

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  295102	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/23/2024
NAME OF PROVIDER OR SUPPLIER  Advanced Health Care of Henderson		STREET ADDRESS, CITY, STATE, ZIP CODE  1285 E Cactus Avenue Las Vegas, NV 89183	

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 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46265</p> <p>Based on record review, interviews, and document review, the facility failed to ensure a resident was protected from over sedation for one unsampled resident. The deficient practice led to resident being over sedated, requiring hospitalization .</p> <p>Findings include:</p> <p>Resident 25 (R25)</p> <p>R25 was admitted on [DATE] with diagnoses including chronic pain and body mass index 19.9 or less.</p> <p>A progress note dated 04/19/2024, documented R25 was sent to hospital after possible overdose, exhibiting signs and symptoms of altered mental status and did not respond after two (2) doses of naloxone (Narcan, drug to reverse effects of opioid medication) were given.</p> <p>A physician order dated 04/09/2024 documented to give Clonazepam 1 mg with special instruction of do not give in combination with opiate, may take at least two hours in between benzodiazepine and opiate administration, avoid over sedation.</p> <p>The medication administration record indicated the following medications were given in the morning on 04/19/2024:</p> <ul style="list-style-type: none"> <li>- Citalopram 40 mg at 6:00 AM (anti-depressant)</li> <li>- Morphine 15 mg at 6:03 AM (opioid pain medication)</li> <li>- Lidoderm patch 5% at 7:00 AM (topical analgesic patch for pain)</li> <li>- Clonazepam 1 mg at 7:30 AM (benzodiazepine for anxiety)</li> </ul> <p>On 07/18/2024 in the afternoon, a Registered Nurse (RN) indicated nurses would use clinical judgment to determine if a resident was over sedated based on the residents' normal level of orientation. The RN explained if a significant amount of sedating medications were given in a short period of time, it might be difficult to determine actual sedation level at time of dosing.</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 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 07/23/2024 in the afternoon, a Licensed Practical Nurse did not recall the specific situation, however verbalized being one of the nurses who gave the medication to R25 and explained a day shift and night shift nurse had given some of the medications in the morning. The LPN verbalized when a resident was receiving both opioid and benzodiazepine there was a standing order to separate the medications by at least two hours to prevent over sedation.</p> <p>On 07/18/2024 at 3:26 PM, the Clinical Nurse Manager indicated a resident on multiple sedation inducing drugs would generally have specific parameters of when the medication could be administered specifically if medications were benzodiazepines and opioid type medications. The Clinical Nurse Manager explained there should have been at least a two-hour window of time between the Clonazepam and Morphine to accurately determine if resident was over sedated.</p> <p>On 07/19/2024 at 10:27 AM, the Medical Director indicated being familiar with the resident and situation involving resident hospitalization . The Medical Director verbalized the number of medications administered in the morning of 04/19/2024, likely contributed to over sedating the resident and confirmed the order was not followed appropriately to ensure at least two hours between dosage of opiates and the benzodiazepine medications. The Medical Director reported the over sedation of R25 would not necessarily occur immediately based on several factors, and could present later in day when medication reached peak level in the body.</p> <p>The facility policy titled Pain Management documented patients would have appropriate pain control measures to optimize comfort and wellbeing. Pain levels would be controlled at acceptable levels to maximize recovery and facilitate participation in daily treatments and activities of daily living. Patient expressing or demonstrating pain would be provided with pain relief options including:</p> <ul style="list-style-type: none"> <li>- rest</li> <li>- positioning</li> <li>- relaxation techniques</li> <li>- diversion techniques</li> <li>- heat/cold application</li> <li>- routine and/or as needed medications</li> <li>- adjunctive medications</li> </ul>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30667</p> <p>Based on observation, interview and document review, the facility failed to ensure food stored inside the walk-in freezer were labeled with a date and time, a label was changed to reflect the appropriate date and time, a container of expired seasoning was discarded, a condiment squeeze bottle was labeled and a dietary aide did not touch and adjust their glasses several times during tray line for the lunch meal service. The deficient practices could have led to contamination of kitchen surfaces and food borne illness.</p> <p>Findings include:</p> <p>On [DATE] in the morning, a brief kitchen tour revealed the following:</p> <ul style="list-style-type: none"> <li>-A condiment squeeze bottle containing a yellow substance stored on the counter was not labeled. The cook identified the substance as liquid butter.</li> </ul> <p>Walk-in Freezer #1</p> <ul style="list-style-type: none"> <li>- Cottage Cheese 5 lb. container expired [DATE]</li> <li>- Raw fish stored in container with label used by date [DATE]</li> <li>- Gallon bag containing a corn meal type substance was not labeled.</li> </ul> <p>Walk-in Freezer #2</p> <ul style="list-style-type: none"> <li>-Pan wrapped with aluminum foil contained approximately ,d+[DATE] slices of cheesecake was not labeled.</li> </ul> <p>Seasoning Storage Shelf</p> <ul style="list-style-type: none"> <li>- Pappy's seasoning used by date Nov. 2023</li> </ul> <p>On [DATE] at 8:11 AM, a cook indicated the process for organizing the seasonings was to clean the shelf and relabel the items every week.</p> <p>On [DATE] in the afternoon during the tray line for the lunch meal service, a dietary aide adjusted their glasses several times.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] in the afternoon, the Nutritional Services Director explained the process of the labeling of the seasoning. The Nutritional Services Director was made aware of the Pappy's seasoning was expired. The Nutritional Services Director removed the container from the shelf and showed it to the cook. The Nutritional Services Director indicated the seasoning should have been thrown away. The Nutritional Services Director disclosed had observed the dietary aide adjusting their glasses and wiping their forehead during tray line. The Nutritional Services Director indicated the staff would be in serviced.</p> <p>The facility policy entitled food storage dated 2021, documented all foods should be covered, labeled, and dated. All foods will be checked to assure foods will be consumed by their safe use by dates or discarded.</p> <p>The facility policy entitled Hand Washing dated 2021, documented to wash hands after engaging in other activities that contaminate hands.</p>		