STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295099	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HORIZON RIDGE SKILLED NURSING & REHABILITATION CTR	2855 W. HORIZON RIDGE PARKWAY HENDERSON, NV 89052

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 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review, the facility failed to ensure a resident's care plan for falls was reviewed and revised for effectiveness following each fall episode for 1 of 5 sampled residents (Resident #4). Findings include: Resident #4 (R4) R4 was admitted on [DATE], with [DIAGNOSES REDACTED]. On 03/04/2020 at 8:34 AM, a resident's door was wide open, and an elderly resident was observed on the floor laying face up with the back of head against the left side of the bed and feet against the wall. The resident appeared to just have fallen, landed on a fall mat and was yelling in a loud voice. A Baseline Care Plan for Falls dated 02/22/2020, documented R4 was high risk for falls related to poor safety awareness and interventions included anticipation of needs, place call light within reach and promptly respond to resident's request for assistance. R4's Falls Log revealed the resident had fallen once on 02/21/2020, once on 0[DATE]20, twice on 02/26/2020 and three times 02/28/2020. The medical record lacked documented evidence R4's care plan for falls was revised on 02/28/2020 when R4 had three fall incidents. On 03/04/2020 at 3:15 PM, the Director of Nursing (DON) confirmed care plan revisions were not done when R4 sustained three falls on 02/28/2020. The DON clarified the resident's care plan should be reviewed after each fall so new interventions could be initiated, and ineffective interventions discontinued. The DON indicated fall prevention measures must be carried for residents at risk for falls for example the tab alarm should have been appropriately used. The facility policy on Comprehensive Care Plans revised October 2017, documented care plans were revised with every change of condition.
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** Based on interview, record review and document review, the facility failed to perform skin assessments accurately for 1 of 5 sampled residents (Resident #1), failed to document weekly skin assessments for 1 of 5 sampled residents (Resident #3), and failed to administer medications in a timely manner for 1 of 5 sampled residents (Resident #2). Findings include: Resident #1 (R1) R1 was admitted on [DATE], with [DIAGNOSES REDACTED]. Documentation entitled Weekly Skin Alterations dated 1[DATE], indicated the left trochanter surgical incision measured at 6 centimeters (cm), the left upper thigh surgical incision measured at 4 cm, and the left lateral knee surgical incision measured at 2.5 cm. All areas were pink in color, well approximated and had no drainage. R1 had been seen by the Wound Care Physician and half of the staples were removed from all incisions. The remaining staples would be removed on 12/19/19 and treatment orders would be discontinued as the wound would be resolved. The Baseline Care Plan initiated on 12/09/19, documented R1 had an actual impairment to skin integrity related to surgical interventions to the left hip, left upper thigh and left lateral knee which all resolved on 12/19/19. There were 3 Weekly Skin Checks dated 12/23/19, 12/31/19, and 01/07/19, which contained the same assessment information. As follows: -left hip surgical incision presented pink and red in color, well approximated, and no drainage was noted. -left upper thigh surgical incision presented pink and red in color, well approximated, and no drainage was noted. -left lateral knee surgical incision presented pink and red in color, well approximated, and no drainage was noted. -left upper extremity had a hard cast covered with ace wrap and the area of fracture was not visualized due to the hard cast, range of motion (ROM) and circulation, sensation and movement (CSM) were normal, and all digits were swollen but R1 was able to move all fingers. On 03/04/2020 at 2:32 PM, the Wound Care Nurse confirmed R1's Weekly Skin Check reports contained the same assessment information even after the wound had been resolved on 12/19/19. Resident #3 (R3) R3 was admitted on [DATE], with [DIAGNOSES REDACTED]. On 03/04/2020 at 2:32 PM, the Wound Care Nurse indicated the licensed nurse who admitted the resident would do a full evaluation of the resident including the skin. The Wound Care Nurse would assess the resident and inform the wound doctor to obtain orders to determine what type of treatment should be done on the resident's wound. The Wound Care Nurse would document the initial skin assessment and the assessments with the wound care doctor on the Weekly Skin Alteration report. The Wound Care Nurse confirmed R3's wound had not been resolved and continued to treatment for [REDACTED]. If there were new skin issues, the licensed nurses would document on the residents' medical record and would notify the wound care nurse. The medical record lacked documented evidence weekly skin checks had been completed after 02/06/2020 and Weekly Skin Alteration reports had been completed on 02/25/2020 to 03/04/2020. On 03/04/2020 at 2:32 PM, the Wound Care Nurse acknowledged R3's medical record lacked documented evidence the weekly skin checks were performed after 02/06/2020, and the Weekly Skin Alteration reports were completed after 0[DATE]. On 03/04/2020 at 3:50 PM, the Assistant Director of Nursing verbalized the licensed nurses were expected to assess the residents' skin prior documenting on the medical record. Resident #2 (R2) R2 admitted on [DATE], with [DIAGNOSES REDACTED]. A Nursing Note dated 01/07/2020, documented R2 had complained his/her medication was an hour late. The nurse informed R2 the nurses had an hour before and after to give medication. On 02/05/2020 at 12:00 PM, R2 verbalized the nurses had not been giving medication in a timely manner and were sometimes late. R2 indicated the blood pressure, pain and Adderrall medications had been late. R2 indicated a few nurses were always on time with the medication and some were not. On 02/05/2020 at 11:10 AM, a Physician Assistant stated R2 had complained of medications being late in the past. The provider explained R2 complained mostly of the pain medications. The Physician Assistant indicated providers can only order and would need to rely on the facility to carry out the orders. A Physician order [REDACTED]. The Medication Administration Detail Report for January 2020, revealed the following administration times for [MEDICATION NAME]: -01/30/2020: scheduled 9:00 AM; administered 10:30 AM -01/23/2020: scheduled 9:00 AM; administered 10:27 AM A Physician order [REDACTED]. The Medication Administration Detail Report for January 2020, revealed the following administration times for [MEDICATION NAME]: -01/23/2020: scheduled 4:00 AM; administered 5:10 AM -01/22/2020: scheduled 9:00 PM; administered 11:14 PM -01/21/2020: scheduled 9:00 AM; administered 11:15 PM A Physician order [REDACTED]. The Medication Administration Detail Report for January 2020, revealed the following administration times for [MEDICATION NAME]: -01/19/2020: scheduled 6:30 AM; administered at 8:18 AM -01/22/2020: scheduled 6:30 AM; administered at 8:33 AM -01/28/2020: scheduled 6:30 AM; administered at 8:50 AM On 03/04/2020 at 4:02 PM, the Assistant Director of Nursing (ADON) explained nurses had one hour before and after the scheduled time to administer medications. The ADON indicated any medication given outside the scheduled time frame was considered late. The ADON acknowledged R2's medication were administered late. On 03/04/2020 at 4:20 PM, the Director of Nursing (DON) verbalized the acceptable time frame for staff to administer medications was one hour before and after the scheduled time.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) The DON indicated medications administered outside the one hour window was considered a late administration. The Administering Medication Policy dated (NAME)2016, documented medications shall be administered in a safe and timely manner and as prescribed. Complaint #NV 050
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to respond promptly to a resident in distress following a fall and failed to appropriately use a position tab alarm as a fall prevention measure for 1 of 5 sampled residents (Resident #4). Findings include: Resident #4 (R4) R4 was admitted on [DATE], with [DIAGNOSES REDACTED]. On 03/04/2020 at 8:34 AM, a resident's door was wide open, and an elderly resident was observed on the floor laying face up with the back of head against the left side of the bed and feet against the wall. The resident appeared to just have fallen, landed on a fall mat and was yelling in a loud voice. R4's bed was on lowest position; the call light was hanging on the right rail with an orange string twisted around the call light. A Licensed Practical Nurse (LPN) was standing in front of a medication cart approximately 5 feet away across R4's door. A Registered Nurse (RN) was sitting in front of a monitor at a nurse's station approximately 10 feet from R4's door. The LPN and RN resumed their respective tasks and ignored R4's distress call. On 03/04/2020 at 8:35 AM, the RN called the LPN into R4's room and carried out post-fall interventions including injury, pain assessment and vital signs. Other staff members entered with a Hoyer lift device to assist R4 back into bed. On 03/04/2020 at 9:35 AM, the LPN explained yelling was a constant behavior for R4 and it was hard to tell whether R4 was just yelling or in true distress. The LPN was preparing medications when R4 fell . The LPN acknowledged resuming with task because the LPN was uncertain if R4 was in true distress. On 03/04/2020 at 9:45 AM, the RN acknowledged not responding with urgency when the RN heard R4 screaming. The RN explained screaming was R4's usual behavior and it was hard to tell whether R4 was in true distress. On 03/04/2020 at 8:37 AM, an observation of R4's room revealed an orange box mounted on the wall at the head of the resident's bed. An orange string was observed intricately twisted around the call button dangling from the resident's right grab rail. On 03/04/2020 at 9:35 AM, an LPN confirmed the observation of the orange string being detached from the tab alarm box and dangling from the resident's bed. The LPN verbalized R4 might have pulled on the string. Upon hearing the LPN's explanation, the resident denied pulling on any string. On 03/04/2020 at 9:29 AM, the RN explained the orange box was a tab alarm used as a fall prevention measure for residents at risk for falls. The RN demonstrated the tip of the orange string was inserted into the tab alarm box and the other end was connected to the resident. A blue under pad containing sensors was situated underneath the linens. The tab alarm triggered the camera to start recording when the resident moved significantly or tugged against the orange string. The RN pointed to a small camera on the ceiling pointed towards the resident's bed. The RN indicated the orange string was not supposed to be detached from the wall box and hanging from the bed because the device could not alert staff of an impending fall unless used appropriately. On 03/04/2020 at 11:30 AM, R4 was situated in bed with a bruise on right side of the face which appeared old. An orange string was inserted into the wall box but not connected to the resident nor the under pad. R4 indicated getting confused at times and would attempt to get up when call light response took long. R4 recalled having had many falls at the facility. On 03/04/2020 at 1:30 PM, the Director of Staff Development (DSD), explained the facility had 18 fall rooms equipped with wall-mounted position tab alarms which triggered camera monitoring. The DSD indicated fall rooms were utilized for residents identified as high risk for falls and did not require a physician's orders [REDACTED]. The DSD verbalized the tab alarms were fall prevention measures but they needed to be properly utilized or were ineffective. The DSD verified care plans should be revised following each fall and a change of condition report needed to be completed after each fall. The DSD clarified if a resident had multiple falls within one day, a change of condition report should be completed for each fall not for each day. On 03/04/2020 at 2:10 PM, the Unit Manager explained verbalized the position tab alarm was only useful if it was properly used. On 03/04/2020 at 3:15 PM, the DON verbalized even if R4 had a behavior of screaming the nurses should still check on the resident to rule out an emergent situation. The DON indicated when the LPN and RN ignored R4's cries for help, reflected the nurses have gotten immune to the resident's behavior. This became a safety issue and was unacceptable.