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	11/07/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure the Water Management Program was complete and included all required elements.Findings include:Review of the facility's Water Management Program (WMP) revealed the WMP Team included the Director of Maintenance, Infection Preventionist/Director of Nursing, the Administrator, the Assistant Administrator, and the Maintenance Assistant. The WMP included a written narrative of the water flow in the building. This text narrative indicated the facility included 109 resident rooms; 56 rooms with two shared shower rooms on the North side, and 53 rooms with [NAME] and [NAME] shower set up on the South side. The text narrative specified there were nine 100-gallon water heaters and three 100-pound ice machines. The WMP contained a flow diagram for the path of water through the facility. The flow diagram of the path of water through the facility lacked detail to identify areas where potentially dangerous conditions or limited flow could occur:The flow diagram did not specify the locations within the building where potentially dangerous conditions would occur. A potential area where a dangerous condition may occur is known as a control point. Control measures are actions the facility can take to limit the growth or spread of Legionella. Control limits are an acceptable minimum and maximum limits for a control measure. The flow diagram did not state where in the water path to measure potentially dangerous conditions existed, what the acceptable range for measures would be, or what corrective actions to take if control measures were outside of acceptable limits. The WMP stated in part, Areas Where Legionella Could Grow and Spread: Bacteria growth is more likely in piping systems that are rarely flowed. Dead legs and fixtures that see little use. Shower heads and faucet aerators that collect debris are also more likely to have bacterial growth. Areas of piping of limited flow, should be flushed to avoid bacterial growth. These areas of limited flow were not identified in the facility's WMP.The WMP did not address control points, control measures, control limits, and corrective actions to be taken if needed.On 11/6/2025 in the morning, the Maintenance Director explained the facility had five ice machines, and nine water heaters. The Maintenance Director explained the facility did not monitor for disinfectant levels, and water temperatures were monitored by the dishwasher in the kitchen and the washing machine in the laundry room. The Maintenance Director explained the dishwasher and washing machines would not operate if the temperatures were not within acceptable limits.On 11/6/2025 in the morning, the Infection Preventionist stated the facility did not have any residents with Legionella since the last survey.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. Based on observation, interview, and document review, the facility failed to ensure 1) a medication with instructions to refrigerate was stored in the refrigerator, 2) an opened multi-dose vial (MDV) was labeled with opened date and 3) expired over the counter (OTC) medications were discarded. The deficient practice had the potential to affect the efficacy of medications being provided to residents.Findings include:Medication not refrigeratedOn 11/07/2025 at 9:51 AM, an inspection of the OTC cabinet in the 200-Hall medication storage room revealed two boxes of Arformoterol Tartrate 12 micrograms (mcg) per two milliliters (ml). A blue sticker which read Refrigerate was affixed on the medication container and was labeled with the name of an active resident (Resident 6). The product insert instructed to store the medication inside a refrigerator between 36 degrees Fahrenheit to 46 degrees Fahrenheit. The recorded room temperature for 11/07/2025 was 68.2 degrees Fahrenheit.On 11/07/2025 in the morning, the Assistant Director of Nursing (ADON) confirmed the medication which had a manufacturer's instruction to refrigerate was stored at room temperature inside the OTC cabinet. The ADON explained R6's Arformoterol was discontinued on 10/09/2025 and should have been discarded by the nurse who was tasked to routinely inspect the medication room.MDV not labeled with opened dateOn 11/07/2025 at 10:09 AM, one opened MDV of Lorazepam injection 2 mg/ml with contents remaining was not labeled with an opened date.On 11/07/2025 in the morning, the ADON confirmed Lorazepam MDV had been accessed with remaining contents but was not labeled with opened date. The ADON explained MDVs must be dated because they were good for 28 days once opened.Expired OTC medications On 11/07/2025 at 10:26 AM, an inspection of the OTC cabinet in the 500-Hall medication room revealed 30 vials of Lubricating eye drops (Carboxymethylcellulose sodium 0.5% Lot number 230860 with expiration date August 2025 and a box of Earwax softener drops with expiration August 2025.On 11/07/2025 in the morning, the ADON confirmed the expired OTC medications. The ADON indicated being uncertain who was responsible for inspecting the medication rooms and how frequently inspections were done.On 11/07/2025 at 10:39 AM, the Director of Nursing (DON) indicated the ADON was expected to be familiar with the process of checking medication rooms such as who was responsible and how often. The DON clarified night shift staff should check medication rooms at least once a month and discard expired and discontinued medications. The DON confirmed the improperly stored medication in the 100-Hall OTC cabinet, the MDV which was not labeled with opened date and expired medications in the 500-Hall medication room was an oversight. The Medication Labeling and Storage policy revised February 2023, documented 1) medications requiring refrigeration were stored in the refrigerator, 2) multi-dose vials which had been accessed were dated and discarded after 28 days, and 3) the dispensing pharmacy was contacted for disposal of outdated and discontinued medications.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and document review, the facility failed to ensure the facility assessment tool contained a staffing plan. The deficient practice had the potential to impact the quality of care provided to residents due to staffing levels. Findings include:The Facility Assessment Policy and Procedure dated 2025, documented the facility shall conduct a facility-wide assessment to determine which resources were necessary to care for its residents competently both day-to-day and during emergencies. The facility shall use the facility assessment to inform staffing decisions to ensure there was a sufficient number of staff with appropriate competencies and skill sets necessary for its residents' needs. Consider specific staffing needs for each resident unit and adjust as necessary based on changes to its population. Consider specific staffing needs for each shift, such as day, evening, night and adjust as necessary based on changes.The Facility Assessment Tool reviewed on 08/28/2025, lacked documented evidence of a staffing plan.On 11/06/2025 at 10:30 AM, Administrator confirmed the facility assessment tool did not include a staffing plan but rather a sample staffing schedule with staff names which included licensed nurses and certified nursing assistants (CNAs) required for each unit and shift. The Administrator acknowledged a staffing plan must be included in the facility assessment which identified the number of licensed nurses and CNAs needed for every shift in each unit to provide quality care for residents.On 11/06/2025 at 10:48 AM, the staff scheduler indicated being familiar with the facility assessment and indicated relying on the sample staffing schedule as a guide for staffing the units.On11/07/2025 at 8:39 AM, the staff scheduler explained the former human resources director trained the scheduler to staff the units based on the sample staff schedule and not a formal staffing plan.