STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295110	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Valley Health and Wellness Suites	2965 Wigwam Parkway Henderson, NV 89074

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39418 Based on observation, interview, record review and document review, the facility failed to ensure an initial Preadmission Screening and Resident Review (PASRR) was completed prior to a resident's admission for 1 of 18 sampled residents (Resident 2). The deficient practice had a potential for a newly admitted resident not to receive the necessary screening for the appropriateness to be admitted to a skilled nursing facility. Findings include: Resident 2 (R2) was admitted on [DATE], with diagnoses including depression and anxiety disorder. On 12/17/2024 at 10:46 AM, R2 was observed lying in low bed and remained quiet when being interviewed. There was a one to one (1:1) staff at the bedside and stated the resident could get very anxious when being left alone. The 1:1 staff member indicated the resident does not have any history of falls but wonders around the hallways and gets very anxious. Review of R2's progress notes from admission to current revealed the resident at most times would require 1:1 monitoring due to the severity of the anxiety behavior. R2's Psychiatry Progress Notes dated 05/09/2024 and 06/11/2024, documented under Assessment: 1. Generalized anxiety disorder 2. Unspecified depressive disorder 3. Neurocognitive disorder secondary to dementia Review of R2's hospital records prior to admission to the facility revealed: - Psychiatric Progress Notes dated 05/02/2024, documented diagnoses of anxiety disorder, depression, panic disorder and insomnia. (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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Cardiology Progress Notes dated 05/08/2024, documented under history of present illness: the patient uses 3 liters of oxygen per nasal cannula at home. At this time, the patient was placed on high flow Oxygen and was treated with breathing treatments. Subsequently, the patient was weaned off and place back on 3 liters nasal cannula; however, due to panic attacks the patient was placed back on high flow. The patient was assigned to 1:1 care and medication for anti-anxiety. - Pulmonary Progress Notes dated 05/08/2024, documented under history of present illness: the patient was originally able to wean down to 3 liters nasal cannula, however, began to have panic attacks which required to be placed back on high flow due to desaturation (low blood Oxygen). Due to patient's psychiatric history and requiring psychiatric medications, psychiatry was consulted due to ongoing panic attacks. - Discharge Summary from the hospital dated 05/09/2024, revealed the resident had psychiatric behaviors during the stay at the facility requiring psychiatric medication management and 1:1 monitoring. Discharge diagnoses included depression and anxiety. R2's medical record lacked documented evidence of an admission PASRR. A Level of Care (LOC - assessment of an individual's needs to determine the appropriate level of care within a nursing facility) was present and was dated 07/08/2022. On 12/19/2024 at 12:43 PM, the Director of Admissions acknowledged the lack of a PASRR assessment in R2's medical record. The Director indicated any PASRR older than 2013 was unable to be retrieved due to a system upgrade. The Director performed a PASRR look up for the R2 and revealed the last completed assessment was 2008. The Director confirmed a LOC assessment does not screen for any mental illness (MI) or intellectual disability (ID). On 12/19/2024 at 1:43 PM, the Director of Social Services confirmed the resident should have had a PASRR level 1 screening which evaluated any related diagnosis from the previous hospitalization . The Director acknowledged the resident had behavioral issues during the stay at the hospital and a newer PASRR could have identified any newer MI diagnosis and could have changed the determination or recommendations. The Director indicated based on the demonstration of behaviors and psychiatric evaluation R2's status could have triggered the facility to revisit the resident's current needs or LOC or even a PASRR level 2. The facility policy titled PASRR Documentation Policy revised 06/09/2023, documented all applicants to a Medicaid-certified nursing facility are evaluated for mental illness or intellectual disability, prior to admission. The individual seeking admission receives a PASRR level 1 screen for ID and MI before or upon admission.

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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 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** 40131 Based on observation, interview, record review, and document review, the facility failed to ensure incontinent care was provided to a dependent resident who was soiled, wet, and had requested assistance for 1 of 30 sampled residents (Resident 229). This deficient practice had the potential to result in skin breakdown, infections, discomfort, and a diminished quality of life. Findings include: Resident 229 (R229) was admitted on [DATE], with diagnoses including overactive bladder, cramp and spasm, and pain. On 12/17/2024 at 9:33 AM, R229 was verbally alert and oriented but totally dependent on assistance for care due to a spinal injury. A suprapubic catheter was observed in place, draining yellow urine, with the urinary catheter bag lowered and placed in a basin. R229 verbalized although had the catheter, had intermittently been able to urinate through the urethra. R229 reported an incident had occurred on December 12, 2024, having urinated in bed twice due to a bladder spasm and pressed the call light for help, but no assistance arrived for several hours, and staff were observed walking past the room and ignoring repeated pleas for help. R229 called the facility operator at approximately 11:00 PM to report being wet since 8:00 PM and was promised a staff member would respond, but no one came. When staff arrived, the staff claimed to have previously entered the room but chose not to wake the resident. R229's frustration led to a verbal dispute, and the staff member left without offering help, telling the resident to go ahead, call 911. R229 called 911, and Metro police arrived on the scene, and an investigation was conducted. R229's medical record lacked documented evidence the incontinent care was provided on 12/12/2024 and 12/13/2024. On 12/18/2024 at 2:00 PM, the interim Director of Nursing (DON) indicated being aware of R229's multiple concerns, which had been investigated by the Administrator. The DON explained the process was to answer the call light within 5-10 minutes to check the status of the resident. The DON confirmed staff were expected to provide the care requested by the resident. The DON confirmed the lack of documented evidence showing incontinent care had been provided on 12/12/2024 and 12/13/2024, following R229's admission. The DON indicated staff were expected to provide incontinent care when requested and not ignore the request. On 12/20/2024 at 11:20 AM, a Licensed Practical Nurse (LPN) indicated being assigned to R229 during admission on December 12, 2024. The LPN reported R229 arrived at approximately 4:30 PM from out of state. The LPN explained initial care preparation included room setup and addressing unique needs like a breathing machine, sling, and specific medications. The LPN indicated R229 was upset as the initial care fell short of expectations. The LPN was aware R229 was left wet and soiled for long periods as reported, leading to a call to 911. The LPN indicated the Certified Nursing Assistant (CNA) was expected to clean R229 and to document in the point of care after providing care and emphasized if it was not documented, it was considered not done. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/20/24 at 12:03 PM, a day shift CNA who was assigned to R229 on the day of admission indicated R229 was admitted approximately after 4 PM, in time for meal service and end-of-shift rounds. The CNA explained the resident was dissatisfied due to initial miscommunication about equipment and preferences which led to confusion. The dissatisfaction led to the resident being resistant when obtaining vital signs and weights. The CNA indicated miscommunication contributed to the resident's dissatisfaction. Bowel and bladder care was not provided during the CNA's shift and left for completion at the end of shift at 7:30 PM. The CNA confirmed incontinent care was not provided during the day shift and expected the night CNA would provide the care. The CNA indicated the following day R229 complained was left wet and soiled and had an altercation with the night shift agency CNA. On 12/20/2024 at 12:34 PM, the Administrator confirmed R229's concerns were investigated and addressed. The Administrator indicated delays in response to call lights exacerbating the resident's perception of being ignored. The Administrator was unaware R229 had called 911 after reporting unmet care needs. The Administrator indicated the delays in providing care, especially incontinent care, were unacceptable. The Administrator indicated no intentional neglect was observed, but communication and prioritization were inadequate. On 12/20/2024 at 2:38 PM, the Minimum Data Set (MDS) Director confirmed the Point of Care Activities of Daily Living (ADL) report dated 12/12/2024 and 12/13/2024, which lacked documented evidence incontinent care was provided. A facility policy titled Activities of Daily Living, Optimal Function revised 05/2023, documented tasks related to personal care, including dressing, grooming, oral hygiene, transfer, bed mobility, and communication systems. The facility staff develop and implement interventions in accordance with the resident's assessed needs, goals for care, preferences, and recognized standard of practice that address the identified limitations in ability to perform ADLs. Complaint NV00072983

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	295110	A. Building B. Wing	12/20/2024

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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** 40131 Based on observation, interview, record review, and document review, the facility failed to ensure: nutritional assessments were completed and interventions were implemented when a significant weight change occurred for 1 of 18 sampled residents (Resident 14), and residents' weights were obtained as scheduled for 3 of 18 sampled residents (Residents 14, 16 and 39). The deficient practices could have had the potential to delay interventions, increase the risk of health complications, and negatively impact residents' overall health and well-being. Findings include: 1) Resident 14 (R14) was admitted on [DATE] and readmitted on [DATE], with diagnoses including dementia, dysphagia (difficulty swallowing) and anxiety disorder. The Observation Details List dated 05/09/2024, documented R14 was at risk for malnutrition. R14's Weight Summary documented the following: - 12/05/2024: 131 pounds (lbs.), Routine body mass index (BMI): 26.46 (Height: 4'7) - 11/01/2024: 132 lbs., Routine BMI: 26.66 - 10/08/2024: 130.6 lbs., Routine BMI: 26.38 - 09/01/2024: 130 lbs., Routine BMI: 26.25 - 08/01/2024: 129.3 lbs., Routine BMI: 26.11) - July 2024: (No weights obtained/documented) - 06/30/2024: 139 lbs., Routine BMI: 28.07 - 06/13/2024: 143 lbs., Admission BMI: 28.88 - 05/21/2024: 142 lbs., Routine BMI: 28.68 - 05/07/2024: 160 lbs., Admission BMI: 32.31 R14's medical records lacked documented evidence a nutritional assessment was completed in August when a weight change was identified, and no interventions were implemented. (continued on next page)

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	295110	A. Building B. Wing	12/20/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/18/2024, at 10:02 AM, the Director of Dietary Services (DDS) explained R14 was admitted at 160 lbs. and experienced significant weight loss within a month. The DSS confirmed R14 was on a regular diet with double portions, with a goal to prevent further weight loss. The DSS indicated R14's BMI remained stable. The DDS indicated R14 ate well, followed a no-added-salt diet, but frequently refused breakfast. The DDS explained factors influencing weight changes included hydration levels, errors in weight records, and health conditions such as heart disease or fluid shift. The DDS indicated further nutritional assessments were necessary to establish health trends following significant weight changes. On 12/18/2024 at 11:21 AM, the Registered Dietitian (RD) indicated R14's weight loss in August was desirable and R14's BMI was stable. The RD explained R14 was hospitalized on [DATE] and readmitted on [DATE]. The RD explained a nutritional assessment was warranted when there were significant weight changes and should have been monitored to enable interventions to be implemented. The RD indicated the Director of Nursing (DON) was responsible for weight monitoring. On 12/20/2024 at 12:30 AM, the interim DON explained weight records were documented in the electronic health record, and monthly weights should have been monitored. The DON indicated a nutritional assessment was warranted when significant weight changes occurred. The DON confirmed there was no nutritional assessment completed when R14 experienced a significant weight loss in August. R14's medical records lacked documented evidence the resident was weighed in July, and the resident was reweighed after weight loss was identified in August. On 12/19/2024, at 8:51 AM, R14 was observed at the bedside, appearing agitated and confused. A breakfast tray was set up at the bedside, containing scrambled eggs, bacon, pancakes, oatmeal, and a juice cup with a straw. R14 refused the meal. A Certified Nursing Assistant reported offering an alternative meal, which was also refused. A Care Plan dated 05/07/2024, documented R14 was at risk for malnutrition and dehydration related to COVID-19, dementia and gastroesophageal reflux disease (GERD). The interventions included to monitor the resident's weight. The goal was to maintain nutritional status as evidenced by no significant weight change. On 12/18/2024, at 10:02 AM, the Director of Dietary Services (DDS) explained the weight monitoring protocol involved obtaining weights upon admission and monthly thereafter unless concerns arose, and re-weighs were performed when weight changes were identified. The DSS indicated R14 was admitted at 160 lbs. and experienced significant weight loss within a month. No weights were documented for July, despite discharge and readmission in June. The DSS confirmed R14 was on a regular diet with double portions, consuming 75-100% of meals to prevent further weight loss. The DSS indicated R14's BMI remained stable. The DDS indicated a Registered Dietitian (RD) reviewed nutritional needs and monitored weight changes. On 12/18/2024 at 11:21 AM, the RD confirmed weights were not retaken after weight changes were identified, and a monthly weight was missed in July. The RD indicated the weights should have been obtained upon the resident's admission or readmission and monthly thereafter and retaken when there were weight changes and should have been monitored to enable interventions to be implemented to prevent further weight loss. The RD indicated the Director of Nursing (DON) was responsible for weight monitoring. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/20/2024 at 12:30 AM, the interim DON indicated weight measurements were taken upon admission, readmission, daily for the first three days thereafter, and then monthly. The resident's weights were taken by the CNA and recorded by the DON on the electronic health record, and monthly weights should have been monitored. The DON confirmed the weight was missed in July, and R14's weight was not retaken when weight loss was identified. The DON indicated the weights should have been obtained and documented. 2.) Resident 16 (R16) was admitted on [DATE], with diagnoses including dysphagia, anemia and vitamin deficiency. R16's Weight Summary documented no weights were recorded for July and November 2024. On 12/18/2024 11:11 AM, the RD confirmed there had been no documentation indicating R16's weights were obtained in July and November. The RD explained it was the DON's responsibility to ensure weights were obtained as scheduled and documented in the resident's electronic record. On 12/20/2024 at 2:33 PM, the DON confirmed there was no documented evidence R16's weight was obtained in July and November. The DON stated R16's weight should have been obtained and documented electronically as scheduled or as directed per policy. 37718 Resident 39 (R39) was admitted on [DATE] with diagnoses including stroke, trouble swallowing, diabetes, and malnutrition. A Physician Order dated 06/25/2024 indicated Monthly Weights, Once A Day on the 1st of the Month. R39's record indicated the following weights: 06/27/2024 367 lbs. 09/01/2024 410.5 lbs. 10/08/2024 411.2 lbs. 12/04/2024 159.4 lbs. 12/11/2024 151.8 lbs. There was no weight documented for the month of November A Registered Dietician note dated 12/09/2024 indicated Requested reweigh from nursing. (continued on next page)

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	295110	A. Building B. Wing	12/20/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/18/2024 at 11:12 AM, the Registered Dietician (RD) verbalized R39 had been grossly overweight on admission. The RD verbalized since the resident was on hospice, the diet was centered on the resident's desires and tastes, and extra sweets could be given without restriction. The RD verbalized on 12/04/2024 there was a major weight change as evidenced by a recorded weight of 151.8 lbs. which was a 63.19% weight loss. The RD verbalized the large amount of the loss warranted immediate re-weighing to check the accuracy of the weight. The RD verbalized this had not done immediately. The RD reported requesting nursing to re-weight R39, which was done on 12/11/2024 and confirmed the weight loss. On 12/18/2024 at 11:57 AM, the interim Director of Nurses (DON) reviewed R39's weight record and verbalized R39's weight was not taken for the month of November but should have been. The policy and procedure titled Weighing the Resident revised on 05/05/2023 indicated resident weights would be recorded at least monthly. The policy and procedure indicated if the month-to-month weight shows more than a five percent gain or loss, the resident was reweighed in the presence of licensed personnel.

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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** 39418 Based on observation, interview, record review and document review, the facility failed to ensure a peripherally inserted central catheter (PICC) line dressing care and maintenance was completed for 1 of 18 sampled residents (Resident 35). The deficient practice had a potential for a resident to develop an infection from poor maintenance of an intravenous site. Findings include: Resident 35 (R35) was admitted on [DATE] and a recent re-admission on 12/13/2024, with diagnoses including hemiplegia and cellulitis of the abdominal wall. On 12/17/1024 at 11:04 AM, R35 was observed with a right upper arm PICC line, the dressing on the PICC line was dated 11/21/2024. R35's family member indicated the resident had no intravenous antibiotics or fluids given for more than a month. On 12/17/24 at 2:24 PM, a Registered Nurse (RN) indicated a PICC line dressing should be changed every week by nursing. The RN confirmed the date on R35's PICC line and acknowledged the dressing should have been changed. The RN indicated all care, and maintenance should be documented under the medication and administration record (MAR). R35's physicians order dated 09/07/2024, documented under Other Tests: PICC line placement, Frequency: Once - One Time. The physician's order lacked documented evidence of any orders for the care and maintenance of the PICC line. On 12/19/2024 at 1:43 PM, the Interim Director of Nursing (DON) verbalized the facility expectation was to change a PICC line dressing every week. PICC line dressing was placed as a physician's order as part of the care and maintenance of the line together with saline flushes. The orders were then signed off on the MAR when completed. The Interim DON confirmed the missing orders from R35's medical record and verbalized the orders could have been missed the due to the resident's recent re-admission on 12/12/13/2024. The facility policy tiled PICC Line revised 05/05/2023, documented Licensed Nurses may perform the following procedures with the PICC. 1. Assessing/Dressing Care of a PICC line. Procedure Reference: Lippincott Nursing Procedure 9th. Edition. Label the dressing with the date you performed the procedure or the date the dressing is next due to be changed as directed by your facility.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39418 Based on interview, record review and document review, the facility failed to ensure dialysis communication and post treatment assessments were completed for 2 of 18 sampled residents (Resident 5 and 8). The deficient practice had a potential for residents not to have good communication with dialysis provider impairing continuity of care and not to be assessed post dialysis treatment for adverse reactions. Findings include: 1.) Resident 5 (R5) was admitted on [DATE], with diagnoses including end stage renal disease and generalized anxiety. R5's medical record documented Dialysis Tuesday, Thursday and Saturday at 5:10 AM. A Review of the completed Hemodialysis Communication Record from admission to current, revealed the resident attended dialysis treatment 24 times The communication record revealed the following: On 8 days there was a completed record. There were 8 days where the record was missing. There were 6 days where the record was missing return vital signs and/or dialysis site. There were two days where the resident refused dialysis treatment. 2.) Resident 8 (R8) was admitted on [DATE], with diagnoses including end stage renal disease and heart failure. R8's medical record documented Dialysis: Tuesday, Thursday and Saturday at 3:10 PM. Review of the completed Hemodialysis Communication Record from November to current, revealed the resident attended dialysis treatment on 20 days. The record revealed there were 13 days missing the communication record. There were 6 days which were missing return vital signs and/or observation of the dialysis site and one day which was missing information from the dialysis center. On 12/18/2024 at 1:02 PM, the interim Director of Nursing (DON) indicated dialysis residents should have a communication record on file for every dialysis treatment. Reviewed the scanned dated communication records with the interim DON and agreed the records were not complete. The interim DON acknowledged all components of the communication record should be completed as well. The Interim DON agreed the importance of checking vital signs and dialysis access was to ensure the resident was not experiencing any latent effects of dialysis treatments and ensuring no bleeding at the access sites. The facility policy titled Shunt Care - Arteriovenous (AV) revised 05/05/2023, documented Post Dialysis Care: Make sure vital signs upon return from dialysis, check access site upon return from dialysis.

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37718 Based on observation, interview, and record review, the facility failed to obtain informed consents, monitor behaviors, and document non-pharmacological interventions for the use of psychoactive medications, for 2 of 18 sampled residents (Residents 46 and 38). The deficient practices had the potential to cause residents to use an unnecessary medication with possible adverse effects. Findings include: 1.) Resident 46 (R46) was admitted on [DATE] with diagnoses including schizoaffective disorder, insomnia, and depression. A Physician Order dated 09/17/2024 indicated to take Zoloft (an anti-depressant medication) 25 milligrams (mg) once daily for depression. A Psychiatric Note dated 12/12/2024 indicated the patient had been taking Zoloft 25 mg by mouth daily for depression. The record lacked evidence of a physician order to monitor behavior or side effects for Zoloft; ongoing monitoring for behavior or side effects of Zoloft; and an informed consent for the use of Zoloft had been obtained from R46 prior to use of the Zoloft. On 12/20/2024 at 11:05 AM, the interim Director of Nursing (DON), verbalized informed consent should have been obtained prior to the resident starting the Zoloft on 09/17/2024. The DON verbalized not knowing why the consent had not been obtained prior to starting the medication. On 12/20/2024, in the afternoon, the DON reviewed R46's record and verbalized the facility practice for use of psychoactive medications was to first obtain a physician order to monitor for specific behaviors and for side-effects related to the use of the medication, and then to document ongoing monitor done by licensed nurses. The DON verbalized these elements had not been implemented for R46 and the facility had not followed their process. 40131 2.) Resident 38 (R38) was admitted on [DATE], with diagnoses including psychotic disorder with delusions, anxiety disorder and schizophrenia. A Physician Order dated 07/04/2024, documented to administer Hydroxine Hydrochloride (HCL) 25 milligram (mg) three times a day for anxiety disorder. A Physician Order dated 06/25/2024, documented to administer Seroquel 50 mg daily for schizophrenia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295110	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Valley Health and Wellness Suites	2965 Wigwam Parkway Henderson, NV 89074

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician order dated 11/04/2024, documented to administer Trazodone tab 100 mg at bedtime for insomnia. There was no consent was obtained and no monitoring. The Medication Administration Record documented the psychoactive medications were administered. The Psychoactive Medication Therapy for Hydroxyzine to treat an anxiety disorder, Seroquel for schizophrenia, and Trazodone for insomnia revealed informed consents were obtained verbally via telephone were undated and unwitnessed. On 12/19/2024 at 2:14 PM, the DON explained the facility would continue medications initiated in the hospital, obtain a psychiatric consultation within 24-48 hours following admission, and obtain verbal consents while providing education on the medication's purpose. The DON explained the verbal consents required documentation and signatures from two licensed nurses as witnesses for validity. The DON indicated R38 had a guardian, and verbal consent for multiple psychotropic medications had been granted by phone. The DON verified the verbal informed consents for Hydroxyzine, Seroquel, and Trazodone were not dated and lacked witness signatures and monitoring the effectiveness of the medication was not completed The facility policy titled Medication Management - Psychotropic Drugs dated 04/17/2024 required obtaining physician orders for immediate care and a consent form for each prescribed psychotropic medication. Documentation included whether the intended or actual benefits were understood by the resident. Telephone consents were acceptable if the required information was discussed with the resident or legal representative and documented in the chart, with signatures from two witnesses required. The policy included monitoring and documenting the resident's response to psychotropic medication for efficacy and adverse consequences, including observed symptoms, behaviors, side effects, progress toward therapeutic goals, adverse outcomes, and the effectiveness of non-pharmacological approaches.