STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29E037	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Pines Nursing and Rehab Center	2860 E. Cheyenne Avenue North Las Vegas, NV 89030

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40142 Based on interview, record review and document review, the facility failed to ensure the facility followed through on a resident's request regarding personal mail for 1 of 38 sampled residents (Resident 176). The deficient practice had the potential to negatively impact the resident's well-being. Resident 176 (R176) R176 was admitted on [DATE], with diagnoses including idiopathic neuropathy, depression and generalized anxiety disorder. On 11/05/2024 at 11:13 AM, R176 appeared neat, well-groomed with pleasant demeanor while seated inside the resident's room in the semi-secured unit. R176 indicated living in a church-based homeless shelter prior to being admitted to the facility in May 2024. R176 reported having requested the social worker multiple times to have R176's personal mail picked up from the shelter as the resident was expecting some checks, bills and letters which were important to the resident. R176 indicated not hearing back from the social worker and expressed worry regarding several months' worth of personal mail getting discarded. A psychotherapy assessment dated [DATE], revealed R176 was homeless prior to being admitted in May 2024. On 11/06/2024 at 1:07 PM, the Social Services Director (SSD) confirmed the SSD had spoken with R176 on multiple occasions and R176 had requested the SSD to assist the resident to pick up personal mail from the homeless shelter. The SSD explained the facility had two vans which were used to transport residents to appointments. According to the SSD the vans were available on Fridays, but the church office was only open on Tuesdays and Thursdays. The SSD provided an electronic mail (e-mail) correspondence between the SSD and a representative from the shelter. The e-mail correspondence dated 10/14/2024, documented the SSD had reached out to the shelter regarding R176's personal mail. A representative from the shelter responded to the SSD within the day and informed the SSD R176's mail could be picked up anytime during normal operating hours on Tuesdays or Thursdays. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/06/2024 at 1:15 PM, the SSD confirmed not communicating R176's request to pick up personal mail with any member of the inter-disciplinary team (IDT) which included facility leadership. The SSD verbalized assuming R176's mail could not be picked up because the vans were busy during the shelter's normal operating hours. The SSD confirmed not updating R176 regarding the status of personal mail since 10/14/2024. On 11/06/2024 at 1:28 PM, the Administrator indicated R176's request to pick up mail from the homeless shelter was a reasonable request which could have been accommodated sooner had the SSD communicated the request with the IDT. The Administrator stated several months' worth of personal mail was of high importance to any resident and the SSD should have sought the assistance of leadership to arrange for the pickup of R176's mail sooner. The Resident's rights policy (undated), documented the resident had the right to make choices regarding personal affairs, be treated with respect and courtesy, receive unopened mail, to complain about care or treatment and receive prompt response to resolve the complaint.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 37718 Based on interview, employee file review, and document review, the facility failed to ensure verification of a professional license was conducted in accordance with the abuse prevention policy for 1 of 10 sampled employee files (Employee 9). The failure resulted in Employee 9 (E9) working as a Registered Nurse (RN) in the care of residents for over six months using another person's RN license. An unqualified person practicing as an RN could result in an adverse health outcome to residents. Findings: The policy and procedure titled Compliance with Reporting Allegations of Abuse/Neglect/Exploitation, revised 04/01/2024, indicated the facility would implement procedures for screening potential employees. Background and credential checks would be conducted for each potential employee and documented proof the screening occurred would be maintained. The policy indicated the facility would verify credentials such as licenses prior to an employee beginning work. On 11/08/2024, in the morning, the Payroll/Staffing Coordinator verbalized each RN must possess a valid state license in order to be employed as an RN at the facility. On 11/08/2024, E9's file was reviewed with the HR Administrative Assistant. E9 was hired as an RN on 12/26/2023. Employee screening was performed on 12/26/2023. The background check included documentation of E9's social security number and a copy of the driver's license. The file indicated E9 was permanently hired as an RN on 01/11/2024 by the HR Administrative Assistant. The file indicated E9 was terminated from employment on 07/08/2024. On 11/08/2024, in the morning, the HR Administrative Assistant verbalized E9 had furnished the facility with an RN license number. When the number was checked it indicated the license holder had a different middle and last name than E9. The HR Administrative Assistant revealed E9's name matched only the first of the name of the RN license holder provided. The HR Administrative Assistant verbalized E9 had explained this was because they were in the process of getting a divorce and the name on the license was being changed but this name change had not been completed. The HR Administrative Assistant revealed the status of E9's name change had not been verified with the Board of Registered Nursing. The HR Administrative Assistant revealed the information should have been verified. On 11/08/24 at 1:12 PM, the HR Director verbalized the facility process was to check two forms of identification (ID) for each applicant. The ID must match the professional license. The HR Director revealed E9 had worked as an RN caring for residents in the facility. The HR Director verbalized RN duties included performing health assessments and administering medications. The HR Director verbalized impersonating an RN was dangerous and was considered a crime. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/08/24 at 1:37 PM the Administrator verbalized the facility failed to ensure E9's social security number and driver's license matched the name of the RN license number provided. The facility had employed E9 as an RN despite not having the required ID and license match. The Administrator verbalized the facility had repeatedly asked E9 to furnish updated ID to reflect an alleged name change without result. E9 then had failed to show up for work and was terminated. The Administrator verbalized after terminating E9, the Administrator had been contacted by a representative from the Board of Nursing and had been informed E9 had never been licensed as an RN and had supplied the facility with the license number for a different RN. On 11/08/2024, in the afternoon, the Administrator further verbalized the facility should have waited until the ID matched the RN license before employing E9. The Administrator revealed employing a person pretending to be an RN could result in harm to residents under their care. The Administrator stated there had been no known adverse incidents involving E9, however all of the residents had been placed at risk for the duration of E9's employment of over six months. Complaint 72554

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50289 Based on observation, interview, record review, and document review, the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) level two referral was completed for 3 of 38 sampled residents (Residents #39, 50, & 82). The deficient practice had the potential to deprive the residents of concern and other residents of necessary behavioral health services. Findings include: Resident 39 (R39) R39 was readmitted on [DATE], with diagnoses including schizoaffective disorder, vascular dementia with behavioral disturbance, and anxiety disorder. On 11/05/2024 in the afternoon, R39 stated had been at the facility for over a year. The resident was happy with the food but would like BBQ foods more often. The resident had an issue with laundry having lost some clothes but has been resolved. The resident was happy with physical therapy and the nursing care. The resident also asked the Activities Department to take the residents on more trips away from the facility which The Activities Department said would take note of. A PASARR level one document dated 01/04/2017, revealed R39 did have the dementia diagnosis, however, no other mental illness (MI), intellectual disability, (ID) mental retardation (MR) or any related condition (RC) and was deemed appropriate for nursing facility placement. A review of the resident's medical notes revealed R39's schizoaffective disorder was diagnosed on [DATE] and the resident's anxiety disorder was diagnosed on [DATE]. Resident 50 (R50) R50 was admitted on [DATE], with diagnoses including schizophrenia, unspecified dementia with behavioral disturbance, and major depressive disorder. On 11/05/2024 in the afternoon, R50 was slightly confused. The resident was waiting to see a cop and a schoolteacher and wanted to find the guy upstairs. The resident was otherwise happy with the functioning of the facility. A PASARR level one document dated 04/21/2016, revealed R50 did have the dementia diagnosis, however, no other mental illness (MI), intellectual disability, (ID) mental retardation (MR) or any related condition (RC) and was deemed appropriate for nursing facility placement. A review of the resident's medical notes revealed R50's schizophrenia was diagnosed on [DATE] and the resident's major depressive disorder was diagnosed on [DATE]. Resident 82 (R82) (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R82 was readmitted on [DATE], with diagnoses including schizoaffective disorder, vascular dementia with behavioral disturbance, anxiety disorder, and major depressive disorder. On 11/05/2024 in the afternoon, R82 stated had been at the facility for over 4 years. The resident felt the facility overall was an alright place to reside and liked to participate in activities of interest to the resident. A PASARR level one document dated 07/10/2018, revealed R82 did not have dementia, mental illness (MI), intellectual disability, (ID) mental retardation (MR) or any related condition (RC) and was deemed appropriate for nursing facility placement. A review of the resident's medical notes revealed R82's schizoaffective disorder was diagnosed on [DATE], the vascular dementia with behavioral disturbance was diagnosed on [DATE], the anxiety disorder was diagnosed on [DATE], and the resident's major depressive disorder was diagnosed on [DATE]. On 11/06/2024 in the morning, the Marketer stated Social Services were responsible for the PASARRs. On 11/06/2024 in the afternoon, the Medical Records Staff indicated there was no other PASSAR information available for these residents' indication a PASSAR II referral had been sent. On 11/06/2024 in the afternoon, the Social Services Director explained the SSD was responsible for referring residents who met criteria for PASARR two by completing the PASARR requests and referral was to be completed in their morning meeting. When asked if a residents' diagnoses of anxiety disorder, schizoaffective disorder, schizophrenia, and major depressive disorder would be representative of mental illness, intellectual disability, or a related condition which the Medicaid Service Manual documents a PASARR II must be completed for, SSD agreed these diagnoses would be an indication. The Division of Health Care Financing and Policy- Medicaid Services Manual- for Nursing Facilities Policy dated 05/01/2015, documented when an individual has been identified with possible indicators of mental illness, intellectual disabilities or related condition, a PASARR Level II screening must be completed to evaluate the individual and determine if nursing facility services and/or specialized services are needed and can be provided in the nursing facility. Examples include: a resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting a presence of a mental disorder (where dementia is not the primary diagnoses), or an intellectual disability or related condition was not previously identified and evaluated through PASARR. Social services would be responsible for keeping track of each resident's PASARR screening status and referring to appropriate authority. The medical record lacked documented evidence referrals for a PASARR level two screening were completed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50289 Based on interviews, record review, and document review, the facility failed to ensure a care plan was revised after resident-to-resident incidents for 1 of 38 sampled residents (Resident 167). The deficient practice placed the resident at risk for inappropriate care, supervision, and accidents. Findings include: Resident 167 (R167) R167 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease, dementia with behavioral disturbances, anxiety disorder, muscle wasting and atrophy, and cardiac pacemaker. Resident 39 (R39) R39 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, vascular dementia with behavioral disturbances, schizoaffective disorder, diabetes, congestive heart failure, and anxiety disorder. A Nursing Progress Note dated 09/13/2024 at 5:55 PM revealed R167 was in the dining area and was standing up hitting another resident (R39). The residents were separated and taken to their individual rooms. Nursing asked the resident what happened. R167 stated was minding own business when the other resident (R39) started trouble for no reason. No injuries were observed, and no complaints of pain were verbalized. An SBAR Communication form was filled out. The facility's investigation documentation revealed R167 had retrieved R39's cup during an activity in the dining room. When R39 realized R167 had R39's cup, R39 went over to R167 and asked for the cup back. R167 was not able to mentally process the situation, and when R39 went to reach for the cup, R167 pushed R39 backwards causing R39 to fall to the floor from the resident's wheelchair. A care plan for physical aggression had not documented R167 had a resident-to-resident altercation. However, there were new interventions dated 9/13/2024 documenting the facility was going to start eye on eye supervision, initiate a psychiatric evaluation, and separate immediately. Resident 119 (R119) R119 was admitted to the facility on [DATE] with diagnoses including diabetes, major depressive disorder, schizoaffective disorder, chronic obstructive pulmonary disease, chronic pain syndrome, and generalized anxiety disorder. A Nursing Progress Note dated 09/14/2024 at 5:54 PM revealed R119 was in their room when R167 came into the room and stated this room was R167's room. R119 told R167 the room belonged to R119. This is when R167 pushed R119. R119 stumbled back and fell landing on their knees. The residents were separated and R167 was taken to their room. No injuries were observed, and no complaints of pain were verbalized. An SBAR Communication form was filled out. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's investigation documentation revealed R167 and R119 were heard shouting during a disagreement. Staff went to the hallway to investigate the situation. Upon arrival, facility staff witnessed R167 physically pushing R119 to the ground, leaving R119 on their knees. A care plan for physical aggression had not documented R167 had another resident-to-resident altercation. However, there were new interventions dated 9/14/2024 documenting the facility was going to legal 2000 discharge the resident to the hospital for physical aggression. Resident 129 (R129) R129 was admitted to the facility on [DATE] with diagnoses including history of other mental and behavioral disorders, dementia with behavioral disturbances, diabetes, cognitive communication deficit, psychosis, and anxiety disorder. Facility investigation report documented on 9/16/2024 at 2:00 PM, R167 and R129 were walking toward each other. R167 pushed their walker into R129 three times, causing R129 to lose their balance and fall to the ground. An SBAR Communication form was filled out for this 9/16/2024 incident. A care plan for physical aggression had not documented R167 had another resident-to-resident altercation and there were no new interventions dated 9/16/2024 documented. Resident 18 (R18) R18 was admitted to the facility on [DATE] with diagnoses including schizophrenia, dementia with behavioral disturbances, schizoaffective disorder, cognitive communication deficit, extrapyramidal and movement disorder, and anxiety disorder. Facility investigation report documented on 11/01/2024 at 6:00 AM, R167 was being escorted to their room by the nurse for verbal aggression. R18 attempted to assist the nurse in escorting R167 back to R167's room which caused R167 to become upset. R167 swung at R18 which caused R18 to swing at R167. Staff attempted to separate the two residents. During the separation, all three parties fell to the floor. Both residents were helped up and escorted to their individual rooms and assessed for injuries and pain. An SBAR Communication form was filled out for this 11/01/2024 incident. A care plan for physical aggression had not documented R167 had another resident-to-resident altercation and there were no new interventions dated 11/01/2024 documented. The medical record lacked documented evidence the care plan for R167 was revised to include the resident-to-resident altercations and new preventative strategies for those altercations for the most recent altercations. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/08/2024 in the afternoon, the Director of Nursing (DON) stated an SBAR Communication Form would constitute a change of condition. The DON indicated the resident care plan could be updated after the incident or upon readmission like it was for R167. The DON further explained if there was already a care plan for the situation, the facility won't necessarily update it any further after another event. When asked if the current interventions for R167 were working, the DON agreed the interventions had not worked since there had been another altercation. On 11/08/2024 in the afternoon, the Administrator (Admin) agreed the interventions for R167 had not worked since there had been another altercation. The Admin explained it was important to update the care plan as it is what steers the care to be given and without an updated care plan, monitoring the care can be difficult. The Admin stated each incident should have had a revision to the resident's care plan. A facility policy titled Care Plans, Comprehensive Person-Centered (revised March 2022) documented assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' condition changes. The policy also revealed the interdisciplinary team reviews and updates the care plans when there has been a change in the resident's condition, when the desired outcome is not met, or when the resident has been readmitted to the facility from a hospital stay. FRIs #NV00072203, #NV00072209, #NV00072237, #NV00072599

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 40142 Based on observation, interview and document review, the facility failed to ensure an opened multi-dose vial (MDV) of Tubersol (used for intradermal Tuberculosis (TB) testing) was dated. The deficient practice could potentially result in inaccurate TB readings which could compromise the facility's TB surveillance protocol. Findings include: On 11/07/2024 at 8:39 AM, an inspection of the 200-Hall medication refrigerator revealed one opened MDV of Tubersol (Lot number 3CA26C1, Expiration 11/07/2024) which was not labeled with an open date. On 11/07/2024 at 8:40 AM, the Assistant Director of Nursing (ADON) confirmed the observation and indicated all MDV vaccines were to be labeled with open date and the discard date would be based on the manufacturer's instruction. The product inserts for Tubersol revealed each one-milliliter vial was good for 10 tests. Once accessed, the MDV was good for 30 days after which the vial must be discarded. The Medication Storage and Labeling policy (undated) documented, once MDVs were accessed (needle-punctured), the vial must be dated and discarded within 28 days unless the manufacturer specified a date whether shorter or longer.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 50289 Based on observation, interview, and document review, the facility failed to ensure the resident's food preferences were honored for one unsampled resident (Resident 60). The failure could have resulted in the resident having an allergic reaction to the provided food. Findings include: On 11/06/2024 at 12:53 PM, a Certified Nursing Assistant (CNA) was observed giving R60 a lunch tray in the dining room. The CNA looked at the plated meal and then looked at the ticket. The CNA informed the resident there was no protein on the plate due to the resident's Dairy Allergen. R60 became upset and wanted to speak to kitchen staff. On 11/06/2024 at 12:58 PM, a kitchen staff member was observed apologizing to the resident and then brought the resident out a piece of meatloaf for the resident to eat. The resident ate the meatloaf. On 11/06/2024 at 1:01 PM, the CNA and surveyor observed R60's plate and the CNA confirmed the meal ticket read, seasoned green peas, herbed rice, dinner roll, and caramel apple upside down cake and confirmed R60's plate did not include the herbed rice but did include a bowl of hamburger toppings without a hamburger. The CNA also confirmed the dairy allergy was notated on the meal ticket. The CNA verbalized discrepancies between meal tickets versus meal trays was a common occurrence. On 11/7/2024 at 2:50 PM, the Dietary District Manager (DDM) explained the reason there was no protein on R60's plate was because the main protein of meatloaf contained dairy in the recipe, and the alternate protein was a quiche which also contained dairy in the recipe. The system did not populate a protein being they both contained dairy and R60 had a dairy allergy. The DDM observed R60's ticket and confirmed the resident's lack of a protein and the dairy allergen. The DDM was also not sure why the resident received hamburger topping without the hamburger, nor was the DDM sure why the resident was not served the rice. The DDM indicated R60's meal ticket had a note which stated, dairy allergen because the resident was allergic to dairy products. The Dietary Manager confirmed there had been a mistake during the plate preparation for R60 which should have included the rice. The DDM confirmed there had also been a mistake in serving the resident the meatloaf being R60 was allergic to its ingredients. The DDM also stated would investigate this situation, so the resident does not have protein again on the next rotation of this menu. A Healthcare Services Group policy revised on 02/2023 titled Meal Distribution revealed for point of service dining, the dining services staff, under the supervision of the licensed nurse, will assemble the meal in accordance with the individual meal ticket (in conformity with the individuals diet order, preferences, and plan of care) and present it to the care staff for delivery to the resident.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 50289 Based on observation, interview, and document review, the facility failed to ensure food was served at a preferable and appetizing temperature for four sampled residents (Residents 12, 54, 72, and 119) and two unsampled residents (Residents 27 and 141). The deficient practice had the potential to negatively affect the amount of nutrients consumed by the residents and therefore affect their nutritional status. Findings include: On 11/07/2024 at 01:31 PM, Resident 12 (R12) verbalized the meal tasted poor and the cool temperature didn't help. On 11/07/2024 at 1:33 PM, Resident 54 (R54) indicated the meal tasted poor and the lukewarm to cool temperatures make it worse. On 11/07/2024 at 1:36 PM, Resident 72 (R72) indicated the meal tasted okay, but the cooler temperature was a problem. On 11/07/2024 at 1:38 PM, Resident 27 (R27) verbalized the meal tasted okay but was not a fan of the cool temperature. On 11/07/2024 at 1:39 PM, Resident 141 (R141) also verbalized the meal tasted okay but was not a fan of the cool temperature. On 11/07/2024 at 1:42 PM, Resident 119 (R119) indicated the meal tasted poor and it was very cold. On 11/07/2024 in the afternoon, a test tray was requested on the 600 hall. At 12:58 PM, the test tray food was temped by the DD with the surveyors in the kitchen before going into the food cart. The temperature of the ravioli was 164 degrees Fahrenheit, and the temperature of the pizza was 154.4 degrees Fahrenheit. At 1:00 PM, the meal cart left the kitchen and was taken to the 600 hall. At 1:03 PM, the meal cart arrived on the 600 hall. At 1:20 PM, the first meal tray was served from the meal cart. Staff members delivered the meal trays. At 1:33 PM, the last meal tray was delivered. At 1:34 PM, the test tray food was temped by the Dietary Director (DD) with the surveyors. The temperature of the ravioli was 123.6 degrees Fahrenheit, and the temperature of the pizza was 115 degrees Fahrenheit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29E037	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Pines Nursing and Rehab Center	2860 E. Cheyenne Avenue North Las Vegas, NV 89030

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/07/2024 at 1:37 PM, two surveyors and the DD thought the food tasted very good and had nice textures. However, the two surveyors thought the food was cooler than would have liked. The DD acknowledged the food was cooler than what the DD expected. On 11/08/2024 in the morning, the DD explained the food should not have taken over 15 minutes to begin to be served to the residents. The DD also explained the trays should not have been taken out of an insulated cart and put onto an uninsulated cart to then be delivered to the residents. The DD stated the food should be taken to the residents directly from the insulated cart to preserve the food temperatures. On 11/08/2024 in the morning, a test lunch tray was requested on the 600 hall. At 2:20 PM, the test tray food was temped by the DD with the surveyors in the kitchen before going into the food cart. The temperature of the chicken was 122.4 degrees Fahrenheit, the temperature of the rice was 121 degrees Fahrenheit, the temperature of the fish was 132.8 degrees Fahrenheit, and the temperature of the broccoli was 123 degrees Fahrenheit. At 2:24 PM, the meal cart left the kitchen and was taken to the 600 hall. At 2:27 PM, the meal cart arrived on the 600 hall. At 2:30 PM, the first meal tray was served from the meal cart. Staff members delivered the meal trays. At 2:41 PM, the last meal tray was delivered. At 2:42 PM, the test tray food was temped by the Dietary Director (DD) with the surveyors. The temperature of the chicken was 100.4 degrees Fahrenheit, the temperature of the rice was 104.4 degrees Fahrenheit, the temperature of the fish was 113.7 degrees Fahrenheit, and the temperature of the broccoli was 110.3 degrees Fahrenheit. On 11/08/2024 at 2:44 PM, two surveyors thought the food tasted very good and had nice textures. However, the two surveyors thought the food was cold. The DD acknowledged the food was cold based off the temperatures taken of the food. The DD refused to try the food. On 11/08/2024 at 03:51 PM, Resident 12 (R12) verbalized the meal temperature was cold. On 11/07/2024 at 3:53 PM, Resident 54 (R54) indicated the meal temperature was cooler then was liked. On 11/07/2024 at 3:59 PM, Resident 72 (R72) indicated the meal temperature was cold. On 11/07/2024 at 4:01 PM, Resident 27 (R27) verbalized the meal temperature was cooler than was liked. On 11/07/2024 at 4:02 PM, Resident 141 (R141) also verbalized the meal temperature was cold. On 11/07/2024 at 4:04 PM, Resident 119 (R119) indicated the meal temperature was very cold. (continued on next page)

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	29E037	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Pines Nursing and Rehab Center	2860 E. Cheyenne Avenue North Las Vegas, NV 89030

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Healthcare Services Group policy titled Food: Preparation revised 02/2023, references the use of the FDA 2022 Food Code for Time/Temperature Control for Safety.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29E037	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Pines Nursing and Rehab Center	2860 E. Cheyenne Avenue North Las Vegas, NV 89030

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50289 Based on observation, document review and interview, the facility failed to ensure stored foods were stored in accordance with professional standards for food service safety and hand washing areas were accessible to kitchen staff. This deficient practice posed a potential risk to safety and health standards which could lead to contamination and place residents at risk of foodborne illness. Findings include: On 11/05/2024 in the morning, during a tour of the kitchen and dietary areas, an open box of unbaked cookies was found being stored in the 500-hall nourishment freezer without a way to control for contamination of the cookies by facility staff, housekeeping staff, and/or kitchen staff whom all had access to the open box in the nourishment room freezer. A Healthcare Services Group Policy revised 02/2023 with the subject entitled Food Storage: Cold Food revealed all foods, frozen and refrigerated, will be stored in accordance with the guidelines of the FDA Food Code (2022). The Dietary Supervisor verified there were no measures in place to protect the unbaked cookies, being stored in the 500-hall nutrition room freezer, from contamination. The Dietary Supervisor explained the open box of unbaked cookies should not have been placed in/ stored in the nourishment room freezer. The Dietary Manager also mentioned this open box of unbaked cookies did not belong to Activities Department because activities come to the kitchen for their food and does not have a way to bake the unbaked cookies themselves. On 11/05/2024 in the morning, during a tour of the kitchen and dietary areas, there was a dish cart blocking the entrance to the handwashing sink and there was a plunger being stored in the handwashing sink. These two items were blocking the access to and use of the handwashing sink. A Healthcare Services Group Inservice & Policy Training V2 document with the subject entitled Hand Hygiene for Dining Services revealed situations requiring handwashing with soap and water included: after handling dirty dishes or trash, when one takes one step away from their workstation, or between tasks. The Dietary Supervisor acknowledged the handwashing sink in the dish room was inaccessible to be used properly for the above situations.