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	03/20/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29141 Based on record review and interview, the facility failed to ensure proper Medicare Notice of Medicare Non-Coverage letter was completed and provided for 1 of 3 unsampled residents selected for beneficiary notification review. The deficient practice resulted in non-compliance with Medicare requirements, that could hinder the resident's ability to make informed decisions regarding their coverage and care. Findings include: Resident #99 (R99) R99 was admitted to the facility on [DATE], with diagnoses including fall, right hip fracture and syncope. Review of R99 S's CMS (Centers for Medicare and Medicaid Services) SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review form provided by the Case Manager on 03/19/2025, revealed R99's Medicare Part A skilled services episode started on 08/30/2024 and the last covered day for Part A services was on 09/18/2024. R99 was discharged home on 09/19/2024. The medical record lacked documented evidence the Notice of Medicare Non-Coverage letter was provided to R99 or to resident's representative. On 03/19/2025 at 11:00 AM, the facility's Case Manager could not produce evidence the Notice of Medicare Non-Coverage letter was provided to R99. On 03/20/2025 at 9:45 AM, the facility's Administrator stated it was the expectation the facility followed the CMS guidelines and provide the Notice of Medicare Non-Coverage letter to resident and/or resident representative three days prior to the end of the benefits. The facility's undated policy titled Notice of Medicare Non-Coverage (NOMNC) documented the facility would provide a NOMNC letter to eligible beneficiaries, even if they agree to terminate services. The NOMNC would be delivered at least two days before Medicare covered services end, or the last day of service if care is not provided daily, and the original signed document must be retained in the beneficiary's file.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295107	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER Advanced Health Care of Paradise		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29141 Based on observation, interview, medical record review, and document review, the facility failed to implement care plan interventions for 4 of 13 sampled residents and one unsampled resident (Resident #11), for pressure reducing device (Resident #92), intravenous midline care (Residents #17 and 21), feeding assistance (Resident #11 and 21), and constipation care (Resident #39). The deficient practice had the potential to compromise the quality of care, disrupt continuity in treatment, and may lead to negative outcomes, including deterioration in residents' overall health. Findings include: Resident #92 (R92) R92 was admitted on [DATE] with diagnoses including dementia, benign prostatic hyperplasia (BPH), chronic hypoxic respiratory failure, diabetes mellitus, and bed-bound status. The admission skin assessment dated [DATE], revealed an unspecified open area in coccyx. Skin assessment dated [DATE], documented R92 had a deep tissue injury (DTI) with moisture-associated skin damage (MASD) in the coccyx area. [NAME] risk observation for the prediction of pressure ulcer dated 03/12/2025, documented R92 was at moderate risk for pressure ulcers and the care plan included air mattress. A physician's order dated 03/11/2025 documented place air mattress and verify placement every shift. A care plan dated 03/11/2025 for pressure ulcer revealed interventions including pressure reducing devices as indicated. On 03/18/2025 at 8:46 AM, R92 was in bed and no air mattress was observed. On 03/18/2025 at 2:15 PM, a Certified Nursing Assistant (CNA) confirmed R92 was not on an air mattress. Treatment administration record (TAR) revealed nurses documented air mattress placement was verified every shift, from 03/11/2025 through 03/18/2025. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/18/2025 at 2:27 PM, the wound care nurse explained air mattresses were ordered based on the wound conditions and the prediction of wound progress based on the risk assessment and resident's condition. The wound care nurse confirmed a request for air mattress was transmitted to a vendor the same day the physician order was obtained on 03/11/2025. The wound care nurse acknowledged did not follow the order to ensure the air mattress was delivered and placed on R92's bed. The wound care nurse indicated nurses would verify the placement of the air mattress and notify the Wound Care Nurse if the resident had not received the mattress. The wound care nurse acknowledged did not verify the placement of the air mattress when performed the wound care on 03/17/2025. On 03/18/2025 at 2:40 PM, a Registered Nurse stated being not aware R92 had an order for an air mattress. The RN when to R92's room and confirmed the air mattress was not in place. After revising the TAR, the RN acknowledged had documented the air mattress placement without verifying. On 03/20/2025 at 7:40 AM, the wound care Nurse Practitioner (NP) explained R92 was at risk to develop pressure ulcers due to the several co-morbidities that included diabetes, hypoxia, anemia, poor mobility and bed bound. The NP indicated R92 had a deep tissue injury in the coccyx area, a lesion that the extent of the damage could not be superficially observed until the skin was open. The NP verbalized as protocol, residents with DTI, unstageable pressure ulcers and pressure ulcers stage 3 and above were required to be placed on an air mattress to prevent the development and worsening of pressure ulcers. The NP explained the mattress uses inflatable air tubes to inflate and deflate, mimicking patient movement, to relieve pressure and ensure proper air circulation, preventing pressure wounds and preventing pressure in areas with less padding. The NP confirmed had signed the order for low air loss mattress for R92 on 03/11/2025 and expected the nurses to follow the order as standard of practice. 40142 Resident 17 (R17) R17 was admitted on [DATE], with diagnoses including hemiplegia hemiparesis following cerebral infarction and sepsis. R17's care plan for midline care initiated 02/18/2025, documented an intervention to receive treatment in accordance with physician's order. Site care and dressing changes per protocol. On 03/18/2025 at 9:32 AM, R17's right upper arm midline dressing was dated 03/10/2025 with ends coming loose. A Registered Nurse (RN) confirmed the observation and indicated midline dressing changes were done weekly on Sundays. A physician's order dated 02/18/2025, documented to change midline dressing weekly. Clean with alcohol stick or chloraprep at insertion site, air dry, apply skin prep to area and air dry. Apply bio-patch to insertion site. Cover with transparent dressing. The observation revealed R17's midline dressing change had not been performed since 03/10/2025 (eight days). Resident 21 (R21) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R21 was admitted on [DATE], with diagnoses including metabolic encephalopathy, dementia and history of craniotomy. R21's care plan for midline care initiated 03/04/2025, documented an intervention to receive treatment in accordance with physician's order. Site care and dressing changes per protocol. On 03/18/25 at 10:12 AM, R21's right upper arm midline dressing was dated 03/09/2025 with ends coming loose. The Clinical Nurse Manager (CNM) confirmed the observation and indicated midline dressing changes were done weekly on Sundays. The observation revealed R21's midline dressing change had not been performed since 03/09/2025 (nine days). R21's nutrition care plan initiated on 03/10/2025, documented an intervention to provide R21 with one-on-one (1:1) feeding assistance due to a diagnosis of protein calorie malnutrition. Two meal observations on 03/19/2025 (breakfast) and 03/20/2025 (breakfast) revealed there was no staff member providing feeding assistance to R21. Resident 11 (R11) R11 was admitted on [DATE], with diagnoses including unspecified dementia and severe protein calorie malnutrition. R11's nutrition care plan initiated on 03/10/2025, documented an intervention to provide R11 with one-on-one (1:1) feeding assistance due to risk in alterations in nutritional status. One meal observation on 03/19/2025 (breakfast) revealed there was no staff member providing feeding assistance to R11. Resident 139 (R139) R139 was admitted on [DATE], with diagnoses including ulcerative colitis and diverticulitis. R139's Bowel and Bladder care plan initiated on 03/06/2025, documented interventions to follow the bowel brigade. Review of medical record revealed R139's last bowel movement was on 03/11/2025 and the bowel brigade was not followed. Specifically, the bowel brigade called for enema administration on 03/16/2025 (Day 5 of no BM) but this was not administered until 03/20/2025 (nine days of no BM). The Comprehensive Care Plan policy (undated) documented, the facility would develop person-centered care plan. The care plan should be evaluated to determine if current interventions were being followed and effective in attaining identified goals. Outcomes were monitored and interventions evaluated after implementation of the care plan.

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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** 29141 Based on observation, record review, interview, and document review, the facility failed to ensure care not provided to residents, were not documented in the medical record as completed for the application of antimicrobial wipes for 1 of 13 sampled residents (Resident #92), and for wound care and intravenous midline dressing change for 2 of 13 sample residents (Resident #17 and 21). Failure to accurately document care in the medical record had the potential to compromise patient safety by leading to gaps or errors in care, delay necessary interventions, and hinder continuity of treatment that could lead to deterioration of resident's health due to unmet care needs. Findings include: Resident #92 (R92) R92 was admitted on [DATE] with diagnoses including included dementia, benign prostatic hyperplasia (BPH), chronic hypoxic respiratory failure, diabetes mellitus, and bed-bound status. A physician order dated 03/15/2025 documented to wipe down resident's entire body with Chlorhexidine (CHG) wipes once daily to be applied in between 6:00 AM to 2:00 PM, related to Candida auris infection. (CHG is an antimicrobial agent used as a topical antiseptic and disinfectant, effective against bacteria, yeasts, and some viruses). On 03/19/2025 at 9:00 AM, the treatment administration record (TAR) was reviewed. The TAR revealed the CHG wipes were applied from 03/15/2025 through 03/19/2025 as ordered and signed by a Registered Nurse (RN). On 03/19/2025 at 9:30 AM, the RN who signed the TAR for the application of CHG wipes, explained the Certified Nursing Assistants (CNAs) were responsible to execute the order for wiping down R92 and was not sure if the CNAs already did it. On 03/19/2025 at 10:00 AM, the CNA assigned to provide care to R92 confirmed the the wiping procedure was not performed at that time. On 03/19/2025 at 11:45 AM, an observation of the application of CHG wipes was conducted with two Certified Nursing Assistances (CNAs). One of the CNAs verbalized it was the first time these wipes were used. The CNA confirmed on 03/17/2025 and 03/18/2025, regular wipes and soap and water were used to wipe the resident down. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/19/2025 at 2:00 PM, a second review of the TAR revealed new charting entries which were not documented when the record was reviewed in the morning. The new charting indicated CHG wipes were not applied on 03/17/2025, since the Certified Nursing Assistant did not wipe the resident with the CHG. The information was documented in the TAR as charted on 03/17/2025 at 7:52 AM by an RN. The TAR also documented new charting entry stating the wipes were applied on 03/18/2025 at 4:30 PM, after changed bed to air mattress. This information was documented in the TAR as charted on 03/19/2025 at 12:16 PM by the same RN. The TAR revealed another new charting entry explaining the wipes were applied on 03/19/2025, however the CNA stated had not wiped the resident with CHG in the morning. This information was documented in the TAR as charted on 03/19/2025 at 12:20 PM by the same RN. These three administration entries were not documented on the TAR when it was revised in the morning. On 03/19/2025 at 1:30 AM, the RN confirmed the TAR comments were documented extemporaneously after knowing the CNAs did not apply the CHG wipes to R92. The RN acknowledged had documented and signed the administration of the CHG wipe without verifying the application. The RN confirmed a new order for wiping down the resident was obtained to extend the treatment since the wipes were not applied as ordered. On 03/19/2025 at 2:00 PM, the Director of Nursing (DON) explained the RN should not have documented extemporaneous comments in the TAR since it could be considered alteration of medical records. The DON indicated it was the expectation that nurse did not chart care as provided, when it did not occur. 40142 Wound Care Resident 17 (R17) R17 was admitted on [DATE], with diagnoses including hemiplegia hemiparesis following cerebral infarction and sepsis. A physician's order dated 02/19/2025, documented to provide wound care to coccyx pressure ulcer: clean with wound cleanser, pat dry, apply Triad cream and cover with foam dressing daily. Change dressing as needed. A physician's order dated 02/19/2025, documented to provide wound care to left heel pressure ulcer: clean with wound cleanser, pat dry, apply Sure prep and cover with foam dressing every Tuesday and Friday, change dressing as needed. A physician's order dated 02/19/2025, documented to provide wound care to right heel pressure ulcer: clean with wound cleanser, pat dry, apply Sure prep and cover with foam dressing every Tuesday and Friday, change dressing as needed. On 03/18/2025 at 9:47 AM, a Registered Nurse (RN) and a Certified Nursing Assistant (CNA) entered R17's room and removed the resident's blue socks. The resident's right and left heel each had a beige foam dressing dated 03/13/2025. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The treatment administration record (TAR) reflected treatments were administered to R17's bilateral heels on 03/14/2025 and 03/18/2025. On 03/18/2025 in the afternoon, the Registered Nurse (RN) and wound care nurse confirmed the observation of R17's bilateral heel dressings which were dated 03/13/2025 did not align with documented care which was supposedly provided on 03/14/2025 and 03/18/2025. Resident 21 (R21) R21 was admitted on [DATE], with diagnoses including metabolic encephalopathy, dementia and history of craniotomy. On 03/18/25 at 10:12 AM, R21 laid in bed appearing weak and lethargic. R21 responded with singular words or nodding head. The wound care nurse and a CNA lifted the resident's blanket which revealed R21's right and left heel each had a beige foam dressing dated 03/13/2025. A physician's order dated 03/04/2025, documented to provide wound care to left heel pressure ulcer: clean with wound cleanser, pat dry, apply Sure prep and cover with foam dressing every Tuesday, Thursday and Saturday, change dressing as needed. A physician's order dated 03/04/2025, documented to provide wound care to right heel pressure ulcer: clean with wound cleanser, pat dry, apply Sure prep and cover with foam dressing every Tuesday, Thursday and Saturday, change dressing as needed. R21's TAR reflected wound care to R21's bilateral heels were signed as having been administered on 03/15/2025 and 03/18/2025. On 03/18/2025 in the afternoon, the RN and wound care nurse confirmed the observation of R21's bilateral heel dressings which were dated 03/13/2025, did not align with documented care which was supposedly provided on 03/15/2025 and 03/18/2025. On 03/18/2025 at 10:25 AM, the wound care nurse acknowledged R21's TAR reflected R21's coccyx wound treatments were not administered on 03/06/2025, 03/08/2025 and 03/11/2025. The wound care nurse acknowledged there was no documented evidence the wound care nurse provided the service on the above-mentioned dates, because the wound care nurse was under the impression the RN's comments of not-administered wound care nurse to perform was sufficient to convey treatment had been administered by the wound care nurse. The wound care nurse indicated there was no other place in the EHR to reflect the missed treatments were indeed provided by the wound care nurse. On 03/18/2025 at 10:30 AM, the wound care nurse explained having the habit of pre-signing all wound care treatments before actual administration because the tasks were scheduled to be performed for the rest of the day. The wound care nurse acknowledged signing R17's and R21's wound treatment services on 03/18/2025 even if wound care had not been performed. On 03/19/2025 at 3:19 PM, the Director of Nursing (DON) indicated wound care services should be signed off after the administration of the task and not ahead of time. The DON acknowledged observation of R17 and R21's foam dressings dated 03/13/2025 did not align with documented care in the TAR, which went against the [NAME] standards of practice which the facility adopted to follow. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Midline Dressing Changes Resident 17 (R17) R17 was admitted on [DATE], with diagnoses including hemiplegia hemiparesis following cerebral infarction and sepsis. On 03/18/2025 at 9:32 AM, R17 laid awake and alert in bed. A single lumen midline was observed on R17's right upper arm with dressing dated 03/10/2025 with ends coming loose. A Registered Nurse (RN) confirmed the observation and indicated midline dressing changes were done weekly on Sundays. The RN indicated R17's the midline had not been used in the facility. A physician's order dated 02/18/2025, documented to change midline dressing weekly. Clean with alcohol stick or chloraprep at insertion site, air dry, apply skin prep to peri-cath area and air dry. Apply bio-patch to insertion site. Cover with transparent dressing. The Medication Administration Record (MAR) for March 2025, documented a nurse performed dressing change to R17's midline on 03/16/2025. On 03/18/2025 in the afternoon, an RN and Clinical Nurse Manager (CNM) confirmed observation of R17's midline dressing which was dated 03/10/2025 did not align with documented care supposedly provided on 03/16/2025. On 03/18/2025 at 12:29 PM, the Infection Preventionist (IP) could not speak to why the nurse assigned to R17 on 03/16/2025, had signed for the dressing change administration when the actual midline dressing was labeled 03/10/2025. Resident 21 (R21) R21 was admitted on [DATE], with diagnoses including metabolic encephalopathy, dementia and history of craniotomy. On 03/18/25 at 10:12 AM, R21 laid in bed appearing weak and lethargic. The Clinical Nurse Manager (CNM) extended R21's right arm which revealed a double lumen midline with dressing dated 03/09/2025 with ends coming loose. The CNM explained R21's midline was being used for IV banana bag (electrolytes) administration. On 03/18/2025 at 10:15 AM, the CNM reviewed R21's MAR and confirmed there was documented care for R21's midline on 03/16/2025 which did not align with the actual observation of the midline dressing dated 03/09/2025. The CNM described R21's midline dressing as not appearing new and edges were coming loose. On 03/19/2025 at 3:04 PM, the DON indicated being made aware actual observations of R17's and R21's midline dressing dates did not align with documented care in the residents' MAR which went against professional standards of practice for documenting care. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/19/2025 in the afternoon, the DON indicated nurses were not permitted to sign off on a medication or treatment without administering or providing the service. The DON indicated nurses were not permitted to document administration of a medication or treatment service prior to actual administration. The DON indicated the facility followed the [NAME] standards of practice and provided the following: The Lippincott Nursing Procedure (ninth edition) indicated, documentation was a valuable method for demonstrating a nurse had applied knowledge, skills and judgement according to professional standards of practice. Document only care, treatments and medications which the nurse themselves had provided or administered. Nurses must never chart in advance and must ensure documentation reflected ongoing care. Delayed documentation increased the potential for omissions, errors, and inaccuracies due to memory lapses.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40142 Based on observation, interview, record review and document review, the facility failed to ensure assistance was provided for residents who were assessed or evaluated to require one-on-one (1:1) feeding assistance for 1 of 13 sampled residents (Resident 21) and one unsampled resident (Resident 11). The deficient practice placed the residents at risk for significant weight loss and malnutrition. Findings include: Resident 21 (R21) R21 was admitted on [DATE], with diagnoses including metabolic encephalopathy, dementia and history of craniotomy. On 03/19/2025 at 9:18 AM, R21's head of bed was elevated approximately 30 degrees, R21 appeared weak and lethargic and responded with singular words or nodding head. A signage on the wall read 1:1 feeding assistance. Sit resident up in chair during mealtimes. A meal tray was observed on the resident's bedside table and contained a bowl of cream of wheat covered in plastic wrap and an Ensure supplement. The meal ticket read regular pureed diet with thin liquids. There were no staff members observed in the room. A physician's order dated 03/05/2025, documented to provide R21 with 1:1 feeding assistance. The five-day minimum data set (MDS) dated [DATE], revealed R21 was dependent on staff for eating. On 03/19/2025 at 9:25 AM, a Certified Nursing Assistant (CNA1) entered R21's room and stated R21 had refused to eat. CNA1 defined refusal as the resident's failure to respond to the CNA when CNA1 asked R21 if the resident wanted to eat. CNA1 explained having three residents requiring feeding assistance and CNA1 could not transfer R21 from bed to chair by themselves and was too shy to ask for help from other CNAs who were busy as well. The vitals report dated 03/19/2025, revealed R21 consumed 1 percent (%) to 25% of the breakfast meal. On 03/20/2025 at 9:20 AM, R21 laid in bed with eyes closed, head of bed elevated approximately 30 degrees. An untouched breakfast tray was observed on R21's bedside table which contained a bowl of cream of wheat, a bowl of pureed eggs, a cup of apple juice and an Ensure supplement. There were no staff members in the room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/20/2025 at 9:24 AM, CNA2 indicated being assigned to R21 but CNA2 also had two other residents who required feeding assistance, so CNA2 asked CNA3 to assist R21 with breakfast. CNA3 indicated having already attempted to offer R21 breakfast but R21 refused to eat. CNA3 defined refusal as the resident not responding to CNA3 when the CNA3 asked R21 if R21 wanted to eat. CNA2 and CNA3 were inside R21's room and confirmed a signage on the wall read 1:1 feeding assistance, sit resident up in chair during mealtimes. CNA2 and CNA3 confirmed the observation R21 laid in bed and was not seated on chair, and R21's meal tray had been untouched with spoon clean and food bowls still covered with plastic wrap. On 03/20/2025 at 9:28 AM, CNA2 and CNA3 indicated the observation of R21's breakfast service reflected instructions to sit resident up in chair was not followed and the untouched tray reflected the lack of a proactive attempt to feed the resident's breakfast meal. In addition, CNA3 indicated not informing the nurse regarding R21's refusing breakfast. On 03/20/2025 at 9:30 AM, CNA2 recounted a day last week when CNA2 was assisted by another staff member in transferring R21 to the chair for meal service which resulted in a 50% consumption of the meal because the resident was more alert and participative in the meal task. CNA2 indicated personally observing how the intervention of sitting the resident up had a positive impact on the resident's consumption. On 03/20/2025 at 9:32 AM, the Licensed Practical Nurse (LPN) indicated expecting CNAs to inform the nurse of all refused services which included meals. The LPN indicated being informed of resident refusals gave nurses the opportunity to make own attempts with providing the service, identifying the resident's reason for refusal so findings could be documented in the resident's electronic health record (EHR) and communicated with the inter-disciplinary team (IDT) particularly the Registered Dietician (RD), the Director of Nursing (DON) and the physician. On 03/20/2025 at 9:40 AM, the Director of Nursing (DON) entered R21's room and confirmed the signage on the wall which read, 1:1 feeding assistance, sit resident up on chair during mealtimes. The DON confirmed the observation of R21 lying in bed instead of sitting on a chair, and the meal tray having been untouched with food bowls and juice still covered with plastic wrap and spoon clean. Using a loud voice and clear speech, the DON asked R21 if the resident wanted to eat breakfast. The resident responded to the DON, I'll try. The DON asked R21 if the resident preferred to sit in a chair for breakfast, the resident responded to the DON, yes. On 03/20/25 at 9:50 AM, R21 appeared well-groomed with hair combed while seated on a chair. CNA2 pointed to the resident's tray and stated R21 had fully consumed the cream of wheat, 25 % of pureed egg and 120 milliliters (ml) of the Ensure supplement. CNA2 indicated the resident's consumption would be documented as 75%. On 03/20/2025 at 10:00 AM, the DON indicated the intervention to sit R21 up in a chair during meals was an intervention which was expected to be followed. The DON indicated not knowing whether the intervention was a family request, a therapy recommendation or a physician's order, but CNAs who read the signage were expected to follow them. Resident 11 (R11) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R11 was admitted on [DATE], with diagnoses including unspecified dementia and severe protein calorie malnutrition. On 03/19/2025 at 9:08 AM, R11 laid awake in bed appearing weak and responded with soft voice. A breakfast tray containing scrambled eggs and pureed bread was observed on a table in front of the resident. A signage on the wall read, Provide 1:1 feeding assistance. There were no staff members in the room. On 03/19/2025 at 9:10 AM, CNA1 indicated R11 did not need assistance with meals because the resident was an independent eater. CNA1 entered R11's room and confirmed there was a signage with instructions to provide the resident with 1:1 feeding assistance, but the CNA verbalized not being aware of this instruction. A five-day MDS dated [DATE], revealed R11 was independent with eating. A physician's progress note dated 03/17/2025, documented R11 was drowsy, slept a lot and was not eating much, put on 1:1 feed. A physician's order dated 03/17/2025, documented to provide R11 with 1:1 feeding assistance. The vital report dated 03/19/2025, revealed R11 consumed 1% to 25% of the breakfast meal. On 03/20/2025 at10:00 AM, the DON explained R11's MDS assessment was completed by a therapy staff member who assessed the resident to be independent with eating from a functional ability standpoint. According to the DON, R11 was evaluated by a provider on 03/17/2025 and ordered to put R11 on 1:1 feeding assistance due to increased fatigue and poor meal intakes. The DON indicated the morning observation of R11's meal service on 03/19/2025, reflected physician's order to provide the resident with feeding assistance was not followed and should have been. On 03/20/2025 at 10:05 AM, the DON indicated expecting 1) CNAs to practice teamwork and seek assistance from one another when there were multiple resident requiring assistance during meals, 2) proactive attempts must be made to be successful with meal service, and 3) resident refusals must immediately be reported to the nurse to give the nurse the opportunity to make own attempts, identify reasons for refusal, document event in the EHR and communicate with the IDT. On 03/20/2025 at 10:19 AM, the RD confirmed R21 and R11 both had orders for 1:1 feeding assistance because both residents had issues with alertness, weakness and poor consumption. The RD explained being sat up in a chair was an intervention in R21's case because the resident was often drowsy and became more alert and participative with meals when seated on chair. According to the RD, R21 had a two-pound weight loss which did not rise to a level of significant weight loss but had the potential to result in significant weight loss if interventions were not being implemented. The RD indicated R11 was also in the RD's focus list due to poor intakes related to weakness, impaired cognition and debility. The RD indicated not being informed R21 and R1 were not being provided 1:1 feeding assistance as ordered, prior to today. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/20/2025 in the afternoon, the RD and Dietary Manager indicated residents were no longer transported to the main dining area for meals unlike before. The RD and dietary manager indicated expressing residents such as R21 and R11 would benefit from being transported to the dining room where the residents had a higher chance of being awake, alert and participative with meal service. According to the RD and dietary manager, transporting residents to the dining room would also enable CNAs to assist multiple residents at the same time. The RD and dietary manager indicated not hearing back from leadership regarding transporting dependent residents to the dining area for meals. The Activities of Daily Living (ADL) policy (Undated) documented, a resident unable to carry out ADL would receive necessary services to maintain good nutrition. For these residents, care plan goals may not be stated in terms of what the resident was able to achieve but in terms of the outcome of care and/or services provided.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29141 Based on observation, record review, interview, and document review, the facility failed to ensure prescribed antimicrobial wipes were used for the treatment of a multidrug resistant fungal infection for 1 of 13 sampled residents (Resident #92). The deficient practice had the potential to increase the risk of complications for the affected resident, compromise the overall quality of care, lead to further spread of the infection, and jeopardizing the health and safety of other residents and staff within the facility. Findings include: Resident #92 (R92) R92 was admitted on [DATE] with diagnoses including included dementia, benign prostatic hyperplasia (BPH), chronic hypoxic respiratory failure, diabetes mellitus, and bed-bound status. A physician order dated 03/10/2025, revealed R92 was on strict contact isolation for Candida auris in the groin area (Candida auris is a multidrug-resistant fungal pathogen that can cause serious infections, particularly in healthcare settings, and is difficult to treat with standard antifungal medication. A physician order dated 03/15/2025 documented to wipe down resident's entire body with Chlorhexidine (CHG) wipes once daily to be applied in between 6:00 AM to 2:00 PM, related to Candida auris infection. (CHG is an antimicrobial agent used as a topical antiseptic and disinfectant, effective against bacteria, yeasts, and some viruses). On 03/19/2025 at 9:00 AM, the treatment administration record (TAR) was reviewed. The TAR revealed the CHG wipes were applied from 03/15/2025 through 03/19/2025 as ordered and signed by a Registered Nurse (RN). On 03/19/2025 at 9:30 AM, the RN who signed the TAR for the application of CHG wipes, explained the Certified Nursing Assistants (CNAs) were responsible to execute the order for wiping down R92 and was not sure if the CNAs had already did it. On 03/19/2025 at 10:00 AM, the CNA assigned to provide care to R92 confirmed the wiping procedure was not performed at that time. On 03/19/2025 at 11:45 AM, an observation of the application of CHG wipes was conducted with two Certified Nursing Assistances (CNAs). One of the CNAs verbalized it was the first time these wipes were used. The CNA confirmed on 03/17/2025 and 03/18/2025, regular wipes and soap and water were used to wipe the resident down. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/19/2025 at 2:00 PM, a second review of the TAR revealed new charting entries which were not documented when the record was reviewed in the morning. The new charting indicated CHG wipes were not applied on 03/17/2025, since the Certified Nursing Assistant did not wipe the resident with the CHG. The information was documented in the TAR as charted on 03/17/2025 at 7:52 AM by an RN. The TAR also documented new charting entry stating the wipes were applied on 03/18/2025 at 4:30 PM, after changed bed to air mattress. This information was documented in the TAR as charted on 03/19/2025 at 12:16 PM by the same RN. The TAR revealed another new charting entry explaining the wipes were applied on 03/19/2025, however the CNA stated had not wiped the resident with CHG in the morning. This information was documented in the TAR as charted on 03/19/2025 at 12:20 PM by the same RN. These three administration entries were not documented on the TAR when it was revised in the morning. On 03/19/2025 at 1:30 AM, the RN confirmed the TAR comments were documented extemporaneously after knowing the CNAs did not apply the CHG wipes to R92. The RN acknowledged had documented and signed the administration of the CHG wipe without verifying the application. The RN confirmed a new order for wiping down the resident was obtained to extend the treatment since the wipes were not applied as ordered. On 03/19/2025 at 2:00 PM, the Director of Nursing (DON) explained the RN should not have documented extemporaneous comments in the TAR, since it could be considered alteration of medical records. The DON indicated it was the expectation that nurse did not chart care as provided when it did not occur. The facility undated policy titled Administration of Medication version E1019, documented licensed staff would administer medications in accordance with professional standard.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29141 Based on observation, interview, medical record review, and document review, the facility failed to ensure a physician order for an air mattress was followed for 1 of 13 sampled residents (Resident #92), and wound care treatment was provided as per physician's order for 2 of 13 sampled residents (Residents #17 and 21). The deficient practice placed the residents at risk to develop new pressure ulcers and had the potential to worsen or delay healing of the existing pressure ulcer and increase patient pain and discomfort. Findings include: Resident #92 (R92) R92 was admitted on [DATE] with diagnoses including included dementia, benign prostatic hyperplasia (BPH), chronic hypoxic respiratory failure, diabetes mellitus, and bed-bound status. The admission skin assessment dated [DATE], revealed an unspecified open area in coccyx. Skin assessment dated [DATE], documented R92 had a deep tissue injury (DTI) with moisture-associated skin damage (MASD) in the coccyx area. [NAME] risk observation for the prediction of pressure ulcer dated 03/12/2025, documented R92 was at moderate risk for pressure ulcers and the care plan included air mattress. A physician's order dated 03/11/2025 documented place air mattress and verify placement every shift. A care plan dated 03/11/2025 for pressure ulcer revealed interventions including pressure reducing devices as indicated. On 03/18/2025 at 8:46 AM, R92 was in bed and no air mattress was observed. On 03/18/2025 at 2:15 PM, a Certified Nursing Assistant (CNA) confirmed R92 was not on an air mattress. Treatment administration record (TAR) revealed nurses documented air mattress placement was verified every shift, from 03/11/2025 through 03/18/2025. On 03/18/2025 at 2:27 PM, the wound care nurse explained air mattresses were ordered based on the wound conditions and the prediction of wound progress based on the risk assessment and resident's condition. The wound care nurse confirmed a request for air mattress was transmitted to a vendor the same day the physician order was obtained on 03/11/2025. The wound care nurse acknowledged did not follow the order to ensure the air mattress was delivered and placed on R92's bed. The wound care nurse indicated nurses would verify the placement of the air mattress and notify the Wound Care Nurse if the resident had not received the mattress. The wound care nurse acknowledged did not verify the placement of the air mattress when performed the wound care on 03/17/2025. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/18/2025 at 2:40 PM, a Registered Nurse stated being not aware R92 had an order for an air mattress. The RN when to R92's room and confirmed the air mattress was not in place. After revising the TAR, the RN acknowledged had documented the air mattress placement without verifying. On 03/20/2025 at 7:40 AM, the wound care Nurse Practitioner (NP) explained R92 was at risk to develop pressure ulcers due to the several co-morbidities that included diabetes, hypoxia, anemia, poor mobility and bed bound. The NP indicated R92 had a deep tissue injury in the coccyx area, a lesion that the extent of the damage could not be superficially observed until the skin was open. The NP verbalized as protocol, residents with DTI, unstageable pressure ulcers and pressure ulcers stage 3 and above were required to be placed on an air mattress to prevent the development and worsening of pressure ulcers. The NP explained the mattress uses inflatable air tubes to inflate and deflate, mimicking patient movement, to relieve pressure and ensure proper air circulation, preventing pressure wounds and preventing pressure in areas with less padding. The NP confirmed had signed the order for low air loss mattress for R92 on 03/11/2025 and expected the nurses to follow the order as standard of practice. 40142 Resident 17 (R17) Resident # 17 was admitted on [DATE], with diagnoses including hemiplegia hemiparesis following cerebral infarction and sepsis. An admission skin assessment dated [DATE], revealed R17 was admitted with a coccyx (tailbone) deep tissue injury (DTI) measuring 5 centimeters (cm) by 4.6 cm, a left heel DTI measuring 1.5 cm by 2.0 cm and a right heel DTI measuring 2.0 cm by 2.0 cm. On 03/18/2025 at 9:32 AM, R17 laid awake and alert in bed and able to express needs. R17 reported receiving inconsistent care to bilateral heel ulcers and the coccyx wound. On 03/18/2025 at 9:47 AM, a Registered Nurse (RN) and a Certified Nursing Assistant (CNA) entered R17's room and removed the resident's blue socks. The resident's right and left heel each had a beige foam dressing dated 03/13/2025. R17 was then turned to left side which revealed a small light-colored unopened area over the coccyx which was described by the RN as a moisture associated skin damage (MASD). A physician's order dated 02/19/2025, documented to provide wound care to coccyx pressure ulcer: clean with wound cleanser, pat dry, apply Triad cream and cover with foam dressing daily. Change dressing as needed. A physician's order dated 02/19/2025, documented to provide wound care to left heel pressure ulcer: clean with wound cleanser, pat dry, apply Sure prep and cover with foam dressing every Tuesday and Friday, change dressing as needed. A physician's order dated 02/19/2025, documented to provide wound care to right heel pressure ulcer: clean with wound cleanser, pat dry, apply Sure prep and cover with foam dressing every Tuesday and Friday, change dressing as needed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The treatment administration record (TAR) for February 2025 and March 2025, revealed coccyx wound treatments were not administered on 02/21/2025, 02/25/2025, 03/03/2025, 03/10/2025, and 03/17/2025. The TAR reflected wound care was not administered to R17's right and left heel on 02/21/2025, 02/25/2025, and 03/04/2025. Comments for non-administration read, to be done by wound care nurse. The TAR reflected wound care had been administered for R17's coccyx, right heel and left heel pressure ulcers on 03/18/2025 by the wound care nurse. On 03/18/2025 at 10:15 AM, the RN acknowledged routinely signing off on R17's wound care as not administered wound care nurse to perform because the RN expected the wound care nurse to be providing the wound treatment on those days. The RN stated instead of documenting not administered on the resident's TAR, the RN should have left the TAR blank until the wound care nurse themselves provided the service to ensure provision of care and accurate documentation. The RN verbalized the observation of R17's foam dressings on bilateral heels dated 03/13/2025 did not align with the TAR which reflected treatments were administered to R17's bilateral heels on 03/14/2025 and 03/18/2025. On 03/18/2025 at 10:25 AM, the wound care nurse acknowledged R17's TAR reflected R17's coccyx wound treatments were not administered on 02/21/2025, 02/25/2025, 03/03/2025, 03/10/2025, and 03/17/2025 and wound care was not administered to R17's right and left heel on 02/21/2025, 02/25/2025, and 03/04/2025. The wound care nurse acknowledged there was no documented evidence the wound care nurse had provided the service on the above-mentioned dates because the wound care nurse was under the impression the RN's comments of not-administered wound care nurse to perform was sufficient to convey treatment had been administered by the wound care nurse. The wound care nurse indicated there was no other place in the electronic health record (EHR) to reflect the missed treatments were indeed provided by the wound care nurse. On 03/18/2025 at 10:30 AM, the wound care nurse confirmed wound care for R17's coccyx, left heel and right heel wounds had already been signed off as administered by the wound care nurse on 03/18/2025 when in fact the service had not yet been administered. The wound care nurse explained having the habit of pre-signing all wound care which were scheduled to be performed for the rest of the day. The wound care nurse confirmed the observation of R17's foam dressings on bilateral heels dated 03/13/2025 did not align with the TAR which reflected treatments were administered to R17's bilateral heels on 03/14/2025 and 03/18/2025. Resident 21 (R21) R21 was admitted on [DATE], with diagnoses including metabolic encephalopathy, dementia and history of craniotomy. An admission skin assessment dated [DATE], revealed R21 was admitted with a coccyx DTI measuring 5.0 cm by 4.5 cm, a left heel DTI measuring 1.5 cm by 1.5 cm and a right heel DTI measuring 2.0 cm by 2.0 cm. On 03/18/25 at 10:12 AM, R21 laid in bed appearing weak and lethargic. R21 responded with singular words or nodding head. The wound care nurse and a CNA lifted the resident's blanket which revealed R21's right and left heel each had a beige foam dressing dated 03/13/2025. R21's coccyx wound did not have a foam dressing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 03/04/2025, documented to provide wound care to coccyx pressure ulcer: clean with wound cleanser, pat dry, apply Triad cream and cover with foam dressing daily, change dressing as needed. A physician's order dated 03/04/2025, documented to provide wound care to left heel pressure ulcer: clean with wound cleanser, pat dry, apply Sure prep and cover with foam dressing every Tuesday, Thursday and Saturday, change dressing as needed. A physician's order dated 03/04/2025, documented to provide wound care to right heel pressure ulcer: clean with wound cleanser, pat dry, apply Sure prep and cover with foam dressing every Tuesday, Thursday and Saturday, change dressing as needed. The TAR for March 2025 revealed wound treatments were not administered to R21's coccyx, right heel and left heel pressure ulcers on 03/06/2025, 03/08/2025 and 03/11/2025 Comments for non-administration read, not administered-to be done by wound care nurse. The TAR reflected wound care to R21's bilateral heels were signed off as having been administered on 03/15/2025 and 03/18/2025. On 03/18/2025 at 10:15 AM, the RN acknowledged routinely signing off on R21's wound care as not administered- wound care nurse to perform because the RN expected the wound care nurse to be providing the wound treatment on those days. The RN stated instead of documenting not administered on the resident's TAR, the RN should have left the TAR blank until the wound care nurse themselves provided the service to ensure the provision and documentation of care was accurate. The RN verbalized the observation of R21's foam dressings on bilateral heels dated 03/13/2025 did not align with the TAR which reflected treatments were administered to R21's bilateral heels on 03/15/2025 and 03/18/2025. On 03/18/2025 at 10:25 AM, the wound care nurse acknowledged R21's TAR reflected R21's coccyx wound treatments were not administered on 03/06/2025, 03/08/2025 and 03/11/2025. The wound care nurse acknowledged there was no documented evidence the wound care nurse had provided the service on the above-mentioned dates because the wound care nurse was under the impression the RN's comments of not-administered wound care nurse to perform was sufficient to convey treatment had been administered by the wound care nurse. The wound care nurse indicated there was no other place in the EHR to reflect the missed treatments were indeed provided by the wound care nurse. On 03/18/2025 at 10:30 AM, the wound care nurse confirmed wound care for R21's coccyx, left heel and right heel wounds had already been signed off as administered by the wound care nurse on 03/18/2025 when in fact the service had not yet been administered. The wound care nurse explained having the habit of pre-signing all wound care which were scheduled to be performed for the rest of the day. The wound care nurse confirmed the observation of R21's foam dressings on bilateral heels dated 03/13/2025 did not align with the TAR which reflected treatments were administered to R21's bilateral heels on 03/15/2025 and 03/18/2025. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/19/2025 at 3:19 PM, the Director of Nursing (DON) indicated the RN who was documenting R17's and R21's scheduled wound treatments as not administered to be done by wound care nurse should have left the TAR blank and allow the wound care nurse who would be providing the treatments, to sign on wound care services after the administration of the task and not ahead of time. The DON acknowledged observation of R17 and R21's foam dressings dated 03/13/2025 did not align with documented care in the TAR and went against basic nursing documentation guidelines, and this practice was unacceptable. On 03/20/2025 at 7:56 AM, the wound Nurse Practitioner (NP) indicated expecting nurses to follow treatment orders to encourage proper healing and prevent complications of wounds. The NP indicated expecting wound dressings to be signed and dated for accountability purposes and to ensure care was provided to the wound. The Administration of Medications policy (undated) documented, licensed personnel would appropriately administer prescribed medications and immediately chart the administration in the electronic health record. The Treatment of Pressure Ulcers policy (undated) documented, all treatments require a physician's order. The wound care nurse was responsible for ensuring appropriate treatments and protective measures were in place and implemented. The policy indicated interventions for the care of residents with moderated risk for pressure ulcers may benefit from approaches included air mattress.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40142 Based on observation, interview, record review and document review, the facility failed to ensure the facility's bowel protocol was followed for a resident who was constipated for 1 of 13 sampled residents (Resident 139). The deficient practice placed the resident at risk for bowel complications such as fecal impaction. Findings include: Resident 139 (R139) R139 was admitted on [DATE], with diagnoses including ulcerative colitis and diverticulitis. On 03/20/2025 at 2:12 PM, R139 was seated in wheelchair with family member present. R139 responded slowly to questions using singular words. The family member indicated visiting the resident daily and expressed concern regarding R139 not having a bowel movement (BM) since 03/11/2025. The family member reported R139 had been suffering from stomach issues for [AGE] years and BMs were very irregular, but the family member had a routine which worked for them at home. R139's family member indicated administering a stool softener and a laxative after two days of no BM. If this was not successful, the family member would administer an enema (a liquid inserted into the rectum to stimulate a BM) after four days of no BM and an enema was effective 100 percent of the time. On 03/20/2025 at 2:18 PM, R139's family member indicated no nurse had discussed the bowel protocol with the family member, but the physician presented some options during a visit on 03/16/2025 however, the physician did not mention an enema which led the family member to think an enema was not among the options available. The family member indicated not being aware R139 had a physician's order for an enema which was to be administered on Day 5 of no BM. A nursing progress note dated 03/18/2025, revealed R139's last recorded bowel movement (BM) was on 03/11/2025. R139's abdomen was distended; bowel sounds present on all quadrants. Physician notified, ordered KUB (non-invasive diagnostic tool which uses radiography imaging to visualize the kidneys, ureter, and bladder). On 03/20/2025 at 2:20 PM, R139's family member indicated being aware a KUB was ordered and carried out on 03/18/2025. The family member claimed to have requested a copy of the results from a nurse on the afternoon of 03/19/2025 and was informed results were not yet available. On 03/20/2025 at 2:27 PM, R139's family member pressed on R139's abdomen and described the resident's abdomen as distended and more rigid than usual. The family member pressed on R139's stomach and asked R139 if there was pain or discomfort from being constipated to which R139 responded, Yes. The Bowel Brigade (bowel protocol) policy (undated), documented to administer Milk of Magnesia on Day three of no bowel movement. (continued on next page)

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	295107	A. Building B. Wing	03/20/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R 139's medical record revealed a physician's order dated 03/11/2025, documented to administer Milk of Magnesia 30 cubic centimeters (cc) by mouth in the morning. The medication administration record (MAR) for March 2025, revealed Milk of Magnesia was administered to R139 on 03/13/2025. Result: ineffective. The Bowel Brigade (bowel protocol) policy (undated), documented to administer Dulcolax suppository on Day four of no bowel movement. Review of R 139's medical record revealed a physician's order dated 03/11/2025, documented to administer Dulcolax suppository 10 milligrams (mg) per rectum in the morning on Day four of no bowel movement. The medication administration record (MAR) for March 2025, revealed Milk of Magnesia was administered to R139 on 03/14/2025. Result: ineffective. The Bowel Brigade (bowel protocol) policy (undated), documented to administer Fleet Enema on Day five of no bowel movement. Review of R 139's medical record revealed a physician's order dated 03/11/2025, documented to administer Fleet Enema in the morning on Day five of no bowel movement. The medical record lacked documented evidence Fleet Enema was offered or administered to R139 on 03/16/2025 (day five of no BM) or at any given time until 03/20/2025 (nine days with no BM). On 03/20/2025 at 1:49 PM, the Infection Preventionist (IP) indicated being familiar with the facility's bowel brigade and R139's constipation issues. The IP reviewed R139's medical record and confirmed R139 had orders for Fleet enema but the enema had not been offered or discussed with the family member or administered per facility protocol. The IP indicated no nurse had discussed the bowel brigade with R139's family member or gathered information such the effectiveness of the enema procedure with R139. The IP indicated R139's KUB results were received by the facility at approximately 8:00 AM on 03/19/2025 and a copy of the results should have been provided to the family member upon request on the afternoon of 03/19/2025. On 03/20/25 at 2:37 PM, the Director of Nursing (DON) explained the bowel brigade was entered as a standing order for all residents except when contraindicated. The DON indicated medical record reflected fleet enema was not offered, discussed, refused or administered to R139 on 03/16/2025 and as of 03/20/2025, which was not in accordance with the facility's bowel brigade and physician's orders. The KUB report dated 03/18/2025, revealed R139 had mild increased feces throughout the colon. The Bowel Brigade policy (undated) documented, each resident would receive bowel care per general orders on a routine and consistent basis to ensure adequate bowel evacuation to prevent complications or discomfort which may arise to acute constipation or fecal impaction.

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NAME OF PROVIDER OR SUPPLIER Advanced Health Care of Paradise		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40142 Based on observation, interview, record review and document review, the facility failed to ensure physician's orders to provide one-on-one (1:1) feeding assistance were followed for 1 of 13 sampled residents (Resident 21) and one unsampled resident (Resident 11). The deficient practice placed the residents at risk for significant weight loss and malnutrition. Findings include: Resident 21 (R21) R21 was admitted on [DATE], with diagnoses including metabolic encephalopathy, dementia and history of craniotomy. On 03/19/2025 at 9:18 AM, R21's head of bed was elevated approximately 30 degrees, R21 appeared weak and lethargic and responded with singular words or nodding head. A signage on the wall read 1:1 feeding assistance. Sit resident up in chair during mealtimes. A meal tray was observed on the resident's bedside table and contained a bowl of cream of wheat covered in plastic wrap and an Ensure supplement. The meal ticket read regular pureed diet with thin liquids. There were no staff members observed in the room. A physician's order dated 03/05/2025, documented to provide R21 with 1:1 feeding assistance. The five-day minimum data set (MDS) dated [DATE], revealed R21 was dependent on staff for eating. On 03/19/2025 at 9:25 AM, a Certified Nursing Assistant (CNA1) entered R21's room and stated R21 had refused to eat. CNA1 defined refusal as the resident's failure to respond to the CNA when CNA1 asked R21 if the resident wanted to eat. CNA1 explained having three residents requiring feeding assistance and CNA1 could not transfer R21 from bed to chair by themselves and was too shy to ask for help from other CNAs who were busy as well. The vitals report dated 03/19/2025, revealed R21 consumed 1 percent (%) to 25% of the breakfast meal. On 03/20/2025 at 9:20 AM, R21 laid in bed with eyes closed, head of bed elevated approximately 30 degrees. An untouched breakfast tray was observed on R21's bedside table which contained a bowl of cream of wheat, a bowl of pureed eggs, a cup of apple juice and an Ensure supplement. There were no staff members in the room. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/20/2025 at 9:24 AM, CNA2 indicated being assigned to R21 but CNA2 also had two other residents who required feeding assistance, so CNA2 had asked CNA3 to assist R21 with breakfast. CNA3 indicated having already attempted to offer R21 breakfast but R21 refused to eat. CNA3 defined refusal as the resident not responding to CNA3 when the CNA3 asked R21 if R21 wanted to eat. CNA2 and CNA3 were inside R21's room and confirmed a signage on the wall read 1:1 feeding assistance, sit resident up in chair during mealtimes. CNA2 and CNA3 confirmed the observation R21 laid in bed and not seated on chair and R21 meal tray had been untouched with spoon clean and food bowls still covered with plastic wrap. On 03/20/2025 at 9:28 AM, CNA2 and CNA3 indicated the observation of R21's breakfast service reflected instructions to sit resident up in chair, was not followed and the untouched tray reflected the lack of a proactive attempt to feed the resident's breakfast meal. In addition, CNA3 indicated not informing the nurse regarding R21's refusing breakfast. On 03/20/2025 at 9:30 AM, CNA2 recounted a day last week when CNA2 was assisted by another staff member in transferring R21 to the chair for meal service which resulted in a 50% consumption of the meal because the resident was more alert and participative in the meal task. CNA2 indicated personally observing how the intervention of sitting the resident up had a positive impact on the resident's consumption. On 03/20/2025 at 9:32 AM, the Licensed Practical Nurse (LPN) indicated expecting CNAs to inform the nurse of all refused services which included meals. The LPN indicated being informed of resident refusals, gave nurses the opportunity to make own attempts with providing the service, identifying the resident's reason for refusal so findings could be documented in the resident's electronic health record (EHR) and communicated with the inter-disciplinary team (IDT) particularly the Registered Dietician (RD), the Director of Nursing (DON) and the physician. On 03/20/2025 at 9:40 AM, the Director of Nursing (DON) entered R21's room and confirmed the signage on the wall which read, 1:1 feeding assistance, sit resident up on chair during mealtimes. The DON confirmed the observation of R21 lying in bed instead of sitting on a chair, and the meal tray was untouched with food bowls and juice still covered with plastic wrap and spoon clean. Using a loud voice and clear speech, the DON asked R21 if the resident wanted to eat breakfast. The resident responded to the DON, I'll try. The DON asked R21 if the resident preferred to sit in a chair for breakfast, the resident responded to the DON, yes. On 03/20/25 at 9:50 AM, R21 appeared well-groomed with hair combed while seated on a chair. CNA2 pointed to the resident's tray and stated R21 had fully consumed the cream of wheat, 25 % of pureed egg and 120 milliliters (ml) of the Ensure supplement. CNA2 indicated the resident's consumption would be documented as 75%. On 03/20/2025 at 10:00 AM, the DON indicated the intervention to sit R21 up in a chair during meals was an intervention which was expected to be followed. The DON indicated not knowing whether the intervention was a family request, a therapy recommendation or a physician's order but CNAs who read the signage were expected to follow them. Resident 11 (R11) (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R11 was admitted on [DATE], with diagnoses including unspecified dementia and severe protein calorie malnutrition. On 03/19/2025 at 9:08 AM, R11 laid awake in bed appearing weak and responded with soft voice. A breakfast tray containing scrambled eggs and pureed bread was observed on a table in front of the resident. A signage on the wall read, Provide 1:1 feeding assistance. There were no staff members in the room. On 03/19/2025 at 9:10 AM, CNA1 entered R11's room and confirmed there was a signage with instructions to provide the resident with 1:1 feeding assistance. The CNA confirmed R11 had a meal tray in front with no staff present in the room. A physician's progress note dated 03/17/2025, documented R11 was drowsy, slept a lot and was not eating much, put on 1:1 feed. A physician's order dated 03/17/2025, documented to provide R11 with 1:1 feeding assistance. The vital report dated 03/19/2025, revealed R11 consumed 1% to 25% of the breakfast meal. On 03/20/2025 at 10:00 AM, the DON explained R11 was evaluated by a provider on 03/17/2025 who ordered to put R11 on 1:1 feeding assistance due to increased fatigue and poor meal intakes. The DON indicated the morning observation of R11's meal service on 03/19/2025 reflected the physician's order to provide the resident with feeding assistance was not followed and should have been. On 03/20/2025 at 10:05 AM, the DON indicated expecting 1) CNAs to practice teamwork and seek assistance from one another when there were multiple resident requiring assistance during meals, 2) proactive attempts must be made to be successful with meal service, and 3) resident refusals must immediately be reported to the nurse to give the nurse the opportunity to make own attempts, identify reasons for refusal, document event in the EHR and communicate with the IDT. On 03/20/2025 at 10:19 AM, the RD confirmed R21 and R11 both had orders for 1:1 feeding assistance because both residents had issues with alertness, weakness and poor consumption. The RD explained being sat up in a chair was an intervention in R21's case because the resident was often drowsy and became more alert and participative with meals when seated on chair. According to the RD, R21 had a two-pound weight loss which did not rise to a level of significant weight loss but had the potential to result in significant weight loss if interventions were not being implemented. The RD indicated R11 was also in the RD's focus list due to poor intakes related to weakness, impaired cognition and debility. The RD indicated not being informed R21 and R11 were not being consistently provided 1:1 feeding assistance as ordered, prior to today. On 03/20/2025 in the afternoon, the RD and Dietary Manager indicated residents were no longer transported to the main dining area for meals unlike before. The RD and dietary manager indicated expressing residents such as R21 and R11 would benefit from being transported to the dining room where the residents had a higher chance of being awake, alert and participative with meal service. According to the RD and dietary manager, transporting residents to the dining room would also enable CNAs to assist multiple residents at the same time. The RD and dietary manager indicated not hearing back from leadership regarding transporting dependent residents to the dining area for meals. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Activities of Daily Living (ADL) policy (undated) documented, a resident unable to carry out ADL would receive necessary services to maintain good nutrition. For these residents, care plan goals may not be stated in terms of what the resident was able to achieve but in terms of the outcome of care and/or services provided.

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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** 40142 Based on observation, interview, record review, and document review, the facility failed to ensure a justification for a midline (a type of peripheral intravenous catheter inserted into a large vein in the upper arm for longer therapy) was obtained and midline dressing changes were administered as ordered for 2 of 13 sampled residents (Residents 17 and 21). The deficient practice placed the residents at risk for midline complications such as occlusion and infection. Findings include: Resident 17 (R17) R17 was admitted on [DATE], with diagnoses including hemiplegia hemiparesis following cerebral infarction and sepsis. A hospital discharge summary dated 02/17/2025, revealed R17 was treated for sepsis and had completed intravenous (IV) antibiotic therapy on 02/13/2025. R17's discharge medications did not include any IV medications. An admission note dated 02/17/2025, documented R17 was admitted with a right upper arm midline. The medical record lacked documented evidence a clarification order was obtained from a physician on whether R17's midline was to be maintained or discontinued. On 03/18/2025 at 9:32 AM, R17 laid awake and alert in bed. A single lumen midline was observed on R17's right upper arm with dressing dated 03/10/2025 with ends coming loose. A Registered Nurse (RN) confirmed the observation and indicated midline dressing changes were done weekly on Sundays. The RN indicated R17's the midline had not been used in the facility. A physician's order dated 02/18/2025, documented to change midline dressing weekly. Clean with alcohol stick or chloraprep at insertion site, air dry, apply skin prep to peri-cath area and air dry. Apply bio-patch to insertion site. Cover with transparent dressing. The Medication Administration Record (MAR) for March 2025, documented a nurse had performed dressing change to R17's midline on 03/16/2025. On 03/18/2025 at 12:25 PM, the RN reviewed R17's medical record and indicated R17's midline was last used in the hospital, but there was no evidence a nurse-physician discussion had occurred regarding whether R17's midline was to be maintained or removed. The RN confirmed another nurse signed for R17's midline dressing change in the MAR on 03/16/2025 which did not align with actual observation of R17's midline dressing which was dated 03/10/2025. On 03/18/2025 at 12:29 PM, the Infection Preventionist (IP) confirmed R17 was admitted with a right upper arm midline with no evidence of a nurse-physician discussion on whether the line should be maintained or removed. The IP could not speak to why the nurse assigned to R17 on 03/16/2025 signed for the dressing change administration on the MAR when the actual dressing was labeled 03/10/2025. (continued on next page)

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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	Resident 21 (R21) R21 was admitted on [DATE], with diagnoses including metabolic encephalopathy, dementia and history of craniotomy. On 03/18/25 at 10:12 AM, R21 laid in bed appearing weak and lethargic. R21 responded with singular words or nodding head. The Clinical Nurse Manager (CNM) extended R21's right arm which revealed a double lumen midline with dressing dated 03/09/2025, with ends coming loose. The CNM explained R21's midline was being used for IV banana bag (electrolytes) administration. On 03/18/2025 at 10:15 AM, the CNM reviewed R21's MAR and confirmed there was documented care for R21's midline on 03/16/2025, which did not align with the actual observation of the midline dressing dated 03/09/2025. The CNM described R21's midline dressing as not appearing new and edges were coming loose. The CNM corroborated the RN's explanation of the facility protocol where midline dressing changes were performed every Sunday and as needed. On 03/19/2025 at 3:01 PM, the Director of Nursing (DON) explained when a resident was admitted with a midline, the admission nurse or any nurse assigned to the resident should obtain clarification orders from the physician on whether the line would be maintained or discontinued. The DON explained IV dressing changes were performed weekly by Sunday night shift nurses or as needed. On 03/19/2025 at 3:04 PM, the DON indicated being made aware actual observations of R17's and R21's midline dressing dates did not align with documented care in the residents' MAR, which went against basic documentation guidelines and was unacceptable. The DON verbalized consequences to not performing midline care placed residents at risk for an infection. The DON indicated the facility did not have a policy specific for midlines, but the Peripherally Inserted Central Catheter (PICC) Dressing Change policy was applicable for midlines. In addition, the DON indicated the facility followed the [NAME] standard or practice. The PICC Dressing Change policy (undated), documented dressing must be labeled with date, time and initials of person performing the task. The Lippincott Nursing Procedure (ninth edition) documented; IV maintenance required transparent dressings were changed every five to seven days.

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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** 29141 Based on observation, interview, and record review, the facility failed to ensure infection control measures were implemented according to the plan of care for a resident with indwelling urinary catheter and intravenous midline catheter (Resident 26). The deficient practice had the potential to increase the risk of healthcare-associated infections, compromise the resident's safety, and placed other residents and staff at risk by undermining the facility's overall infection prevention protocols. Findings include: Resident 26 (R26) R26 was admitted on [DATE] with diagnoses including septic shock, respiratory failure with hypoxia, pneumonia, and lung cancer. A physician's order dated 03/05/2025, documented to place R26 on enhanced barrier precautions due to the indwelling catheter and right arm intravenous midline catheter. On 03/18/25 at 10:07 AM, a therapist entered the room to transport R26 to the physical therapy department. The therapist assisted the resident for the transfer from the bed to a wheelchair. The therapist emptied the urinary bag connected to an indwelling catheter, then placed dignity cover over the urinary bag. The therapist used glove to perform the procedure but did not wear a gown. On 03/18/2025 at 10:10 AM, a registered Nurse confirmed the observation and indicated the therapist should have used the required personal protective equipment (PPE) when provided urinary care to R26. The RN explained gloves and gown should have been used to handle the urinary bag. On 03/20/2025 at 11:00 AM, the Infection Preventionist Nurse explained enhanced barrier precautions included the use of glove and gown and should have been adopted during the indwelling catheter care. Care plan dated 02/17/2025 documented, staff to don gloves and gown prior to beginning high-contact Patient care activities including assisting with toileting. The facility undated policy titled Enhanced Barrier Precautions version E1009, revealed the facility would adopt guidelines provided by the Centers for Disease Control and Prevention (CDC) regarding prevention of spread of multi-drug-resistant organism with the use of enhanced barrier precautions. The policy indicated these precautions would be applied for resident with certain conditions including indwelling medical devices such as urinary catheter and intravenous lines.