STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295098	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sage Creek Post-Acute	2350 Ione 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)
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** Based on observation, interview, record review and document review the facility failed to ensure: 1) a sequential compression device (SCD- a device used to prevent blood clots by promoting blood circulation) was accurately documented, applied and in use as ordered by the physician for 1 of 32 sampled residents (Resident 8) and 2) a physician order for fluid restriction was followed for 1 of 32 sampled residents (Resident 2). The deficient practice had the potential to place residents at risk for blood clot formation and electrolyte imbalance. Findings include: 1)Resident 8 (R8) was admitted to the facility on [DATE] with diagnoses including unspecified dementia, chronic obstructive pulmonary disease, and rhabdomyolysis. A Physician order dated 04/12/2026 documented sequential compression device (SCD) to bilateral lower extremities while in bed every shift. A Physician progress note dated 04/12/2026 documented R8 required deep vein thrombosis (DVT) precautions and to place SCDs. On 04/28/2026 at 9:49 AM, R8 was lying in bed, an SDC machine was hanging on the foot board at the foot of R8's bed. The SCD machine was not turned on. On 04/29/2026 at 9:53 AM, R8 was lying in bed, an SCD machine was hanging on the foot board at the foot of R8's bed. The SCD machine was not turned on. Review of R8's Medication Administration Record (MAR) for 04/2026 documented the SCD was applied as per physician orders daily at 6:30 AM. On 04/29/2026 at 12:04 PM, a Licensed Practical Nurse (LPN) explained was unaware if R8's SCD was currently applied. The LPN acknowledged had documented the SCD was applied at 6:30AM and that staff should round frequently to ensure the machine was on and functioning. On 04/29/2026 at 12:17 PM, the LPN confirmed R8's SCD machine was not turned on. On 04/29/2026 at 1:11 PM, the LPN explained the SCD for R8 was used to help prevent deep vein thrombosis due to R8 not getting up and walking. The LPN explained the SCD machine should be checked and monitored throughout the day to ensure it was turned on and functioning properly. On 04/30/2026 at 8:06 AM, R8 was lying in bed, no SCD machine was observed in R8's room. On 04/30/2026 at 8:13 AM, a Registered Nurse (RN) confirmed R8 had no SCD machine. The RN acknowledged had documented on R8's MAR the SCD was applied as per physician orders at 6:30AM (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and explained the SCD machine should have been checked to ensure it was available and turned on prior to documenting the treatment was provided. The RN located the SCD pump in a plastic bag lying in R8's bedside chair underneath a blanket. The RN explained the process would be to ensure the machine was turned on and functioning properly as per physician orders. The RN explained R8 needed the SCD machine to prevent blood clots as R8 could not get up out of bed and reposition independently. On 04/30/2026 at 11:38 AM, the Director of Nursing (DON) explained the SCD machine was used to help to prevent blood clots in residents, especially for residents unable to take anticoagulants. The expectations would be for staff to utilize the SCD machine according to physician orders and to document application of the SCD after ensuring the machine was connected, turned on, and functioning properly. On 04/30/2026 at 1:42 PM, the DON explained there was no facility policy specific to the use of SCD or implementing physician orders. The facility policy titled Charting and Documentation, revised 07/2017, documented documentation in the medical record would be complete and accurate. 2) Resident 2 (R2) was admitted on [DATE], with diagnoses including hyponatremia and acute kidney injury. A physician order dated 04/20/2026 documented a total daily fluid restriction of 1,000 milliliters (mL). The order specified dietary fluids were limited to 480 mL per day, consisting of 240 mL at breakfast, 120 mL at lunch, 120 mL at dinner, and an additional 240 mL of Nepro daily. Nursingˆprovided fluids were limited to 280 mL per day, with 140 mL allocated to the morning and 140 mL to the night shift. On 04/29/2026 at 9:20 AM, a water pitcher was observed on the resident's bedside table containing approximately 500 mL of water; the pitcher had a total capacity of 800 mL. An empty plastic cup with a capacity of approximately 7 ounces was also observed on the bedside table. On 04/30/2026 at 12:00 PM, a water pitcher and a cup of water were observed on the resident's bedside table. The cup contained approximately 200 mL of water, and the pitcher contained approximately 400 mL. A Registered Nurse (RN) confirmed the observation. The RN explained residents who were on fluid restrictions typically received approximately 120 mL of water with each medication pass. The RN acknowledged the pitcher should not have been placed in R2's room because it allowed the resident unrestricted access to fluids, making it difficult for staff to accurately monitor and control the resident's total daily fluid intake as ordered by the physician. On 04/30/2026 at 12:15 PM, R2 was observed eating in the dining area of the east hall. The dietary ticket on the meal tray indicated a fluid restriction of 4 ounces (oz). The meal provided to R2 included a cup of soup (4 oz, equivalent to 120 mL), a glass of cranberry juice (8 oz, equivalent to 240 mL), and ice cream (4 oz, equivalent to 120 mL). The total amount of fluids served was approximately 16 oz, which was three times the amount prescribed for the resident's fluid restriction. This observation was confirmed by a Certified Nursing Assistant (CNA), who stated R2 was on a fluid restriction. The CNA acknowledged the fluids served were not consistent with the information documented on the dietary ticket. On 04/30/2026 at 1:42 PM, the Director of Nursing (DON) acknowledged the physicianˆordered fluid (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	restriction should have been followed. The DON stated that R2 had been showing improvement in their clinical condition, as reflected in recent laboratory results, but regardless of the improvement, staff were expected to comply with all physician orders, including fluid restrictions. The facility policy titled Encouraging and Restricting Fluids, last revised in October 2010, indicated specific physician instructions regarding fluid restrictions were to be followed. The policy stated when a resident was placed on a fluid restriction, water pitchers and cups were to be removed from the resident's room.

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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** Based record review, document review, and interview, the facility failed to communicate an episode of shortness of breath requiring intervention to the hemodialysis clinic prior to treatment for 1 of 32 sampled residents (Resident 28). The deficient practice had the potential for the hemodialysis provider to initiate treatment without knowledge of the resident's recent symptoms, which could have impacted treatment decisions and placed the resident at risk for complications.Findings include:Resident 28 (R28) was admitted [DATE], readmitted [DATE], with diagnosis including unspecified encephalopathy, anemia, end stage renal disease, and dependence on renal hemodialysis. On 04/28/2026 at 11:46 AM, R28 reported they recently became sick at hemodialysis. R28 explained being sent to the hospital by the hemodialysis clinic and hospitalized .A Care Plan initiated 04/15/2026, documented R28 required hemodialysis. Goals included R28 would be free of signs or symptoms of complications related to hemodialysis.A Respiratory Note dated 04/20/2026 at 9:01 AM, documented R28 was checked due to a drop to 88% in the oxygen level in the blood. R28 was readjusted for better gas exchange and a nurse provided treatment. R28's oxygen level improved to 94%. R28's breath sounds were diminished in all lobes and heard bilaterally. R28 was provided oxygen at two liters via nasal cannula for hemodialysis. R28's white blood cells were elevated and a chest x-ray would be ordered.A Nurse's Note dated 04/20/2026 at 10:03 AM, documented R28 had complaints of congestion in the morning. R28 went to the hemodialysis appointment.A Nursing Hemodialysis Communication Observation/assessment dated [DATE], the form used to communicate resident information between the facility and the hemodialysis clinic on hemodialysis days was reviewed. The section to be completed by the licensed nurse prior to hemodialysis treatment contained resident and access information and vitals including an oxygen saturation of 92%. The section designated to report R28's general condition including recent changes was left blank. The form lacked documented evidence the hemodialysis clinic was notified R28 had an episode of shortness of breath prior to departure from the facility for hemodialysis. A Nurse's Note dated 04/20/2026 at 1:36 PM, documented the hemodialysis clinic reported R28 was sent to a hospital emergency room for evaluation due to congestion and confusion.A Nurse Practitioner Note dated 04/20/2026 at 11:57 PM, documented patient was sent to acute hospital from the hemodialysis clinic due to altered mental status and shortness of breath. On 04/29/2026 at 12:49 PM, a Registered Nurse (RN), explained a communication form had to be completed prior to the resident leaving for hemodialysis. The form included most recent medication administered, last meal, most recent vitals, pain level and a section to report any findings or changes for the resident. The RN confirmed an incident of shortness of breath, even if it was resolved, needed to be reported to the hemodialysis clinic on the communication form to ensure they were aware of the event, and the resident was monitored during hemodialysis. On 04/30/2026 at 9:00 AM, the Assistant Director of Nursing (ADON) acknowledged R28's hemodialysis communication form did not include information regarding the congestion and shortness of breath R28 experienced prior to hemodialysis. The ADON explained the information should have been included in the form to alert the hemodialysis clinic of a new condition and to help prevent complications during the hemodialysis treatment. On 04/30/2026 at 2:00 PM, the Director of Nursing (DON), confirmed communication regarding R28's condition of shortness of breath was not provided to the hemodialysis clinic. The DON stated changes in the resident including shortness of breath should have been reported to the hemodialysis clinic to ensure increased monitoring and timely intervention, and to prevent complications during hemodialysis.A Nursing Home Out Patient Dialysis Agreement dated 08/21/2017, documented effective coordination of medical care for residents who would be receiving care from both parties would be provided. A facility policy titled End-Stage Renal Disease, Care of a Resident with, revised September 2010, documented agreements between the facility and the contracted End Stage Renal Disease facility included all aspects of how (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's care would be managed including how information would be exchanged between the facilities.

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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** Based on observation, record review, interview, and document review, the facility failed to obtain physician orders for the insertion, use, and monitoring of a peripheral intravenous (IV) catheter, and failed to ensure IV site care and dressing requirements were followed for 1 of 32 sampled residents (Resident 23). The deficient practice had the potential to result in complications related to improper IV management, including infection, infiltration, or other adverse outcomes such as phlebitis.Findings include:Resident 23 (R23) was admitted on [DATE] with diagnoses including metabolic encephalopathy, metabolic acidosis, rhabdomyolysis, and a history of neuropathy.On 04/28/2026 at 9:00 AM, R23 was observed with an intravenous (IV) catheter inserted in the left forearm. The dressing on the IV site did not contain a label with information of the insertion date or the date of the last dressing change.A physician order dated 04/24/2026 documented dextroseˆsodium chloride 5-0.45% IV solution to be administered at 70 milliliters per hour IV for one liter once. The medication administration record (MAR) revealed the IV solution was administered as ordered on 04/24/2026.The medical record lacked documented evidence that physician orders were obtained for the IV catheter insertion or for required IV site care, including monitoring for bleeding, catheter dislodgement, infiltration, signs of infection, dressing changes, and discontinuation of the IV catheter.On 04/28/2026 at 2:21 PM, a Licensed Practical Nurse (LPN) who provided care to R23 confirmed the observation. The LPN was unable to provide a rationale for R23 having an IV catheter that was not in use and acknowledged to be unaware of its presence. The LPN reviewed the physician orders and confirmed although R23 had received IV fluids, there were no orders for the catheter's insertion, use, monitoring, or discontinuation.On 04/30/2026 in the afternoon, the Director of Nursing stated nursing staff should have obtained physician orders for the IV catheter insertion and required care and acknowledged that the catheter should have been discontinued when it was no longer in use.The facility policy titled Peripheral IV Catheter Insertion (undated) documented a provider's order was required prior to inserting a peripheral IV catheter. The policy further indicated a label containing the date and time of insertion, the initials of the nurse who performed the procedure, and the length and gauge of the catheter was to be placed on the catheter site. This information was also required to be documented in the resident's medical record.