

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Sage Creek Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 2350 lone Road Las Vegas, NV 89123	

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)
<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40142</p> <p>Based on interview, record review and document review, the facility failed to ensure nephrostomy care was provided in accordance with physician's order and facility policy for 1 of 4 sampled residents (Resident 2). The deficient practice placed the resident at risk for complications related to the nephrostomy tubes.</p> <p>Findings include:</p> <p>Resident 2 (R2)</p> <p>R2 was admitted on [DATE], with diagnoses including malignant neoplasm of the bladder and sepsis.</p> <p>A hospital discharge summary dated 09/20/2024, revealed R2 had bilateral nephrostomy tubes (a thin, flexible tube inserted through the back into the kidneys to allow drainage of urine to bypass a blockage to urine flow). R2's nephrostomy became obstructed and needed to be revised.</p> <p>A physician's order dated 09/22/2024, documented to provide nephrostomy care every shift, may change bag as needed.</p> <p>The Medication Administration Record (MAR) for September 2024, lacked documented evidence nephrostomy care was performed on 09/22/2024 evening shift (PM), 09/23/2024 morning and evening (AM/PM shift) and on 09/24/2024 (PM shift).</p> <p>On 03/13/2025 at 1:14 PM, the Assistant Regional Director of Clinical Services (ARDCS) explained nephrostomy care included emptying the bag, making sure the nephrotomy was draining below the level of the kidney, checking for kinks, and identifying and reporting complications. The ARDCS confirmed there was no documentation nephrostomy care was provided on 09/22/2024 (PM shift), 09/23/2024 (AM/PM shift) and 09/24/2024 (PM shift). The ARDCS indicated nephrostomy care ensured complications such as infections and skin breakdown were prevented and should be carried out as ordered.</p> <p>The Care of Nephrostomy Tube policy revised October 2010, documented a physician's order was required for nephrostomy care procedure. Nephrostomy care included: 1) Check placement of the tubing and integrity of the tape during assessments, 2) Ensure drainage is below the level of kidneys, 3) Check for kinks, 4) Empty drainage bag, 5) Change drainage bag monthly or as needed and 6) notify physician of complications such as dislodgement.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Complaint #NV00072509</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40142</p> <p>Based on observation, interview, record review and document review, the facility failed to ensure 1) an intravenous (IV) medication bag was labeled with the resident's name for 1 of 4 sampled residents (Resident 4) and 2) the facility's policies on peripheral IV insertion and removal were followed for 1 of 4 sampled residents (Resident 2). The deficient practice placed residents at risk for medication errors and complications related to IV accesses.</p> <p>Findings include:</p> <p>Resident 4 (R4)</p> <p>R4 was admitted on [DATE], with diagnoses including diverticulitis (an inflammation or infection of one or more small pouches in the digestive tract) of large intestines.</p> <p>On 03/13/2025 at 8:27 AM, a Licensed Practical Nurse (LPN) was preparing to administer Ciprofloxacin IV 400 milligrams (mg)/200 milliliters (ml) reconstituted solution to R4. The IV medication was pre-packaged in an aluminum container with a sticker label taped in front. After removing the IV medication bag from the aluminum package, the LPN affixed the sticker label unto the IV medication bag. The sticker label contained the resident's name, medication name, dose, route and frequency. After priming the IV tubing, the LPN entered R4's room.</p> <p>On 03/13/2025 at 8:46 AM, an empty IV medication bag attached to IV tubing was observed hanging on an IV pole at the right side of R4's bed. The IV bag read Metronidazole 500 mg/100 ml, the IV bag did not have a sticker label bearing the resident's name. The LPN confirmed the observation.</p> <p>On 03/13/2025 at 8:48 AM, the LPN explained reconstituted IV antibiotics such as Metronidazole and Ciprofloxacin came in aluminum packs for protection and were always delivered with a sticker label bearing the resident's name and order specifications. The LPN stated the facility process required nurses to remove the sticker label from the original package and affix the sticker on the IV bag. According to the LPN, the practice ensured the six rights of medication administration (right medication, right patient, right time, right dose, right route and right frequency) were being followed. The LPN indicated the medication administration record revealed the Metronidazole was last administered to R4 on 03/13/2025 at 6:19 AM by the night shift nurse.</p> <p>A physician's order dated 03/10/2025, documented to give Metronidazole Solution 500 mg/100 ml, intravenously every eight hours for diverticulitis for seven days.</p> <p>On 03/13/2025 at 2:21 PM, the Assistant Regional Director of Clinical Services (ARDCS) indicated the night nurse should have taken the sticker label from the original package and affixed the label on the IV medication bag to demonstrate the medication was prescribed and intended for R4. According to the ARDCS, administering unlabeled IV medication bags went against the facility practice.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Administering Medications policy documented the individual administering the medication must verify the resident's identity before administering the medication and verify the medication was for the right resident, right medication, right time, right method prior to administering medication. Medications ordered for a particular resident may not be administered to another resident.</p> <p>Resident 2 (R2)</p> <p>R2 was admitted on [DATE], with diagnoses including malignant neoplasm of the bladder and sepsis.</p> <p>A hospital discharge summary dated 09/20/2024, documented R2 was treated for sepsis and was being monitored by infectious disease team. R2 had completed antibiotic therapy and R2's discharge medications did not include any intravenous (IV) medications.</p> <p>The admission assessment dated [DATE], lacked documented evidence R2 was admitted with an IV access.</p> <p>A physician's order dated 09/20/2024, documented to change peripheral IV access every 72 hours and as needed for dislodgement, may extend for seven days for poor venous access as needed. Rotate IV site.</p> <p>A physician's order dated 09/21/2024, documented to give Piperacillin Sodium-Tazobactam reconstituted solution 3.375 grams intravenously every eight hours for leukocytosis (elevated white blood cells indicative of infection) for seven days.</p> <p>A physician's order dated 09/21/2024, documented normal saline flushes, use 10 milliliter (ml) IV every 12 hours for patency. First administration morning shift on 09/21/2024.</p> <p>The medical record lacked documented evidence a physician's order to insert a new peripheral line or discontinue an existing peripheral line was obtained and carried out.</p> <p>On 03/13/2025 at 2:08 PM, the Charge Registered Nurse (RN) recalled being assigned to R2 on a few occasions, but the RN could not recall if R2 was admitted with an IV access or whether the resident's IV line was inserted at the facility. The RN emphasized R2 had an IV access because the RN recalled administering IV medications to R2.</p> <p>On 03/13/2025 at 1:49 PM, the Assistant Regional Director of Clinical Services (ARDCS) confirmed R2's medical record reflected R2 was not admitted with an IV access. The ARDCS acknowledged there was no evidence a physician's order was obtained to remove an existing peripheral line or to insert a new one. The ARDCS indicated peripheral lines were intended for short term use and were typically replaced every 72 hours unless the physician ordered to maintain the line for longer use. The ARDCS indicated documentation requirements for peripheral line insertion and/or removal were not followed in the case of R2.</p> <p>The Peripheral IV Catheter Removal policy dated 2001, listed documentation requirements to include any communication with the physician, date and time of the procedure, location of catheter, which was removed, reason for removal (end of treatment, complication, rotation of site, etc.).</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Peripheral IV Catheter Insertion policy dated 2001, listed documentation requirements to include provider's order, date and time of procedure, type, length and gauge of catheter, insertion site (specific vein and limb), number of attempts, condition of IV site, resident's response to the procedure and signature and title of person who performed the procedure.</p>		