STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295105	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Nevada State Veterans Home	36 Battleborn Way Sparks, NV 89431

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848 Based on observation, interview, clinical record review, and document review, the facility failed to ensure a resident's right to choose to not be approached by individuals providing pet therapy when the resident had a documented allergy to animal hair and a care plan addressing the resident's desire to not be asked about receiving pet therapy was respected for 1 of 19 sampled residents (Resident #16). This deficient practice had the potential to result in the resident feeling disrespected due to the resident's requests not being honored in the facility. Findings include: Resident #16 Resident #16 was admitted to the facility on [DATE], with diagnoses including bipolar disorder, unspecified, major depressive disorder, recurrent, unspecified, and post-traumatic stress disorder, chronic. On 03/10/2025 at 1:27 PM, Resident #16 was sitting on the side of the resident's bed when a handler and a therapy dog stood at the doorway to the resident's room and asked Resident #16 if the resident would like a visit from the dog. Resident #16 responded by clenching the resident's fists and raising the resident's voice when answering the handler. The resident verbalized the resident had told the dog handler many times the resident was allergic. The handler informed the resident the handler was unaware the resident did not want to see the dog because there were several different handlers and dogs involved in the program and different people visited the facility. The resident responded by asking the handler how many times the resident would have to inform people he did not want to see the dogs. The resident verbalized the resident felt disrespected because the resident was unable to be around the dogs due to an allergy and had made the resident's wishes known but was still approached for pet therapy. The documented allergies in the electronic health record for Resident #16 included an allergy to animal hair/dander with an active date of 01/06/2025. The allergy severity was documented to be moderate. A care plan for Resident #16, revised on 12/21/2024, documented the resident preferred not to have dog therapy. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/11/2025 at 2:50 PM, the Licensed Practical Nurse (LPN) for Resident #16 verbalized the LPN was not aware of any residents the pet therapy handlers would need to avoid approaching. On 03/11/2025 at 2:51 PM, the Certified Nursing Assistant for Resident #16 verbalized the staff were not made aware of when the pet therapy handlers and dogs would be on the unit. On 03/12/2025 at 10:40 AM, the Volunteer Services Director/Interim Activities Director (AD) verbalized the pet therapy organization should have been informed of which residents did not wish to receive pet therapy and should have been escorted by a staff member who could have informed the handler to avoid Resident #16's room. On 03/13/2025 at 3:09 PM, the Director of Nursing (DON) verbalized a resident with a care plan indicating the resident was not to receive pet therapy should not have been approached for pet therapy. The DON confirmed the facility staff should have communicated with the animal's handler to ensure the resident was not approached. The facility document titled Visiting Pet Policies, undated, documented residents would not be forced to have contact with animals or pets. Contact would be based on the resident's verbal permission or preference. The facility policy titled Resident Rights, revised 01/2023, documented residents had the right to dignity, self-determined, and person-centered care.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50210 Based on observation, interview, clinical record review, and document review, the facility failed to ensure nurses performed the job duties as outlined in the State Board of Nursing Nurse Practice Act with safe medication administration when 1) qualified Licensed Practical Nurses (LPN) and Registered Nurses failed to verify the appropriateness of a medication order for 1 of 19 sampled residents (Resident #69) and 2) eye drops were administered with incorrect technique for 1 of 4 residents observed during medication administration (Resident #72). The deficient practice resulted in a physician order being inaccurately transcribed onto a resident's electronic health record (EMR) and medication administration record (MAR), as well as the misadministration of ordered medication. Findings include: Resident #69 Resident #69 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of heart failure, unspecified. Resident #69's January, February, and March 2025 MARs documented Spironolactone oral tablet. Give 12.5 milligrams (mg) by mouth one time a day. Hold if heart rate was less than 60 beats per minute, related to heart failure, unspecified. The list of chart codes documented a check mark indicated the medication was administered, and 11 indicated vitals were outside of parameters. Spironolactone had check marks on the following dates when the resident's heart rate was below 60 beats per minute: -On 01/08/2025 pulse was 58 -On 01/29/2025 pulse was 55 -On 02/17/2025 pulse was 58 -On 02/19/2025 pulse was 58 -On 02/23/2025 pulse was 58 -On 02/24/2025 pulse was 58 -On 02/25/2025 pulse was 58 -On 03/04/2025 pulse was 58 -On 03/05/2025 pulse was 59 -On 03/07/2025 pulse was 59 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Spironolactone had 11s on the following dates when the resident's heart rate was below 60 beats per minute: -On 01/07/2025 pulse was 58 -On 02/09/2025 pulse was 58 An order audit report, dated 03/12/2025, included a physician order dated 05/25/2024, documenting Spironolactone oral tablet. Give 12.5 mg by mouth one time a day related to heart failure, unspecified. On 03/13/2025 at 8:54 AM, a Registered Nurse (RN) verbalized Resident #69's EMR order for Spironolactone documented to hold when the resident's heart rate was less than 60 beats per minute. The nurse confirmed if the resident's heart rate was under 60 beats per minute, the nurse would hold the medication. On 03/13/2025 at 12:04 PM, the Director of Nursing (DON) verbalized the DON expected nurses to adhere to professional standards of medication administration by verifying the right person, time, route, dosage, medication, and documentation of medication administration. The DON confirmed Resident #69's EMR physician orders documented to hold Spironolactone if heart rate was less than 60 beats per minute. The DON verbalized a check mark on the MAR would indicate the nurse verified and followed the order while a 5 or 11 on the MAR would indicate the medication was held. The DON confirmed Resident #69's 2025 MARs documented check marks for the Spironolactone on the dates above. The DON verbalized Resident #69's EMR lacked documentation the physician was asked for clarification regarding the Spironolactone order. On 03/13/2025 at 12:44 PM, the DON explained after the DON was made aware of concerns regarding Resident #69's Spironolactone order, the DON sought clarification from the Physician. The DON was informed the original Spironolactone order lacked parameters, and pulse rate did not need to be monitored for Spironolactone. The DON explained the nurses were responsible for reviewing medication orders daily. The DON explained when the facility went through a change of ownership, physician orders were transcribed from the previous EMR to the current EMR and some orders were transcribed inaccurately, including Resident #69's Spironolactone. The Nurse Practice Act Nevada Administrative Code (NAC) 632.236 Understanding and verifying orders, documented before an LPN carried out a physician order, the Licensed Practical Nurse must understand the reason for the order, verify the order was appropriate, and verify there were no documented contraindications in carrying out the order. An RN would perform or supervise the verification of an order given to ensure the order was appropriate, properly authorized and lacked documented contraindications in carrying out the order. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled, Medication Administration, dated 11/2024, documented all medication would be administered per physician orders. Medication orders initiated by the pharmacy were verified by the DON, executive director, or designee. Staff members responsible for administering medications reviewed the physician's order prior to administering medications. Cross reference with F842. 49557 Resident #72 Resident #72 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A Physician's Order dated 12/25/2024, document Artificial Tears ophthalmic solution one percent (Carboxymethylcellulose Sodium), instill one drop in both eyes three times a day for dry eye. On 03/12/2025 at 9:04 AM, an LPN administered Artificial Tears to Resident #72. During administration, the LPN failed to draw the resident's lower eyelid down prior to administration of the medication. A portion of the eye drops fell below the resident's eye, onto the resident's skin. The LPN handed Resident #72 a tissue, and the resident wiped the medication from below the resident's eyes. On 03/13/2025 at 8:12 AM, the DON explained it was the DON's expectation of nursing staff to adhere to nursing standards of practice as well as state and federal guidelines when administering medications to residents. The correct process for administering eye drops to residents was to perform hand hygiene, open the medication, ensure the eye was free from any discharge, hold the eye open (the DON demonstrated pulling the lower eye lid down), and administer the eye drop. The DON explained if an eye drop was not administered with correct technique an infection could occur, or the medication could be less effective when the eye/eyelid was not held open as the resident could receive less than the ordered amount of the medication. The facility policy titled Eye - Instillation of Medications, dated 04/01/2008, documented all eye medications would be administered appropriately and with a physician's order. The procedure included having the resident tilt the resident's head backward, drawing the lower eyelid down, having the resident look up, and dropping one drop of medication every three to five minutes in the pouch of the lower lid.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40377 Based on personnel record review, document review, and interview, the facility failed to ensure direct care staff maintained current Cardio-Pulmonary Resuscitation (CPR) certification for 2 of 11 sampled direct care employees (Employee #11 and #12). This deficient practice could result in a negative outcome for a resident requiring CPR while awaiting the arrival of emergency medical personnel. Findings include: Employee #11 Employee #11 was hired by the facility as a Registered Nurse (RN) with a start date of [DATE]. The RN's personnel record lacked documented evidence of CPR training and certification. Employee #12 Employee #12 was hired by the facility as an RN/Infection Preventionist with a start date of [DATE]. The RN's personnel record documented CPR training and certification expired on ,d+[DATE]. The RNs' Job Description documented the minimum job requirements included CPR certified. On [DATE] at 1:17 PM, the Human Resources Director verbalized CPR certification was required of all direct care staff and confirmed Employees #11 and #12 did not have a current CPR certification and their respective Job Description documented the requirement. The Facility Assessment, last revised ,d+[DATE], documented licensed nurses and certified nursing assistants would maintain cardiopulmonary resuscitation certification.

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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** 41848 Based on observation, interview, clinical record review, and document review, the facility failed to ensure a resident received individualized activities to meet the resident's interests and need to have assistance with the use of electronic devices for 1 of 19 sampled residents (Resident #74). This deficient practice had the potential to result in a resident feeling isolated and frustrated from lack of social interaction and opportunities to pursue personalized interests. Findings include: Resident #74 Resident #74 was admitted to the facility on [DATE], with diagnoses including post-traumatic stress disorder, chronic and major depressive disorder, recurrent, moderate On 03/10/2025 at 11:31 AM, Resident #74 verbalized the resident did not enjoy participating in group activities but the resident felt very depressed and would have liked for someone to visit the resident in the resident's room when the resident wanted someone to talk to. The resident verbalized the resident wanted help with learning how to use a smart phone and a tablet a family member had sent to the resident. The resident verbalized the resident needed someone to show the resident how to answer the phone and the resident wanted assistance with learning how to access a video streaming application on the tablet. An Activities/Life Enrichment care plan for Resident #74, dated 09/26/2024, documented the resident did not like groups and would rather stay in the resident's room. The goals included for the resident to engage in activities of interest and offer alternate activities the resident could do alone. The activities task in the electronic health record included one date with documentation of a self-directed engagement for Resident #74 in the 14 day look back period. The task documented the resident participated in the self-directed activity of movies and or television on 02/28/2025. On 03/12/2025 at 10:38 AM, the Director of Volunteer Services/Interim Activities Director (AD) verbalized the activities staff would document individualized interactions with the resident under the activities task in the electronic health record. The AD verbalized the activity staff should have been checking in with the resident daily to ensure the resident had what the resident needed to meet the resident's interests and keep the resident occupied and happy while providing the resident with some socialization if the resident wanted to talk. The AD confirmed the activity program would have been able to assist the resident with learning how to use a smartphone or access an application on the resident's tablet. The AD confirmed the last documented activity for Resident #74 was the self-directed activity of movies or television on 02/28/2025. The facility policy titled Activities, revised 10/2022, documented the facility would provide an ongoing program of activities designed to meet the preferences of each resident, including individual activities.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 46301 Based on observation and interview, the facility failed to ensure current nursing hours were posted for 6 of 6 units in the facility. This deficient practice had the potential to result in a lack of awareness for residents and visitors regarding the number of nursing and direct care staff on duty. Findings include: On 03/10/2025 at 7:23 AM, the nursing staff postings in the facility were dated 03/07/2025. On 03/10/2025 at 8:42 AM, the Staffing Coordinator verbalized the Staffing Coordinator was responsible to post the direct care staff posting daily Monday through Friday. On 03/10/2025 at 8:45 AM, a Registered Nurse (RN) verbalized being responsible to post the direct care staff posting on Saturdays and Sundays. The RN confirmed having not posted the direct care staff for 03/08/2025 or 03/09/2025. The Staffing Coordinator and the RN confirmed the nursing staff posting had not been updated since 03/07/2025.

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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. 46301 Based on observation, interview, and document review, the facility failed to ensure a medication cart containing resident medications was secure and expired medications were removed from the active supply in 1 of 3 medication storage rooms and 1 of 3 medication carts reviewed for medication storage. The deficient practice could have facilitated unauthorized access to medications in the carts and had the potential for expired medications to be administered to residents. Findings include: On 03/11/2025 at 8:42 AM, a medication cart was left unlocked in the Tahoe/Truckee unit the with five residents sitting in the same area as the cart. On 03/11/2025 at 8:44 AM, a Registered Nurse (RN) returned to the unsecured medication cart and confirmed the cart was left unlocked. The RN confirmed there were five residents near the unsecured medication cart and could have accessed resident medications. The facility policy titled Medication Labeling and Storage, revised 11/2024, documented the community must store all drugs and biologicals in locked compartments. All medications would be stored appropriately, either in the locked medication cart or medication room. 49557 On 03/13/2025 at 9:16 AM, in the presence of an RN, a medication cart on the Pinion/Aspen unit was inspected. The following items were found in the cart, stored with active medications: -A bottle of Docusate Sodium stool softener, 100 milligram (mg) capsules. The expiration date printed on the bottle was 12/2024. -A bubble pack containing seven tablets of Ondansetron four mg tablets. The expiration date printed on the pharmacy label was 12/03/2024. The RN confirmed the Docusate Sodium capsules and the Ondansetron tablets had expired. The RN verbalized the expired medications should have been removed from the medication cart and destroyed using Drug Buster (a drug disposal system) on or before the expiration date. On 03/13/2025 at 9:31 AM, in the presence of the RN, the medication storage room on the Pinion/Aspen unit was inspected. An intravenous (IV) solution bag containing 1000 milliliters of five percent Dextrose was found in a cabinet. The expiration date printed on the IV solution bag was November 2024. A vial of Tuberculin Purified Protein Derivative with an open date of 01/28/2025 written on the vial and the box was found in the refrigerator. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RN confirmed the IV solution bag had expired. The RN confirmed the open date written on the vial and the box of Tuberculin Purified Protein Derivative was 01/28/2025, and explained the vial should have been discarded within 30 days of the open date. The Tuberculin Purified Protein Derivative (Tubersol) package insert, with product information as of October 2021, documented a vial of Tubersol which had been entered and in use for 30 days should be discarded. On 03/12/2025 at 1:46 PM, the Director of Nursing (DON) verbalized expired medications were to be removed from the medication cart and the medication storage room immediately to prevent the expired medication from being administered to a resident. If expired medications were administered to a resident, the medications could make the resident sick or could be less effective. The facility policy titled Medications - Discontinued for deceased or discharged Residents, revised 03/01/2024, documented all medications which were no longer being administered to residents would be removed and appropriately discarded. All medications which had passed the expiration date on the label were to be properly disposed of and re-ordered if necessary.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 41848 Based on observation, interview, and document review, the facility failed to ensure culinary staff checked the holding temperatures for all hot foods to ensure the foods were at a safe temperature prior to beginning meal service from a satellite kitchen to residents in the [NAME]/Quail dining room during a lunch service with the potential to affect 15 of 15 residents residing on the unit and to ensure vegetables prepared for residents requiring a minced and moist diet in the Aspen/Pinion dining room were at a safe temperature prior to beginning lunch service with the potential to affect 1 of 15 residents residing on the unit. This deficient practice had the potential to result in food not held at appropriate temperatures resulting in the growth of pathogens that cause foodborne illness being served to residents. Findings include: [NAME]/Quail On 03/12/2025 at 11:57 AM, a Culinary Staff member entered the satellite serving kitchen to serve lunch to the 15 residents located in the [NAME]/Quail neighborhood of the facility. The items brought in to be placed on the holding table included the following: - fried fish. - garlic mashed potatoes. - gravy. - steamed vegetables. - mechanical soft fried fish. - mechanical soft steamed vegetables. - corn. On 03/12/2025 at 11:59 AM, the Culinary Staff member checked the holding temperature of the following hot foods: - fried fish was 155 degrees Fahrenheit (F). - gravy was 154 F. - steamed vegetables were 154 F (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/12/2025 at 12:07 PM, the Culinary Staff member began plating food including the mashed potatoes, mechanical soft vegetables, and mechanical soft fish for residents in the [NAME]/Quail neighborhood. On 03/12/2025 at 12:09 PM, the Culinary Staff member confirmed the Culinary Staff member had not checked the temperature for all hot food items on the holding table prior to beginning to plate food for the residents. On 03/12/2025 at 12:10 PM, the Dietary Manager (DM) entered the satellite kitchen and assisted the Culinary Staff member to complete the temperature checks of the hot food. The DM found the mechanical soft fish was 128 F. The DM pulled the mechanical soft fish to reheat the fish to a safe temperature. On 03/12/2025 at 12:15 PM, the DM verbalized all hot foods should have been checked for an appropriate holding temperature of at least 135 F before the Culinary Staff started plating the food. The DM confirmed the Culinary Staff had not recorded the temperature for all hot foods prior to serving the food. 49557 Aspen/Pinion On 03/12/2025 at 11:51 AM, a Culinary Staff member began checking and recording temperatures of the food prepared for lunch on the Aspen/Pinion unit. Vegetables prepared for residents requiring a minced and moist texture diet had a temperature reading of 132 F. The Culinary Staff member verbalized the temperature for the mechanical soft vegetables was out of range. When a temperature was out of range the Culinary Staff member would place the food on the hot holding table and recheck the temperature prior to serving the food to residents to ensure the temperature was within a safe range for consumption. On 03/12/2025 at 12:03 PM, the Culinary Staff member placed the prepared food items on the hot holding table in the Aspen/Pinion unit. On 03/12/2025 at 12:10 PM, the Culinary Staff member began preparing plates for residents. Once prepared, the Culinary Staff member passed the plates to the staff on the opposite side of the counter and the staff would deliver the plates to residents in the dining room. On 03/12/2025 at 12:13 PM, the Culinary Staff member placed a serving of the mechanical soft vegetables on a plate and handed the plate to a staff member in the dining room. The staff member took the plate and turned toward the dining room. On 03/12/2025 at 12:14 PM, the Culinary Staff member confirmed the Culinary Staff member had not rechecked the temperature of the vegetables prior to placing the vegetables on the plate and handing the plate to the staff member in the dining room. On 03/12/2025 at 12:15 PM, the Culinary Staff member rechecked the temperature of the mechanical soft vegetables and the reading on the thermometer was 125 F. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/12/2025 at 12:27 PM, the DM arrived in the satellite kitchen on the Aspen/Pinion unit. The Culinary Staff member explained the temperature of the mechanical soft vegetables was too low. The DM explained when the temperature of food was too low, the food should have been taken off the line and reheated in the microwave until the food was 165 F for at least 15 seconds prior to serving to residents. The facility policy titled Food Temperature, dated 2021, documented the temperature of all food items would be taken and properly recorded prior to service of each meal. All hot food items would be cooked to appropriate internal temperatures, held, and served at a temperature of at least 135 F.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on clinical record review, interview, and document review, the facility failed to ensure an electronic medical record (EMR) accurately reflected a resident's code status for 1 of 19 sampled residents (Resident #52) and physician orders were transcribed accurately into the resident's Medication Administration Record (MAR) and EMR to prevent medication errors for 1 of 19 sampled residents (Resident #69). This deficient practice had the potential for a resident's preference related to cardiopulmonary resuscitation (CPR) to not be followed and to result in a significant medication error and compromised resident safety. Findings include: Resident #52 Resident #52 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of unspecified dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. On [DATE] at 9:13 AM, Resident #52's EMR documented the resident was to receive full treatment CPR. A Physician's Order dated [DATE], documented physician order for life-sustaining treatment (POLST): full treatment CPR. A Nevada POLST dated [DATE], documented do not resuscitate (DNR) and the resident was to receive selective treatment. The POLST was signed by the resident and the physician. On [DATE] at 4:00 PM, a Registered Nurse (RN) explained the RN knew a resident's code status and how to respond in the event of a medical emergency by looking in the resident's EMR. The code status was at the top of the screen when the RN opened a resident's record. The facility social worker and the physician would communicate updates in a resident's code status to the resident's nurse and paper copies of the resident's POLST were kept in a binder at the nurses' station. The RN reviewed Resident #52's EMR and verbalized the resident was a full code (all life-saving measures to be taken). On [DATE] at 4:04 PM, the RN reviewed Resident #52's POLST and verbalized the POLST indicated the resident was a DNR and only selective treatment was to be implemented. The RN confirmed the resident's EMR and POLST did not match. On [DATE] at 8:23 AM, the Director of Nursing (DON) explained a resident's code status was reflected in the EMR at the top of the page when the record was opened and POLSTs were kept in a binder at the nurses' station. Updates in residents' code status were communicated to staff immediately by the POLST being uploaded to the EMR and the physician's order being changed. If a resident's POLST and the code status in the EMR did not match, staff would verify the correct code status with the resident or guardian and assure the update was reflected in the EMR. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON reviewed Resident #52's clinical record and verbalized the EMR and POLST indicated Resident #52 was to only receive selective treatment and was a DNR. The DON verbalized DNR was added to the EMR on [DATE], and a full code order was active from [DATE] through [DATE]. The DON confirmed the physician order related to code status in the resident's EMR was changed several days late. It was important to update the EMR immediately when any changes were made so staff were honoring the resident's wishes. The facility policy titled Cardiopulmonary Resuscitation (CPR), reviewed ,d+[DATE], documented each resident's CPR preference would be expressed in an advance directive document. Each resident's choice regarding CPR or DNR code status would be readily available for quick identification. Staff were to provide CPR in accordance with the resident's advance directive and any related physician order such as code status. The facility policy titled Advanced Directives and Rights Regarding Treatment, reviewed ,d+[DATE], documented residents had the right to refuse treatment. The community would document in the EMR any advance directive the resident executed. Resident choices would be documented and communicated to the interdisciplinary team. 50210 Resident #69 Resident #69 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of heart failure, unspecified. Resident #69's January, February, and [DATE] MARs documented Spironolactone oral tablet. Give 12.5 milligrams (mg) by mouth one time a day. Hold if heart rate was less than 60 beats per minute, related to heart failure, unspecified. On [DATE] at 12:04 PM, Resident #69's EMR documented a physician order dated [DATE], for Spironolactone oral tablet. Give 12.5 mg by mouth one time a day. Hold if heart rate less than 60 beats per minute, related to heart failure, unspecified. An order audit report, dated [DATE], included a physician order dated [DATE], documenting Spironolactone oral tablet. Give 12.5 mg by mouth one time a day related to heart failure, unspecified. On [DATE] at 8:54 AM, an RN verbalized Resident #69 EMR order for Spironolactone documented to hold when the resident's heart rate was less than 60 beats per minute. The nurse confirmed if the resident's heart rate was under 60 beats per minute, the nurse would hold the medication. On [DATE] at 12:04 PM, the DON verbalized the DON expected nurses to adhere to professional standards of medication administration by verifying the right person, time, route, dosage medication, and documentation of medication administration. The DON confirmed Resident #69's MARs and EMR documented to hold Spironolactone if heart rate was less than 60 beats per minute. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:44 PM, the DON explained after the DON was made aware of concerns regarding Resident #69's Spironolactone order, the DON sought clarification from the Physician. The DON was informed the original Spironolactone order lacked parameters, and pulse rate did not need to be monitored for Spironolactone. The DON explained the nurses were responsible for reviewing medication orders daily. The DON explained when the facility went through a change of ownership, physician orders were transcribed from the previous EMR to the current EMR and some orders were transcribed inaccurately, including Resident #69's Spironolactone. Cross reference with F658.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848 Based on interview, clinical record review, and document review, the facility failed to ensure residents were offered timely pneumonia vaccines to complete the recommended pneumonia vaccine schedule for 2 of 5 residents reviewed for immunizations (Residents #21 and #22). This deficient practice had the potential to result in a resident contracting a preventable illness. Findings include: Resident #21 Resident #21 was admitted to the facility on [DATE], with diagnoses including acute respiratory failure, unspecified whether with hypoxia or hypercapnia, pneumonitis due to inhalation of food and vomit, and heart failure, unspecified. The clinical record for Resident #21 did not include documentation of the resident receiving or being offered a pneumonia vaccine. On 03/13/2025 at 8:53 AM, the Infection Preventionist (IP) confirmed the clinical record for Resident #21 lacked documentation of a pneumonia vaccine being offered or administered to the resident. The IP verbalized the consent for vaccinations was not completed and staff should have followed up with the resident or representative to provide education and offer the vaccine to the resident. Resident #22 Resident #22 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including atherosclerotic heart disease of native coronary artery without angina pectoris, ischemic cardiomyopathy, and old myocardial infarction. The clinical record for Resident #22 documented the resident had received the 23-valent pneumococcal polysaccharide (PPV23) vaccine on 12/19/2023. The clinical record did not include documentation of the resident receiving education on or being offered any of the next pneumococcal conjugate vaccines (PCV) in the series at least one year after the resident had received the PPV23 vaccine. The Centers for Disease Control and Prevention (CDC) document titled, Pneumococcal Vaccine Timing for Adults, dated 10/2024, documented for adults [AGE] years or older who had received a PPV23 vaccine at any age, the complete pneumococcal vaccine schedule included two options. Option A was to offer the PCV20 or PCV21 vaccine after one year and Option B was to offer a PCV15 vaccine after one year. On 03/13/2025 at 8:55 AM, the IP confirmed the resident had not been offered any of the additional PCV vaccines to complete the pneumococcal vaccine schedule. The IP verbalized the resident should have been offered one of the PCV vaccines after 12/19/2024, to complete the pneumococcal vaccine series. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Infection Prevention and Control: Influenza and Pneumococcal Immunizations, revised 06/08/2022, documented the facility would provide pneumococcal immunizations to minimize the risk of residents acquiring, transmitting, or experiencing complications from pneumococcal disease. Residents and/or resident representatives would receive information related to the risks and benefits of immunizations. Residents who had previously received only PPSV23 would be offered a PCV (either PCV15 or PCV20) one year after the most recent PPSV23. CDC recommendations would be followed for the administration of vaccines.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848 Based on interview, clinical record review, and document review, the facility failed to ensure a resident was provided education on the risks and benefits of COVID-19 vaccination and a resident was offered the COVID-19 vaccine for 2 of 5 residents reviewed for immunizations (Resident #21 and #22). This deficient practice had the potential to result in residents and their representatives not being given the opportunity to make informed decisions before accepting or declining vaccination and a resident not given the opportunity to accept the vaccine and potentially prevent severe illness and hospitalization from infection with COVID-19. Findings include: Resident #21 Resident #21 was admitted to the facility on [DATE], with diagnoses including acute respiratory failure, unspecified whether with hypoxia or hypercapnia, pneumonitis due to inhalation of food and vomit, and heart failure, unspecified. The clinical record for Resident #21 did not include documentation of the resident receiving or being offered a COVID-19 vaccine. On 03/13/2025 at 8:53 AM, the Infection Preventionist (IP) confirmed the clinical record for Resident #21 lacked documentation of a COVID-19 vaccine being offered or administered to the resident. The IP verbalized the consent for vaccinations was not completed and staff should have followed up with the resident or representative to provide education and offer the vaccine to the resident. Resident #22 Resident #22 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including atherosclerotic heart disease of native coronary artery without angina pectoris, ischemic cardiomyopathy, and old myocardial infarction. The clinical record for Resident #22 documented the resident had refused a COVID-19 vaccination on 10/18/2024 and no education was provided to the resident or representative. On 03/13/2025 at 8:55 AM, the IP confirmed the clinical record for Resident #22 documented the resident had not received education on the COVID-19 vaccine when the resident refused the vaccination on 10/18/2024. The IP verbalized the resident, or representative should have been given education on the risks and benefits of vaccination when the vaccine was offered. The facility policy titled Infection Prevention and Control Vaccination Requirement for SARS-CoV-2 (COVID-19), revised 06/29/2022, documented the facility would maintain compliance with Federal mandates.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 40377 Based on personnel record review, interview and document review, the facility failed to ensure initial elder abuse prevention training was completed timely for 10 of 20 sampled employees (Employees #1, #5, #11, #12, #14, #15, #16, #18, #19, and #20). This deficient practice had the potential to place all residents at risk for abuse and neglect. Findings include: Employee #1 Employee #1 was hired by the facility as the Executive Director with a start date of 09/03/2024. Employee #1's personnel file lacked documented evidence of elder abuse prevention training. Employee #5 Employee #5 was hired by the facility as the Social Services Director with a start date of 01/07/2025. Employee #5's personnel file documented elder abuse prevention training on 03/11/2025, 4 weeks late. Employee #11 Employee #11 was hired by the facility as an Agency Registered Nurse (RN) with a start date on 08/01/2024 and as a facility Registered Nurse with a start date on 01/28/2025. Employee #11's personnel file documented elder abuse training on 02/23/2025, six months late. Employee #12 Employee #12 was hired by the facility as an RN/Infection Preventionist with a start date of 08/01/2024. Employee #12's personnel file lacked documented elder abuse prevention training. Employee #13 Employee #13 was hired by the facility as an RN with a start date of 08/01/2024. Employee #13's personnel file documented elder abuse prevention training on 01/10/2025, five months late. Employee #14 (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employee #14 was hired by the facility as a License Practical Nurse (LPN) with a start date of 08/27/2024. Employee #14's personnel file documented elder abuse prevention training on 12/27/2025, four months late. Employee #15 Employee #15 was hired by the facility as an LPN with a start date of 09/03/2024. Employee #15's personal file documented elder abuse prevention training on 12/17/2024, three months late. Employee #16 Employee #16 was hired by the facility as a Certified Nursing Assistant (CNA) with a start date of 08/01/2024. Employee #16's personnel file documented elder abuse prevention training on 12/23/2024, four months late. Employee #18 Employee #18 was hired by the facility as Culinary Staff with a start date of 01/28/2025. Employee #18's personnel file documented elder abuse prevention training on 03/11/2025, two weeks late. Employee #19 Employee #19 was hired by the facility as Culinary Staff with a start date on 10/28/2024. Employee #19's personnel file lacked documented evidence of elder abuse prevention training. Employee #20 Employee #20 was hired by the facility as a Housekeeper with a start date on 10/08/2024. Employee #20's personnel file lacked documented evidence of elder abuse prevention training. On 03/12/2025 at 2:00 PM, the Human Resources Director (HRD) verbalized elder abuse prevention training was to be completed by all staff within the first orientation, and prior to working with residents. The HRD confirmed Employee #1, #5, #11, #12, #14, #15, #16, #18, #19, and #20 lacked timely completion of elder abuse training and had been working with residents prior to completion. (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy titled, Abuse, Neglect and Exploitation, revised January 2023, documented employees are trained through orientation and on-going sessions on issues related to abuse prohibition practices. All employees will receive training no less frequently than annually on the requirements of the facility's policies and procedures regarding alleged violations and the requirements of federal and state laws.