident 62 (R62) R62 was admitted on [DATE], with diagnosis including Parkinson's disease without dyskinesia, chest pain, and syncope and collapse. On 01/07/2025 at 3:27 PM, R62 was observed sitting in a wheelchair at the resident's bedside. Bed side rails were observed up on bilateral sides of the bed. R62 reported side rails were put up to facilitate movement. A Side Rail Review and Consent dated 12/06/2024, documented the use of side rails was considered for syncope, status post fall, hypertension, and hypothyroidism to aid with repositioning, bed mobility and transfers. R62's medical record lacked documented evidence of a physician order for the use of side rails. On 01/10/2025 at 8:37 AM, a Nurse confirmed side rails were up and in use for R62 to hold on to, for bed mobility. The Nurse acknowledged the medical record lacked a physician order for side rails and explained a physician order should have been obtained. On 01/10/2025 at 9:53 AM, the Director of Nursing (DON) acknowledged the medical record lacked a physician order for the use of bed rails. The DON confirmed a physician order should have been obtained when the side rails review and consent were completed. A facility policy titled Physician Orders revised 05/05/2024, documented the qualified licensed nurse will obtain and transcribe orders according to Facility Practice Guidelines. A call is placed to the physician to confirm the orders and request any additional orders as needed.

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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** 50289 Based on observation, interview and document review, the facility failed to ensure an expired punch card of medications was discarded. The deficient practice had a potential for a non-viable medication to be administered to the resident. Findings include: On [DATE] at 09:45 AM, a punch card of Hydralazine HCL 10 milligram (mg) tablets was observed expired on [DATE], in the 400-hall medication cart. On [DATE] at 09:46 AM, a Licensed Practical Nurse, confirmed the Hydralazine HCL 10mg tablets was expired and should have been discarded for resident safety. On [DATE] at 09:47 AM, the Assistant Director of Nursing, also verified the Hydralazine HCL 10mg tablets was expired and should have been discarded for resident safety. A facility policy titled Medication Storage: 8.2 General Guidelines for Storage of Medication and Biologicals revised [DATE], documented outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction, and reordered from the pharmacy, if replacements are needed.

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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** 29141 Based on observation, interview, and document review, the facility failed to ensure dented cans and expired food products were discarded, and the kitchen floor and essential cooking equipment were cleaned and maintained in sanitary conditions. The deficient practice had the potential to expose residents to foodborne illnesses. Findings include: On [DATE] at 8:00 AM, an inspection was conducted in the kitchen with the Kitchen Manager. The following concerns were identified: - The fryer exhibited the oil visibly aged and contaminated. Food debris was prevalent, further contributing to the unsanitary condition. The fryer's surfaces were coated with a layer of grease and food debris. - The floor under the stove and oven was found to be greasy, dusty, and littered with food debris. - The lateral surfaces of the stove were greasy. - The toaster was greasy, with its exterior covered in grease and visibly soiled with food debris. - A mixer was visibly soiled with food remains. - A breadcrumbs container with expiration date [DATE]. - Three cartoons of thickened apple juice 1.36 litters expired on [DATE]. - Two containers of sour cream 5 pounds (LB) expired on [DATE]. - A container of peanut butter expired on [DATE]. - A container of gravy not dated found over the food preparation table. - A plastic receptacle containing hot dogs was found in the walk-in refrigerator with expiration date [DATE]. - Two dented cans of cheese sauce and a can of sliced pickled beets 6 LB each, found in the dry storage. - The potable water dispenser showed with white build up calcium matter around the nozzle. The water supply pipe was covered in formations of blue and white matter. - The ice maker machine had white build up calcium matter in the ice bin baffle. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The exhaust vent of the dishwasher was heavily soiled, with a significant accumulation of dust on its surface. On [DATE] in the morning, the kitchen manager acknowledged all the findings represented unsanitary conditions and should have been corrected timely. The facility policy titled Food Safety in Receiving and Storage dated [DATE], documented food products expiration dates and use-by dates should be checked to ensure dates were within acceptable parameters. The facility policy titled Manual Cleaning and Sanitizing Stationary Equipment and Work Surfaces dated [DATE], indicated stationary equipment and work surfaces would be cleaned and sanitized before use, between use, and any time contamination occurred or was suspected.

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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. hand hygiene was performed for 1 of 24 residents (Resident 16) and enhanced barrier precautions (EBP) were implemented for 2 of 24 residents (Residents 16 and 98) and 2. hand sanitizer was available in the resident care areas. These deficient practices could have led to potential cross-contamination and transmission of infectious diseases among residents and staff. Findings include: A facility policy titled Transmission-Based/Standard Precautions and Enhanced Barrier Precautions, dated 05/15/2023, documented the expansion of EBP to include the use of PPE, such as gowns and gloves, during high-contact resident care activities where opportunities for the transfer of MDROs to staff hands and clothing existed. EBP was required for all residents with wounds or indwelling medical devices, including urinary catheters. EBP was also required during high-contact resident care activities, such as dressing, transferring, providing hygiene, changing linens or briefs, and assisting with toileting. 1. Hand Hygiene and EPB: Resident 16 (R16) R16 was admitted on [DATE], and readmitted on [DATE], with diagnoses including sepsis and dependence on renal dialysis. On 01/07/2025 at 12:25 PM, an EBP signage was posted with personal protective supplies (PPE) available by the door. R16 was alert and oriented, a white bandage was observed wrapped on R16's left upper arm. R16 indicated it was a dialysis shunt access and receiving dialysis three times a week. On 01/08/2025 at 12:30 PM, R16 arrived from the dialysis center in a wheelchair. A registered nurse (RN) assisted R16 at bedside without PPE. The RN confirmed a gown should have been worn when providing direct care to a resident on EBP. The RN explained the hand hygiene and infection protocol should have been implemented to prevent cross-contamination. A Certified Nursing Assistant (CNA) entered the room, did not perform hand hygiene, wore gloves, and assisted R16 without wearing a gown. The CNA transferred R16 to the bed and provided incontinent care. After providing care, with soiled gloves, the CNA grabbed the privacy curtain and moved it aside. The CNA confirmed the EBP signage had been posted but failed to pay attention. (continued on next page)

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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	The CNA acknowledged the requirement to perform hand hygiene and to wear a gown and gloves during care to protect both self and the resident. The CNA admitted to not wearing a gown when assisting the resident from the wheelchair to the bed and during the provision of incontinent care. The CNA acknowledged contaminated gloves should have been removed and hand hygiene performed afterward. The CNA reported receiving recent education regarding infection control protocol. Resident 98 (R98) R98 was admitted on [DATE], and readmitted on [DATE], with diagnoses including palliative care, dysuria (painful or difficult urination), and malignant neoplasm of the prostate. On 01/07/2025 at 12:48 PM, no EBP signage or PPE was available at the door entry. While standing by the door, R98 reported to an RN in the hallway a concern regarding a peeling dressing. An RN inspected R98's back and confirmed R98 had a nephrostomy. The RN indicated was unsure if EBP signage was required. On 01/07/2025 in the afternoon, the charge nurse explained EBP signage and PPE should have been worn, such as gloves and a gown. On 01/09/2025 at 10:41 AM, the Infection Preventionist (IP) indicated residents with devices such as catheters, tubes, or wounds requiring dressings required an EBP during direct and high-contact activities. The IP emphasized the need for gloves, a gown, and hand hygiene before and after procedures. The IP indicated education for staff had been provided during boot [NAME], huddles, and continuing nursing education. The IP indicated performing hand hygiene after incontinent care and wearing a gown during direct care were expected, and noncompliance with these protocols was deemed unacceptable. 29141 On 01/07/2025 at 9:00 AM, three hand sanitizer dispensers located near the entrance of rooms 416, 417 and 419 were empty. The observation was confirmed by a Licensed Practical Nurse (LPN) who indicated housekeeping staff were responsible to replace the empty hand sanitizer cartridge in the dispensers. On 01/07/2025, the housekeeping supervisor explained hand sanitizer dispenser were supplied with new cartridge when nurses notified the Environmental Services. The housekeeping supervisor acknowledged the empty hand sanitizer cartridge should have been replaced to ensure staff compliance with hand hygiene.