STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295107	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health Care of Paradise	3455 Pecos-McLeod Interconnect Las Vegas, NV 89121

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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 0565 Level of Harm - Potential for minimal harm Residents Affected - Many	Honor the resident's right to organize and participate in resident/family groups in the facility. 30667 Based on interview the facility failed to ensure: -A written record of resident council meetings was kept documenting any responses to concerns raised by the Resident Council group, and a report of actions taken and the rationale to the Resident Council. -A written record of grievances was kept documenting any responses and the rationale for responses to grievances regarding resident issues or grievances concerning care and life in the facility. The deficient practice had the potential to adversely affect outcome of issues concerning resident care and life in the facility. Findings include: On 05/21/24 at 10:14 AM, the Administrator explained due to being a short-term facility, the facility does not have a resident council president. However, the facility offered the opportunity for residents to meet on the second Tuesday of the month as a council for residents who would like to participate. The Administrator indicated during the last meeting there were approximately three to four residents who participated. On 05/22/24 at 3:58 PM, when inquired about the resident council minutes, the Administrator indicated the Activities Personnel indicated the Ombudsman took notes during the resident council meeting. The Administrator indicated the Activities Personnel did not take notes during the resident council meetings. The Administrator expressed the Activities Personnel was told the facility was responsible for taking their own notes. The Administrator indicated were responsible for handing the resident grievances in the facility. The Administrator indicated resident grievances were handled at the time grievances were brought up. The Administrator explained the facility used to keep a binder with grievances and a grievance log. The Administrator admitted the facility was not good at keeping up with the logs and may have copies of resident grievances. (continued on next page)

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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F 0565 Level of Harm - Potential for minimal harm Residents Affected - Many	On 05/23/24 at 9:48 AM, a Certified Nursing Assistant (CNA), explained the CNA worked as a Therapy Aide, and conducted activities with the residents. The CNA indicated visited the residents daily and any concerns were brought to and addressed by the Administrator. The CNA explained the Ombudsman suggested regular monthly resident council meetings be held. The CNA indicated Resident Council meetings were conducted every second Tuesday of the month when the Ombudsman came to the facility. The CNA indicated the facility started having resident council meetings in 2023. The CNA indicated the last meeting there were approximately three to four residents in attendance. The CNA confirmed there were no meeting minutes taken and kept by the facility. On 05/23/24 at 12:52 PM, the Administrator confirmed the facility did not have a formal grievance log. The Administrator indicated were not the best at documenting. The Administrator indicated was fortunate to be a small facility, so issues were addressed as the facility was made aware of the issues. The Administrator acknowledged there was no documentation kept related to the resident grievances and the facility did not keep a written log of resident grievances. The Facility Resident's Rights policy dated 2/27/2018, documented the facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. The facility must be able to demonstrate their response and rationale for such response. The facility Grievance Policy (undated) documented the facility will maintain evidence demonstrating the results of all grievances for a period of not less than three (3) years from the issuance of the grievance decision.

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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** 40131 Based on observations, interviews, record reviews, and document review, the facility failed to ensure a physician order was obtained for the use of a splint, care orders on how to manage the resident's splint were transcribed and implemented, and a care plan was initiated for 1 of 16 sampled residents (Resident 7). The deficient practice could have the potential to result in improper healing, increased pain, or further injury. Findings include: Resident 7 (R7) R7 was admitted on [DATE], with diagnoses including falls and fracture of the lower and right radii (radial bone). The hospital Discharge Summary dated 04/24/2024, documented R7 was fully oriented, had an accident at home, sustained a broken wrist, and had findings of non-displaced intra-articular fracture distal radial metaphysis. The recommendation was to avoid surgical interventions and use a removable wrist brace to prevent weight bearing on the affected extremity. The facility's Admission Skin assessment dated [DATE], documented a splint was in place on R7's right wrist. On 05/21/2024 at 12:08 PM, R7 was lying in bed, and a splint on the right wrist was in place. R7 ate lunch with the left hand. A Certified Nursing Assistant (CNA) indicated that R7 always had a right wrist splint in place. R7's medical records lacked documented evidence of a physician's order to use a splint, instructions for managing the splint, and a care plan. On 05/22/2024 at 9:09 AM, R7 was in bed, alert and verbally responsive, with a splint in place on the right wrist. R7 indicated a fall incident at home on 04/21/2024, which resulted in a wrist fracture and required hospitalization . R7 explained the splint was provided in the hospital and had not been removed since admission to the facility. A Registered Nurse (RN) confirmed the splint was in place at all times, but no care orders had been obtained or transcribed, and no care plan had been initiated. The RN explained the admission nurse was responsible for ensuring the assessment was completed and the care orders and a care plan should have been in place. On 05/22/2024 at 10:26 AM, the Director of Nursing (DON) indicated the admission nurse was responsible for obtaining orders for the use of the splints, which should be followed by leadership upon chart review or by the wound nurses during a skin assessment. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/22/2024 at 1:58 PM, the Certified Occupational Therapy Assistant (COTA) indicated R7's evaluation was completed on 04/25/2024, and the splint was identified. The treatment plan did not include the splinting for R7's right wrist, which was for non-weight bearing. The COTA explained R7's gross motor control could not do anything except tap a balloon and provide range of motion; R7 could not grasp onto things and could not use the right hand for the activities of daily living. On 05/22/2024 at 2:03 PM, the Occupational Therapist (OT) indicated R7 was being evaluated for strengthening of the upper extremities. The therapy evaluation identified R7's right wrist splint, but did not include it in the therapy treatment plan. The OT indicated the nursing staff was responsible for obtaining the physician order, including the management of the splint. On 05/22/2024 at 2:07 PM, the Physical Therapy Assistant (PTA) indicated R7's splint order for evaluation and treatment should have been placed by the admission nurse based on the assessment upon R7's admission. On 05/23/2024 at 1:00 PM, the Director of Nursing (DON) explained had spoken to the admission nurse and confirmed the orders were missed and had not been obtained or transcribed. The DON indicated R7's splint required an order, and a care plan should have been formulated based on the assessment. The Splint Management Policy (undated), documented splints would be applied per physician orders.

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observations, interviews, record reviews, and document review, the facility failed to ensure a physician's order for peripheral intravenous (IV) insertion and care orders were obtained, transcribed, and implemented for 1 of 16 sampled residents (Resident 138). The deficient practice could have led to potential complications such as infection, incorrect medication administration, or inadequate treatment. Findings include: Resident 138 (R138) R138 was admitted on [DATE], with diagnoses including urinary tract infection, sepsis, and dehydration. The Nursing Progress Note dated 05/18/2024, documented the initiation of IV fluids at 0.9 percent saline, to be administered at 75 milliliters (ml) per hour for a total of two liters. The Nursing Progress Note dated 05/18/2024, documented R138 was on the second bag of IV fluids at 75 ml/hour, infusing well. On 05/21/2024 at 8:16 AM, R138 was in bed with an IV heplock in place on the right wrist. The heplock appeared old and undated, with the dressing edges peeling off. The IV pole was at the bedside. R138 reported the facility had inserted the IV access four days ago and had asked the staff to remove the heplock as it was not in use. R138's medical records lacked documented evidence a physician's order was obtained for the insertion of an IV, including the care orders for flushing, monitoring the insertion site, or changing the dressing. On 05/21/2024 at 9:01 AM, a Registered Nurse (RN) confirmed there was no order for IV access insertion or related care. The RN noted the IV heplock was old, and the dressing was undated and peeling off. The RN stated that the IV heplock was good for three days, should be monitored, and should have been removed if not in use. The RN indicated the Resource Nurse was responsible for putting in the orders. On 05/23/2024 at 3:10 PM, the Resource Nurse indicated the admission nurse, the nurse who received the order, the resource nurse, or the leadership were responsible for ensuring a physician's order was obtained before the implementation of a task. On 05/23/2024 at 8:54 AM, the Director of Nursing (DON) indicated any IV access required an order for insertion and management, including flushing and monitoring of the insertion site. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Intravenous Access Device (undated), documented upon receipt of a physician's order for IV therapy and/or maintenance of the access device, the flushing protocol for a specific access site, and the type of catheter were reviewed. Clarify the physician's order to include the maintenance protocol, as per the facility policy, if it doesn't address these components. A facility policy titled Selection of IV Catheters (undated), documented a physician's order should be promptly obtained for the removal of any peripheral IV catheter that is no longer essential. A facility policy tiled IV Access Device Maintenance Protocol for peripheral access devices (undated), documented the frequency of saline flushes before and after each use with 3 cubic centimeters, as well as dressing changes with site changes every 3-7 days and as needed.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observations, interviews, record reviews, and document review, the facility failed to ensure the Oxygen (O2) flow rate was followed as ordered or the titration rate and frequency of the administration were clarified for 1 of 16 sampled residents (Resident 137). The deficient practice could have led to potential respiratory distress, inadequate oxygenation, or exacerbation of the resident's underlying health conditions. Findings include: Resident 137 (R137) R137 was admitted on [DATE], with diagnoses including acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, and chronic pulmonary edema. The admission Observation Details List Report dated 05/16/2024, documented R137 had Oxygen via nasal cannula for shortness of breath with exertion or at rest. A Physician order dated 05/16/2024, documented O2 per nasal cannula (NC) at 2 liters per minute (LPM) to maintain SpO2 (peripheral capillary oxygen saturation) of more than 90% (percent). Document LPM. May titrate or discontinue O2 as tolerated while maintaining SpO2 greater than 90% for shortness of breath, dyspnea, or SpO2 less than 90%. The O2 order did not specify whether to administer the O2 continuously or as needed, nor did it specify the titration rate parameters. On 05/21/2024 at 8:43 AM, R137 was in bed with eyes closed, and O2 was flowing at 4 LPM connected to the wall via a nasal cannula. On 05/22/2024 at 8:20 AM, R137 was lying in bed in a supine position with the head of the bed elevated. R137's O2 was flowing at 4 LPM; there were no signs of respiratory distress. R137 indicated was dependent on O2 and the staff administered the O2 continuously. R137 was unsure how much O2 had been receiving. R137 indicated had no shortness of breath. The Medication Administration Record dated 05/22/2024, documented R137's O2 saturation was 98-99%. On 05/22/24 10:27 AM, R137's O2 was flowing at 4 LPM via nasal cannula. A Registered Nurse (RN) verified R137's O2 was flowing at 4 LPM, despite the prescribed 2 LPM. The RN confirmed the active order did not specify whether it should be continuous or if any titration parameters were required. The RN explained the physician order should have been followed because too much O2 may constitute toxicity and could potentially damage the lungs. The RN explained the Licensed Nurses were responsible for ensuring the residents received the correct O2 flow rate as ordered or clarifying orders for clarity. The RN indicated R137's O2 saturation was 94%. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/22/2024 at 1:19 PM, the Director of Nursing (DON) indicated the O2 required an order, and the staff was expected to verify and follow the O2 orders. The DON acknowledged the titration parameters, and the frequency should have been clarified. The Oxygen Administration policy (undated), documented to administer Oxygen in accordance with a physician order. Appropriate safety precautions were utilized to provide safe administration.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, interviews, record reviews, and document reviews, the facility failed to ensure: 1) dialysis intercommunication or post-dialysis treatment information was obtained or maintained for 2 of 2 sampled residents (Residents 28 and 27), 2) the resident's infection status was communicated to transportation staff or to the dialysis center for 1 of 2 sampled residents (Resident 28), and 3) the resident's arteriovenous fistula (AVF) was identified, care orders, and management were obtained, transcribed, and implemented for 1 of 2 sampled residents (Resident 27). The deficient practices could have led to potential cross-contamination among staff members and other residents, increased the risk of infection, and compromised the health and safety of the residents. Findings include: Resident 28 (R28) R28 was admitted on [DATE], with diagnoses including stage 5 chronic kidney disease and dependence on dialysis. A physician order dated 05/08/2024, documented to assess R28's vital signs pre- and post-dialysis. The medical records of R28 did not maintain documented evidence of the interchange of communication or collaboration of care between the facility and the dialysis center. On 05/21/2024 at 9:10 AM, R28 arrived in a wheelchair, accompanied by the facility driver from the dialysis center. The driver indicated did not have the dialysis communication paper post-dialysis treatment. The driver explained previously, a dialysis communication form was filled out by the facility and brought back to the facility with the resident's weight, vital signs, and instructions, but it was not implemented anymore. The driver indicated during dialysis days, the facility sent R28's information like the facesheet and the list of medications. On 05/21/2024 at 10:AM, a Registered Nurse (RN) indicated the dialysis center was responsible for obtaining the vital signs and the resident's weight post-dialysis treatment. The RN confirmed there was no information available about R28's vital signs and weights, nor were there any instructions for post-dialysis treatment. Resident 27 (R27) R27 was admitted on [DATE], with diagnoses including stage 5 chronic kidney disease or end-stage renal disease (ESRD) and dependence on dialysis. A physician order dated 04/30/2024, documented to assess R28's vital signs pre- and post-dialysis on Tuesday, Thursday, and Saturday. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Care plan dated 05/01/2024, documented R27 had a diagnosis of renal failure and was on hemodialysis. The interventions included monitoring weights and restricting fluid intake. Evaluate the record and assess for fluid excess (weight gain, increased blood pressure, edema , worsening of edema, and any change in condition). The goal was R27 would not exhibit signs of fluid volume excess. R27's medical records lacked documented evidence of the interchange of communication or collaboration of care between the facility and the dialysis center which was not maintained in the medical records. On 05/22/2024 at 3:01 PM, the Infection Preventionist (IP) verified and confirmed R28 and R27 were receiving dialysis treatment outside the facility, and there was no interchange of communication information in place. The IP acknowledged the importance of communication from the facility to the dialysis center and vice versa. The IP indicated at the moment, R28 and R27 were the only residents receiving hemodialysis. On 05/22/2024 in the afternoon, the Director of Nursing (DON) confirmed the facility had not utilized the communication form lately. The DON indicated upon leaving the facility for the dialysis center, the resident's information was sent through the driver, but post-dialysis treatment information was not obtained. The DON confirmed the pre- and post-dialysis communication form had not been utilized and was not maintained in the residents' charts. A facility policy titled Dialysis Services (undated), documented for the residents requiring hemodialysis, the facility would coordinate the appropriate care with an outside provider specializing in hemodialysis and renal care needs. The information exchange was beneficial or necessary for the resident's care. The Long Term Care Outpatient Dialysis Services Coordination Agreement: Mutual Obligations with the Collaboration of Care (undated), Both parties should ensure there is documented evidence of collaboration of care and communication between the LTC facility and ESRD dialysis unit. 2) Resident 28 (R28) R28 was admitted on [DATE], with diagnoses including stage 5 chronic kidney disease and dependence on dialysis. On 05/21/2024 at 8:07 AM, R28 was not present in the room, and contact precaution and enhanced barrier precaution signage were posted by R28's room door. Personal protective equipment (PPE) was readily available. A Certified Nursing Assistant (CNA) indicated R28 went out for dialysis early in the morning. A Physician order dated 05/08/2024, documented R28 was on strict contact isolation for Extended Spectrum Beta-Lactamase (ESBL) or infection in the urine and Vancomycin-resistant Enterococcus (VRE). The History and Physical dated 05/09/2024, documented R28 was hospitalized and treated with antibiotics for ESBL in urine and VRE in blood. R28 was on hemodialysis. The recommended course of action was to administer antibiotics and monitor for infection control. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/21/2024 at 9:10 AM, R28 arrived in a wheelchair, accompanied by the facility driver, and headed to R28's room. When entering the room, the driver looked at the contact precaution signage by the door, entered without PPE, and assisted R28 inside. The driver indicated had taken R28 to the dialysis center and picked R28 up post-dialysis treatment. The driver explained was unaware R28 was on contact isolation precautions and there had been no endorsement. The driver indicated during transport, the contact precautions were not observed, and upon arrival at the dialysis center, R28 was placed in the waiting area with other residents. The driver confirmed the dialysis center had not implemented isolation precautions. R28's medical records lacked documented evidence R28's infection status was communicated to the dialysis center. On 05/21/2024 at 9:20 AM, a Registered Nurse (RN) indicated R28 was on contact isolation for bacteremia (infection in the blood) and ESBL in the urine. The RN explained was uncertain if R28's infection status was communicated to the dialysis center. On 05/22/24 03:01 PM, the Infection Preventionist (IP) indicated R28 was admitted with multidrug-resistant organisms (MDRO) and ESBL in urine and was placed in contact isolation with enhanced barrier precautions for the AVF shunt. The IP indicated R28's active infections were not fully treated with intravenous (IV) antibiotic treatment due to the issue of R28's IV access. The IP acknowledged there was no documentation of R28's infection status being communicated to the dialysis center. The IP indicated when infection control was not appropriately communicated and implemented, there was a risk of transmission of infection affecting other individuals. The IP attempted to contact the dialysis center multiple times, but was unsuccessful. A facility policy titled Contact Precautions-Resident Transport (undated), documented to limit the movement and transport of the resident from the essential purposes only. If a resident was transported out of the room, ensure the precautions were maintained to minimize the risk of transmission of microorganisms to other residents and contamination of environmental surfaces or equipment. 3) A Physician order dated 05/10/2024, documented R28 had dialysis on Tuesday, Thursday, and Saturday at 5:00 AM. On 05/21/2024 at 9:30 AM, R28 was verbally alert and oriented, and the AV graft was in place on the left arm. R28 indicated the AV graft was the only access during dialysis treatment. R28's medical records lacked documented evidence a physician order was obtained and transcribed for AV graft monitoring for bleeding, infection, and drainage until 05/21/2024. On 05/22/2024, an RN confirmed care orders and management of R28's AV graft were not obtained or transcribed until 05/21/2024. The RN indicated the AV graft should have been monitored closely for signs of bleeding and infection. On 05/23/2024, the DON indicated the R28's dialysis access should have been monitored, and care orders and management should have been obtained, transcribed, and implemented. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Dialysis Services facility policy (undated), documented for the residents requiring hemodialysis, the facility would coordinate the appropriate care with an outside provider specializing in hemodialysis and renal care needs. The dialysis agreement would cover all aspects of managing the resident's care, including the creation and execution of a dialysis-related care plan.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observations, interviews, record reviews, and document review, the facility failed to ensure the medication error rate was below five (5) percent (%) when two errors, and were identified with 32 opportunities observed, calculating an error rate of 6.25%. Failure to follow physician orders and timely administer medications posed a potential risk of injury or harm to the resident. Findings include: 1. On 05/22/2024 at 8:41 AM, Registered Nurse 2 (RN2) prepared 11 medications, including the standard iron tablet for R187, and administered the medication orally. A Physician order dated 05/10/2024, documented Ferrous Sulfate 325 milligrams (mg) oral tablet, delayed release as a supplement. The Medication Administration Record (MAR) dated 05/22/2024, documented the standard iron was successfully administered. On 05/22/2024 at 2:00 PM, RN2 was uncertain if there was a difference between the standard iron and the delayed release. On 05/22/2024 at 11:54 PM, the Pharmacist explained the standard iron medication and the delayed release had the same ingredients but a different release mechanism. The pharmacist confirmed the standard iron tablets have quicker absorption, whereas delayed-release forms release iron gradually. The Pharmacist further explained the delayed-release iron supplements were designed to bypass the stomach and release iron gradually in the intestines. On 05/22/2024 in the afternoon, the Director of Nursing (DON) acknowledged the standard iron tablet was different from the delayed release. The DON indicated the correct dosage form should have been verified to prevent medication errors. 2. A physician's order dated 05/21/2024, documented to administer Lidocaine 4% adhesive medicated patches at 7:00 AM-9:00 AM. The instructions were to apply two patches topically to painful sites for pain relief, with a schedule of 12 hours on in the morning and 12 hours off in the evening. On 05/22/2024 at 8:21 AM, Registered Nurse 1 (RN1) prepared 10 medications for the unsampled resident in room [ROOM NUMBER], including one (1) Lidocaine 4% patch, which was removed from the packaging. The RN asked the unsampled resident whether the Lidocaine patch would be administered at that time or later after therapy, and the unsampled resident preferred to receive the patch later after therapy. On 05/22/2024 at 3:30 PM, RN2 reoffered the Lidocaine patch, prepared 1 patch, and successfully applied it to the unsampled resident. RN2 confirmed only 1 patch was administered when 2 patches were ordered. (continued on next page)

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	295107	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health Care of Paradise	3455 Pecos-McLeod Interconnect Las Vegas, NV 89121

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/22/2024 in the afternoon, the DON indicated the Licensed Nurses were expected to verify the order prior to administration, ensuring the correct dosage was administered to prevent medication errors. A facility policy titled Medication Error (undated), documented medication errors were to be minimized by following the six rights of medication administration, including the right patient, the right medication, the right dosage, the right dosage form, the right route, and the right time.

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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** 41903 Based on observation, interview, and document review, the facility failed to ensure resident personal information was visible and not accessible to anyone passing by in the hallway, and the medication cart was locked and not left unattended for 2 of 2 medication carts. The deficient practice placed resident confidentiality at risk and could have facilitated unauthorized access to medications in the cart. Findings include: On 05/22/2024 at 2:10 PM, a medication cart located near resident room [ROOM NUMBER] was observed unattended. The computer screen on top of the medication cart was on and displayed resident pictures and names. The medication cart was unlocked. On 05/22/2024 at 2:12 PM, the Nurse acknowledged had walked away to obtain supplies and left the computer screen on and the cart unlocked. The nurse acknowledged the computer screen needed to be off and the medication cart locked to protect resident privacy and prevent anyone walking by from accessing the medication in the cart. The Medication Storage Policy and Procedure, undated, documented medication rooms, carts, and medication supplies were to be locked or attended by persons with authorized access. 40131 On 05/22/2024 at 8:21 AM, Registered Nurse 1 (RN1) prepared medications for an unsampled resident. RN1 had walked away to administer the medication in room [ROOM NUMBER]. The RN parked the medication cart facing the hallway, unlocked and unattended. The computer on top of the medication cart was open, displaying resident pictures and names. Visitors and staff members were walking down the hallway, and the screen was visible and accessible. On 05/22/2024 at 8:26 AM, RN1 acknowledged the medication cart and the computer screen were left unlocked and unattended. RN1 explained locking the medication cart was important to prevent unauthorized access and securing the computer screen to safeguard the resident's privacy. On 05/22/2024 in the afternoon, the Director of Nursing indicated that the medication carts should have been locked when unattended and the computer screens secured to prevent unauthorized access and protect the residents' privacy. The Administration of Medication policy (undated), indicated locking the medication cart whenever it was out of view. Before exiting the medication cart, log out of the electronic medication administration record.

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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 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** 41903 Based on observation, interview, and document review, the facility failed to: 1) discard five expired thickened orange juice containers stored in the nourishment room [ROOM NUMBER]) ensure a Cook was not eating next to the food tray line 3) ensure a Dietary Aide was not touching their face and nose with gloved hands while handling food during tray line and 4) ensure 1 of 4 soap dispensers in the kitchen was refilled timely. The deficient practices could have led to contamination of kitchen surfaces and food borne illness. Findings include: 1) Expired thickened orange juice containers. On [DATE] at 7:45 AM, five thickened orange juice containers were observed in the nourishment room with an expiration date of [DATE]. On [DATE] at 7:45 AM, the Nutritional Services Director confirmed the expiration date for the thickened orange juice containers was [DATE]. The Nutritional Services Director acknowledged expired food items needed to be discarded to prevent food borne illnesses. The Food Storage Policy, undated, documented all foods would be checked to assure that foods would be consumed by their safe use dates, frozen, or discarded. 2) Cook eating next to food tray line. On [DATE] at 12:50 PM, a Cook was observed holding a plate of ribs with gloved hands, eating while standing next to the food tray line. On [DATE] at 12:50 PM, the Cook acknowledged were not supposed to eat next to the food tray line. The Cook explained staff were to eat away from the kitchen, in the dining room or the back office to prevent contamination. On [DATE] at 10:49 AM, the Nutritional Services Director reported based on policy, staff was not to eat food in the food preparation area of the kitchen and the Cook should have taken the plate of food into the dining room or the back office to eat. The Food Handling Policy and Procedure, dated [DATE], documented personnel were not to eat or drink in the food preparation area. 3) Dietary Aide touched their face and nose with gloved hands, while handling food during tray line. On [DATE] at 12:22 PM, a Dietary Aide was observed touching the cheek and nose with gloved hands while handling food during tray line. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1:18 PM, the Dietary Aide acknowledged should not have touched their face with gloved hands while working the food tray line. The Dietary Aide explained according to policy, after touching their face, should have washed hands, and changed gloves to prevent contamination. The Food Handling Policy and Procedure, dated [DATE], documented food handlers must wash their hands after personal body functions and engaging in other activities that contaminated the hands. 4) Soap dispenser not refilled timely. On [DATE] at 07:45 AM, a soap dispenser at the sink closest to the kitchen entrance was observed empty. On [DATE] at 12:15 PM, the soap dispenser at the sink closest to the kitchen entrance was again observed empty. On [DATE] at 12:15 PM, the Nutritional Services Director confirmed the soap dispenser was empty. The Nutritional Services Director reported housekeeping had been notified to provide soap to refill the dispenser and acknowledged it was the kitchen's staff responsibility to have the soap dispenser refilled to prevent contamination in the kitchen. On [DATE] at 02:39 PM, the Housekeeping Supervisor explained staff were to request refills of soap dispensers from Housekeeping. Housekeeping staff would then have the soap replaced immediately upon request. The Housekeeping Supervisor reported it was important to refill soap dispensers quickly to prevent any infection control issues. The Handwashing Policy, dated [DATE], documented all employees' hands must be washed when visibly dirty or contaminated. Handwashing would occur including when coming on duty, before applying and removing gloves, after contact with any equipment or environmental surface that might have been soiled or contaminated, and before and after going on break and at the end of the shift before leaving the facility.

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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 observations, interviews, record reviews, and document reviews, the facility failed to ensure: 1) transmission based precautions (TBP) was implemented during transportation and personal protective equipment (PPE) was donned as required before entering the TBP room for 1 of 16 sampled residents (Resident 28); and 2) hand sanitizer dispensers were refilled for resident rooms (rooms [ROOM NUMBER]). The deficient practices could have the potential to result in the spread of infection, an increased risk of cross-contamination, and compromised safety for other residents and staff members. Findings include: 1. R28 was admitted on [DATE], with diagnoses including stage 5 chronic kidney disease and dependence on dialysis. A Physician order dated 05/08/2024, documented R28 was on strict contact isolation for Extended Spectrum Beta-Lactamase (ESBL) for infection in the urine and Vancomycin-resistant Enterococcus (VRE). The History and Physical dated 05/09/2024, documented R28 was hospitalized and treated with antibiotics for ESBL in urine and VRE in blood. The recommended course of action was to administer antibiotics and monitor for infection control. On 05/21/2024 at 8:07 AM, R28 was not present in the room, contact precaution and enhanced barrier precaution signage were posted by R28's room door. The signage indicated to clean hands before entering and leaving the room, put on gloves and gown before room entry. Personal protective equipment (PPE) was readily available by R28's room entrance. A Certified Nursing Assistant (CNA) indicated R28 went out for dialysis early in the morning. On 05/21/2024 at 9:10 AM, R28 arrived in a wheelchair accompanied by the facility driver and proceeded to R28's room. Upon entering the room, the driver looked at the contact precaution signage by the door, then entered without cleaning hands, no PPE and assisted R28 inside. The driver expressed unawareness R28 was on contact precautions and lacked endorsement, but the driver acknowledged the signage was observed. The driver indicated had taken R28 to the dialysis center and picked R28 up post-dialysis treatment. The driver explained during transport, the TBP protocols were not observed, and upon arrival at the dialysis center, R28 was placed in the waiting area with other residents and individuals. On 05/21/2024 at 9:20 AM, a Registered Nurse (RN) indicated R28 was on contact isolation for bacteremia (infection in the blood) and ESBL urine. The RN confirmed staff members should have worn the required PPE upon entering R28's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/22/2024 at 3:01 PM, the Infection Preventionist (IP) indicated R28 was admitted with bacteremia and ESBL-urine and was placed in isolation with an enhanced barrier for the left AV shunt. The IP explained the staff members were expected to comply with TBP protocols during transportation and entering the TBP rooms, to prevent contamination or the spread of infection to individuals. The Infection Control facility policy (undated), indicated the facility maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment. The infection prevention and control program was designed to help prevent the development and transmission of communicable diseases and infections. 41903 2) On 05/21/2024 at 8:38 AM, the hand sanitizer dispenser at the entrance of resident room [ROOM NUMBER] was observed empty. On 05/21/2024 at 8:42 AM, the hand sanitizer dispenser at the entrance of resident room [ROOM NUMBER] was observed empty. On 05/21/2024 at 9:23 AM, the hand sanitizer dispenser at the entrance of resident room [ROOM NUMBER], was observed empty. On 05/22/2024 at 4:28 PM, the hand sanitizer dispensers at the entrance of resident rooms number 120, 121, and 136 were again observed empty. On 05/22/2024 at 4:28 PM, a nurse confirmed the sanitizer dispensers were empty at the entrance of resident room numbers 120, 121 and 136. The nurse further acknowledged two of the resident rooms, numbers 121 and 136, had enhanced barrier precautions signs posted and acknowledged hand hygiene needed to be done by all staff and visitors prior to entering and exiting all resident rooms to prevent transmission of infection. On 05/23/24 at 02:39 PM, the Housekeeping Supervisor explained staff were to request refills of hand sanitizer from Housekeeping. Housekeeping staff would then have the hand sanitizer replaced immediately upon request. The Housekeeping Supervisor reported it was important to refill hand sanitizer dispensers quickly to prevent any infection control issues. The Alcohol Based Hand Sanitizer Policy dated 04/08/2021 documented, except for situations where hand washing was specifically required, antimicrobial agents such as alcohol-based hand sanitizers were also appropriate for cleaning hands. The purpose was to prevent transmission of infection from one patient to another via the health care worker, remove transient bacteria and prevent illness.