STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29E037	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MISSION PINES NURSING & REHABILITATION 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.

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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** Based on observation, interview, and record review, the facility failed to ensure a privacy cover was placed over an urinary catheter collection bag to promote dignity for 1 of 35 sampled residents (Resident #171). Findings include: Resident #171 (R171) R171 was admitted on [DATE], with [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) dated 02/19/2020, revealed R171 was assessed as severely impaired with a cognitive summary score of 6 over 15 (6/15). On 03/10/2020 at approximately 9:19 AM, R171's urinary catheter collection bag contain yellow urine was hanging on the right side of the bed and visible from the hallway. There was no privacy cover over the bag. On 03/10/20 at approximately 9:19 AM, a Certified Nursing Assistant (CNA) confirmed the observation and verbalized the catheter bag should have been covered due to dignity issues. The CNA verbalized the facility used privacy covers over catheter bags.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the assessment accurately reflected the status of a resident with visual impairment for 1 of 35 sampled residents (Resident #27). Findings include: Resident #27 (R27) R27 was admitted on [DATE], with [DIAGNOSES REDACTED]. On 03/10/2020 at 11:27 AM, R27 demonstrated difficulty reading a document on hand. R27 reported their prescription glasses were lost at a previous facility and a fell ow resident donated a $5-dollar pair of glasses. R27 indicated the glasses were not prescription so R27 could barely read, see or write. On 03/10/2020 at 11:30 AM, R27 recalled informing a nurse about vision issues and was informed a vision referral would be done. The resident could not recall the name of the nurse who was informed. A Social Services Note dated 12/05/19, revealed R27 had impaired vision with difficulty seeing normal size print and reading short and long distances. The Admission Minimum Data Set ((MDS) dated [DATE], documented R27's vision was adequate, sees with fine detail, including regular print, newspaper and books. On 03/11/2020 at 1:46 PM, the MDS Coordinator explained assessments were based on complete chart review, interview and direct observation of the resident. The Inter-Disciplinary Team (IDT) were responsible for certain segments for example social services staff would have been responsible for sections B (hearing, speech and vision). The MDS Coordinator confirmed the Admission MDS failed to identify a vision issue and a care plan was not generated. If a vision care plan was generated, the first intervention would have been to refer the resident for a vision consult. This was not done for R27 who had a vision problem since November 2019. On 03/11/2020 at 2:05 PM, the Social Services Director (SSD) indicated R27 was personally observed and interviewed by the SSD on 12/05/19 when the vision impairment issue was identified. The SSD acknowledged R27 was inaccurately coded as having adequate vision in the admission MDS. On 03/12/2020 at 9:15 AM, the Director of Nursing (DON) verified the resident's assessment drove the resident's care plan. If R27 was assessed inaccurately to have adequate vision, this would explain why vision services were missed and/or delayed and should not have been.
F 0678 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and personnel record review, the facility failed to ensure the nursing staff had current cardio-pulmonary resuscitation (CPR) certification for 10 of 36 sampled employees (Employee #2, #8, #9, #17, #19, #21, #24, #27, #31, #32) and current CPR certification included hands-on practice and in-person skills assessment for 1 of 36 sampled employees (Employee #28). Findings include: 1) Employee #2 (the Director of Nursing) Employee #2's file lacked documented evidence of current CPR certification. 2) Employee #8 (Registered Nurse) Employee #8's file lacked documented evidence of current CPR certification. 3) Employee #9 (Certified Nursing Assistant) Employee #9's file lacked documented evidence of current CPR certification. 4) Employee #17 (Certified Nursing Assistant) Employee #17's file revealed the CPR certification expired on [DATE]. 5) Employee #19 (Certified Nursing Assistant) Employee #19's file revealed the CPR certification expired on [DATE]. 6) Employee #21 (Certified Nursing Assistant) Employee #21's file lacked documented evidence of current CPR certification. 7) Employee #24 (Registered Nurse) Employee #24's file lacked documented evidence of current CPR certification. 8) Employee #27 (Licensed Practical Nurse) Employee #27's file lacked documented evidence of current CPR certification. 9) Employee #28 (Licensed Practical Nurse) Employee #28's file revealed a CPR certification completed on [DATE]. The certification was obtained online without a hands-on component. 10) Employee #31 (Certified Nursing Assistant) Employee #31's file revealed CPR certification expired [DATE]. 11) Employee #32 (Licensed Practical Nurse) Employee #32's file lacked documented evidence of current CPR certification. On [DATE] at 9:38 AM, the Director of Human Resources (HR) confirmed the CPR certifications were missing and not current for the 11 employees. The Director indicated started work at the facility last month and the previous Director of HR failed to track and complete the requirements for the employee files. The Director indicated the Administrator was aware of the missing documentation. The Director was not aware online certifications were not accepted and hands-on training for CPR was required by federal regulations. On [DATE] at 10:50 AM, the Administrator confirmed the missing CPR requirement for the 11 employees. The Administrator indicated started work as the Administrator of the facility last [DATE]. The Administrator indicated the previous Administrator and the previous Director of HR should have kept track and made sure the employees had their requirements current and in place. The facility policy CPR Standard of Practice revised [DATE], documented staff would maintain current CPR certification for healthcare providers through a CPR provider who would evaluate proper technique through in-person demonstration of skills.
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 observation, interview, record review, the facility failed to follow physician orders [REDACTED].#117) and to complete a psychiatric consultation for competency timely for 1 of 35 sampled residents (Resident #120). Findings include: Resident #117 (R117) R117 was admitted on [DATE], with [DIAGNOSES REDACTED]. On 03/10/2020 at 9:53 AM, R117 was not wearing compression stockings. On 03/10/2020 at 1:45 PM, R117's left leg was exposed. R117 was not wearing compression stocking. On 03/11/2020 at 10:07 AM, R117 was not wearing compression stockings. R117 indicated there was an order to wear compression

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) stockings to both legs daily for circulation issues. R117 reported the Certified Nursing Assistant (CNA) put the resident's stockings on after morning care but sometimes the CNA's forgot. A physician order [REDACTED]. On 03/11/20 at 10:24 AM, a CNA indicated being aware R117 had an order for [REDACTED]. On 03/11/20 at 10:25 AM, another CNA indicated being assigned to R117's care and confirmed R117 did not have compression stockings on. The CNA explained R117's compression stockings were applied to bilateral legs in the morning after routine care at about 8:00 AM. The CNA picked up a pair of white compression stockings from R117's shoes. The CNA indicated the stockings were not applied because the stockings were dirty and needed to be washed. On 03/11/20 at 10:37 AM, a Licensed Practical Nurse (LPN) indicated was aware R117 had an order to wear compression stockings during the day. The LPN explained the stockings were applied by the CNA's usually after morning routine care. On 03/11/20 at 11:16 AM, the Unit Manager indicated R117's compression stockings were for used to improve circulation, prevent [MEDICAL CONDITION] (a blood clot) and [MEDICAL CONDITION] control. The stockings were meant to be hand washed to maintain elasticity and this also prevented it from getting lost in laundry. The Treatment Administration Record (TAR) for March 2020, revealed R117's compression stockings were not applied on 03/05/2020, 03/06/2020, 03/07/2020, 03/09/2020 and 03/10/2020. On 03/12/20 at 9:00 AM, the Director of Nursing (DON) explained R117 was a diabetic and at risk for circulatory and skin issues. The DON verified R117's order for compression stockings should be applied all day, usually from 8:00 AM to 8:00 PM. The stockings were expected to be hand-washed to preserve elasticity and prevent from getting lost. The DON reviewed R117's TAR and confirmed the compression stockings were not applied on 03/05/2020, 03/06/2020, 03/07/2020, 03/09/2020 and 03/10/2020 per physician's orders [REDACTED]. Resident #120 (R 120) R120 was admitted on [DATE], with [DIAGNOSES REDACTED]. The Admission Minimum Data Set ((MDS) dated [DATE], documented R120 had a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact. The Quarterly MDS dated [DATE], documented R120 had a BIMS score 15, indicating the resident was cognitively intact. A Physician order [REDACTED]. The medical record revealed the psychiatric evaluation was not completed until 02/11/2020. The facility was not aware of why the psychiatric evaluation was delayed for almost three months after the physician order [REDACTED].
F 0685 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assist a resident in gaining access to vision and hearing services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure services were provided for a visually impaired resident (Resident #27). Findings include: Resident #27 (R27) R27 was admitted on [DATE], with [DIAGNOSES REDACTED]. On 03/10/2020 at 11:27 AM, R27 demonstrated difficulty reading a document on hand. R27 reported their prescription glasses were lost at a previous facility and a fell ow resident donated a $5-dollar pair of glasses. R27 indicated the glasses were not prescription so R27 could barely read, see or write. On 03/10/2020 at 11:30 AM, R27 recalled informing a nurse about vision issues and was informed a vision referral would be done. The resident could not recall the name of the nurse who was informed. A Social Services Note dated 12/05/19, revealed R27 had impaired vision with difficulty seeing normal size print and reading short and long distances. The Admission Minimum Data Set ((MDS) dated [DATE], documented R27's vision was adequate, sees with fine detail, including regular print, newspaper and books. On 03/11/2020 at 1:40 PM, the Unit Manager indicated not being aware R27 had vision problems. On 03/11/2020 at 1:46 PM, the MDS Coordinator explained assessments were based on complete chart review, interview and direct observation of the resident. The MDS Coordinator confirmed R27's Admission MDS failed to identify a vision issue and a care plan was not generated. If a vision care plan was generated, the first intervention would have been to refer the resident for a vision consult. This was not done for R27 who had a vision problem since November 2019. On 03/11/2020 at 2:05 PM, the Social Services Director (SSD) indicated R27 was personally observed and interviewed by the SSD on 12/05/19 when the vision impairment issue was identified. The SSD acknowledged R27 was inaccurately coded as having adequate vision in the admission MDS. The medical record lacked documented evidence R27 was provided a vision consultation since November 2019. On 03/12/2020 at 9:11 AM, the Assistant Administrator explained the facility provided vision services from a provider who came to the facility monthly. Residents who were on the list were seen. If R27 was not identified to have a vision problem R27 would not have been provided a consult. On 03/12/2020 at 9:15 AM, the Director of Nursing (DON) verified the resident's assessment drove the resident's care plan and if R27 was assessed inaccurately to have adequate vision, this would explain why vision services were missed and/or delayed and should not have been.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure 1) interventions were implemented for residents with significant weight changes for 4 out of 9 residents (Resident #145, #166, #114, and #47), 2) weekly weights were monitored after triggering a significant weight change for 5 out of 9 residents (Resident #145, #85, #166, #114, and #47), 3) residents were weighed weekly for four weeks after readmission for 4 out of 9 residents (Resident #145, #166, #114, #47), 4) resident was weighed weekly for four weeks after admission for 1 out of 9 residents (Resident #85), and 5) a physician order [REDACTED]. The Dietitian should discuss and document any weight deviation during the weekly committee meeting. The Dietitian would complete a Nutritional Data Set and Progress Note. The new admission or readmission would be weighed weekly for four weeks. Residents who triggered a significant weight change would be defined as 5% in 1 month, 7.5% in 3 months and/or 10% in 6 months would be addressed by the Weight Variance Committee and placed on Weekly Weight Monitoring. The monthly and weekly weights were to be entered in the electronic health record and reviewed by the committee weekly. The facility Dietitian Assessment Policy (undated), indicated the Standards of Care meeting would discuss and evaluate all residents for weight gains, weight losses and changes in condition. The Dietitian would be present and followed up on any requested evaluations. Resident #145 (R145) R145 was admitted on [DATE] and readmitted on [DATE], with [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) assessment dated [DATE], documented R145 had severe impaired cognition and required supervision with one-person to assist with meals. R145 had a weight loss of 5% or more in the last month or loss 10% of more in the last six months and was not on a physician-prescribed weight-loss regimen. An Annual Medical Nutritional Therapy assessment dated [DATE], documented R145 meal intakes averaged 50-100% for breakfast, lunch and dinner. A Care Plan dated 08/09/18 and revised 12/06/19, documented R145 was at risk for alteration in nutrition and received a mechanically altered diet. The Weight Change History from 03/01/19 thru 10/05/19 for R145 documented the following: Weight-128.7 pounds (06/04/19) Weight-120 pounds (07/05/19) Weight-117.7 pounds (08/05/19) Weight-116 pounds (09/05/19) Weight-119.6 pounds (10/5/19) The Weight Change History revealed the following significant weight changes: -significant weight loss of 8.7 pounds (-6.75%) in one month on 07/05/19 -significant weight loss of 12.7 pounds (-9.8%) in three months on 09/05/19 On 03/10/2020 at 1:55 PM, R145's lunch tray was on the bedside table. R145 had a spoon in the right hand reaching for the food and was not able to self-feed. On 03/11/2020 at 1:37 PM, R145 was in bed staring at the wall. The resident's lunch meal was untouched. On 03/11/2020 at 1:51 PM, a Certified Nursing Assistant (CNA) entered R145's room to assist with the meal. The CNA indicated R145 consumed 25% of the meal. On 03/12/2020 at 1:24 PM, R145's lunch meal was untouched. On 03/12/2020 at 1:44 PM, a CNA entered R145's room to assist with the meal. The CNA indicated R145 consumed 25% of the meal. On 03/12/2020 at 1:27 PM, a CNA verbalized R145 required assistance with meals recently and was eating about 25% of the meals. The CNA indicated R145 on good days was able to self-feed and had a better appetite. The medical record lacked documented evidence R 145 had interventions in place after a significant weight loss of 6.8% in one month on 07/05/19 and weight loss of 9.8% in three months on 09/05/19. The medical record lacked documented evidence R 145 was placed on the weekly weight monitoring after significant weight changes with weight decrease of 6.8% in one month on 07/05/19 and weight decrease of 9.8% in three months on 09/05/19. The medical record lacked documented evidence R145 was weighed weekly for four weeks after readmission on 11/07/19. On 03/12/2020 at 12:17 PM, the Restorative Aide (RA) Manager verbalized residents admitted to the facility were weighed for three consecutive days upon admission and weekly for four weeks. The RA Manager would give the Dietitian a copy of the weights obtained for review. The Dietitian would notify the RA Manager if a reweigh was needed. The RA Manager indicated reweighs were to be completed within the same day. The RA Manager indicated there were no set weight changes to perform a reweigh. The RA Manager indicated reweighs ranged from 8 to 10 pounds depending on the resident, and the dietitian decided if a reweigh was necessary. The RA Manager indicated weekly weights were entered into the electronic health record by the dietitian and monthly weights entered by the RA Manager. On 03/12/2020 at 9:32 AM, the Dietitian indicated weights and reweighs were completed and documented in the electronic health record by the RA. The Dietitian was provided a copy of the weights for review. The Dietitian indicated the RA performed reweighs the same day if there was a significant weight change. The Dietitian verbalized weekly and monthly significant

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F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) weight changes were reviewed during the weekly Standards of Care meeting. Any significant weight changes with 5% change in 31 days or less, 7.5% in 91 days or less, or 10% in 180 days or less would be addressed within the same month. The Dietitian was not aware residents with weight changes were placed on weekly weight monitoring per the facility Weight Standards of Practice policy. The Dietitian acknowledged R145's significant weight loss was not addressed and recommendations were not implemented until 08/01/2019, a month later when completing the annual assessment. The Dietitian indicated R145's significant weight loss of 9.8% in three months on 09/05/19 was overlooked. The Dietitian confirmed R145's weekly weights were not implemented and weights were not completed weekly for four weeks after readmission. Resident #47 (R47) R47 was admitted on [DATE] and readmitted on [DATE], with [DIAGNOSES REDACTED]. On 03/10/20 at 9:17 AM, R47 consumed 75% of the meal and left the eggs untouched. R47 verbalized not liking eggs. R47's tray card did not indicate a dislike of eggs. On 03/10/20 12:13 PM, R47 consumed 50% of the pureed lasagna. On 03/11/20 01:37 PM, R47's lunch tray was untouched. R47 verbalized did not want to eat lunch and wanted to rest. On 03/12/2020 at 1:27 PM, a CNA verbalized R47 consumed 25-50% of the meals and the family brought in ethnic foods. The CNA indicated R47's appetite had decreased recently. 0n 3/12/2020 at 2:11 PM, the Unit Manager indicated R47 appetite varied 25-50% and did not always eat all the food the family brings. A Significant Change MDS assessment dated [DATE], revealed R47 had severe impaired cognition and required supervision and help with setup for eating. A Care plan dated 08/06/19, documented R47 was at risk for choking as evidenced by difficulty with chewing related to use of dentures. A Care plan dated 11/01/19 and revised on 12/04/19, documented R47 was at increased risk for alteration in nutrition due to [DIAGNOSES REDACTED]. A Quarterly Follow-up Nutrition Progress note dated 11/01/19, indicated R47 with variable oral intake. A Nutrition Services Progress Note dated 12/23/19, documented R47 with a significant change and was placed on hospice services. A Physician order [REDACTED]. The Weight Change History from 12/12/19 thru 03/12/2020 for R47 documented the following: Weight-102 pounds (12/12/19) Weight-114.5 pounds (01/01/2020) Weight-123.3 pounds (02/20/2020) Weight-114 pounds (03/04/2020) The Weight Change History revealed the following significant weight changes: - significant weight gain of 12.5 pounds (+12.2%) in one month on 01/01/2020 - significant weight gain of 8.8 pounds (+7.6%) in 51 days on 02/20/2020 - significant weight gain of 16.9 pounds (+15.8%) in three months on 02/20/2020 - significant weight loss of 9.3 pounds (-7.5%) in 13 days on 03/04/2020 - significant weight gain of 12 pounds (+11.7%) in three months on 03/04/2020 The medical record lacked documented evidence R47's significant weight change was acknowledged and interventions were implemented for weight gain of 7.6% in 51 days on 02/20/2020. The medical record lacked documented evidence R47 was placed on weekly weight monitoring after a significant weight gain of 7.6% in 51 days on 02/20/2020 and weight decrease of 7.5% in 13 days on 03/04/2020. The medical record lacked documented evidence R47 was weighed weekly for four weeks after readmission on 12/12/19. On 03/12/20 10:00 AM, the Dietitian verbalized R47's significant weight change was not acknowledged and discussed in the weekly weight meeting for 02/20/2020 per the weight policy. The Dietitian indicated R47's weight in February 2020 and the weight gain of +7.6% in one month on was overlooked and because the Dietitian did not have time enough time to see the resident. The Dietitian was not aware residents with weight changes were to be placed on weekly weight monitoring per the facility Weight Standards of Practice policy. The Dietitian acknowledged R47's weekly weights were not implemented following significant weight changes on 02/20/2020 and 03/04/2020. The Dietitian indicated a reweigh should have been completed on 02/20/2020 by the RA within the same day and was overlooked by the Dietitian. The Dietitian acknowledged R47's weekly readmission weights for four weeks on 12/12/19 were not completed and documented per the weight policy. Resident #85 (R85) R85 was admitted on [DATE], with [DIAGNOSES REDACTED]. The Admission MDS assessment dated [DATE], documented R85 had severe impaired cognition and required supervision with one-person physical assist with eating. On 03/10/2020 at 8:46 AM, R85 consumed 75% of the breakfast meal which included toast, scrambled eggs, oatmeal and juice. R85 verbalized the food was good. On 03/10/2020 at 1:46 PM, R85 consumed 75% of the lunch meal. On 03/11/2020 at 1:29 PM, R85 consumed 75% of the ground chicken and pinto beans for the lunch meal. On 03/12/2020 at 1:27 PM, a CNA verbalized R85's appetite was good, and the resident consumed 75-100% of the meals. The CNA indicated R85 ate all meals in the room. The Initial Medical Nutrition Therapy assessment dated [DATE], documented R85 received a regular, dysphagia mechanical texture diet. The Weight Change History from 01/09/2020 thru 03/12/2020 for R85 documented the following: Weight-148.8 pounds (01/09/2020) Weight-158.2 pounds (0[DATE]) Weight-158.4 pounds (03/03/2020) The Weight Change History revealed the following significant weight change: significant weight gain of 9.4 pounds (+6.3%) in one month on 0[DATE] A Care plan dated 01/09/2020, indicated R85 was at increased risk for nutritional status related to [MEDICAL CONDITION] with [MEDICAL CONDITION]. A Physician order [REDACTED]. The medical record lacked documented evidence the dietitian had seen R85 in the month of February 2020. The medical record lacked documented evidence R85 was placed on the weekly weight monitoring after a significant weight changes for weight increase of 6.5% in one month on 0[DATE]. The medical record lacked documented evidence R85 was weighed weekly for four weeks after admission on 01/03/2020. On 03/11/2020 at 12:05 PM, the Dietitian indicated the Diet Requisition Form was filled out by the nursing staff for consultations and completed within five days. The Dietitian was not aware of the physician to see R85 on 02/05/2020 and acknowledged the physician order [REDACTED]. The Dietitian indicated the significant weight gain of 6.5% in one month was not addressed because it was a weight gain. The Dietitian confirmed the weekly weights were not implemented following a significant weight gain of 6.5% and acknowledged R85's weekly weights were not completed and documented for four weeks following admission. Resident #166 (R166) R166 was admitted on [DATE] and readmitted on [DATE], with [DIAGNOSES REDACTED]. The Admission MDS assessment dated [DATE], documented R166 had moderately impaired cognition and required supervision with one-person physical assist with eating. R166 had a weight loss of 5% or more in the last month or loss 10% of more in the last six months and was not on a physician-prescribed weight-loss regimen. The Weight Change History from 07/05/19 thru 03/12/2020 for R166 documented the following: Weight -161 pounds (07/05/19) Weight -170.4 pounds (08/05/19) Weight -158.1 pounds (09/04/19) Weight -160.6 pounds (10/05/19) Weight -162.2 pounds (11/06/19) Weight -155 pounds (12/04/19) Weight -163 pounds (01/03/2020) Weight -145.8 pounds (0[DATE]) Weight -144 pounds (03/04/2020) The Weight Change History revealed the following significant weight changes: -significant weight gain of 9.4 pounds (+5.8%) in one month on 08/05/19 -significant weight loss of 12.3 pounds (-7.2%) in one month on 09/04/19 -significant weight gain of 8 pounds (+5.2%) in one month on 01/03/2020 -significant weight loss of 17.2 pounds (-10.6%) in one month on 0[DATE] -significant weight loss of 16.4 pounds (-10.1%) in three months on 0[DATE] -significant weight loss of 24.6 pounds (-14.4%) in six months on 0[DATE] A Quarterly Follow-up Nutrition Progress note dated 09/09/19, revealed R166 with an average oral intake of 75-100% for breakfast, lunch and dinner. On 03/10/2020 at 9:19 AM, R166 verbalized not liking the food and had lost weight. R166 indicated the food was cold, tasted bad, and lacked flavor. R166 started going to the dining room for meals in July 2019. R166 indicated weighing 166 pounds and had dropped to 144 pounds recently. R166 indicated the roommate's family brought in snacks to keep at bedside if they were hungry. The medical record lacked documented evidence R166's significant weight changes were acknowledged and interventions were implemented for weight gain of 5.8% in one month on 08/05/19, weight decrease of 7.2% in one month on 09/04/19, and weight increase of 5.2% in one month on 01/03/2020. The medical record lacked documented evidence R166 was placed on the weekly weight monitoring after a significant weight change of weight increase of 5.8% in one month on 08/05/19, a weight decrease of 7.2% in one month on 09/04/19, a weight increase of 5.2% in one month for 01/03/2020, and 0[DATE] (weight decrease of 10.6% in one month, weight decrease of 10.1% in three months, weight decrease of 14.4% in six months). The medical record lacked documented evidence R166 had been weighed weekly for four weeks after readmission on 02/07/2020. On 03/12/2020 at 1:27 PM, a CNA verbalized R166 went to the dining room for lunch and ate in the room for breakfast and dinner. The CNA indicated R166 consumed 0-25% of breakfast, 75% of lunch, and 75% of dinner. The CNA indicated R166 disliked the food, ordered hot dogs most of the time and snacks in between meals. On 03/12/2020 at 1:26 PM, the Dietitian confirmed R166's significant weight changes were not acknowledged or discussed in the weekly weight meetings held on 08/05/19, 09/04/19 and 01/03/2020. The Dietitian indicated not usually addressing weight gain concerns for residents which was why weights on 08/05/19 and 01/03/2020 were not discussed in the weekly meeting. The Dietitian was not aware of discussing and evaluating weight gains per the facility Dietitian Assessment policy. The Dietitian verbalized the weight loss of 7.2% in one month on 09/04/19 did not have nutritional interventions in place to prevent further weight loss. The Dietitian acknowledged R166's weekly weights were not implemented following significant weight changes and weekly weights were not completed for four weeks following admission per the weight policy. Resident #114 (R114) R114 was admitted on [DATE] and readmitted on [DATE], with [DIAGNOSES REDACTED]. The Admission MDS dated [DATE], revealed R144 was cognitively intact and required supervision with setup for eating. A Care plan dated 10/17/18, revealed R114 was at risk for alteration in nutrition and history of gradual weight changes. The Admission Order and Plan of Care dated 01/22/2020, revealed R114 was on a regular diet, pureed texture, nectar-like thickened liquid. The Quarterly Follow-up Nutrition Progress note dated 10/15/19, documented R114 with an average of 75-100% oral intake for breakfast, lunch and dinner. The

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F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) Weight Change History from 04/0419 thru 01/24/2020 for R114 documented the following: Weight-134.4 pounds (04/04/19) Weight-118.8 pounds (05/05/19) Weight-111.1 pounds (06/04/19) Weight-112.4 pounds (07/05/19) Weight-114 pounds (08/05/19) Weight-120.8 pounds (09/04/19) Weight-127.4 pounds (10/05/19) Weight-126.8 pounds (11/06/19) Weight-126.8 pounds (12/04/19) Weight-130 pounds (01/01/2020) Weight-127.3 pounds (01/24/2020) The Weight Change History revealed the following significant weight changes: -significant weight loss of 15.6 pounds (-11.6%) in one month on 05/05/19 -significant weight loss of 22 pounds (-16.4%) in three months on 07/05/19 -significant weight gain of 6.8 pounds (+6%) in one month on 09/04/19 -significant weight gain of 9.7 pounds (+8.7%) in three months on 09/04/19 -significant weight loss of 14.6 pounds (-10.7%) in six months on 09/04/19 -significant weight gain of 15 pounds (+13.3%) in three months on 10/05/19 -significant weight gain of 15.7 pounds (+14.1%) in six months on 12/04/19 -significant weight gain of 17.6 pounds (+15.7%) in six months on 01/01/2020 The medical record lacked documented evidence R114's significant weight change was acknowledged and interventions were implemented for weight gain of 14.1% in six months on 12/04/19. The medical record lacked documented evidence R114 had been placed on the weekly weight monitoring after a significant weight changes of weight decrease of 11.6% in one month on 05/05/19, weight decrease of 16.4% in three months on 07/05/19, weight gain of 6% in one month on 09/04/19, weight gain of 14.1% in six months on 12/04/19, weight gain of 15.7% in six months on 01/01/2020. The medical record lacked documented evidence R114 had been weighed weekly for four weeks after readmission on 01/22/2020. On 03/12/2020 at 1:27 PM, a CNA verbalized R114 had a good appetite, consumed 75-100% of the meals and received snacks in between meals. On 03/12/2020 at 1:26 PM, the Dietitian confirmed R114's significant weight change was not acknowledged or discussed in the weekly weight meeting for 12/04/19 per the weight policy. The Dietitian indicated R114 was not seen in December 2019 due to quarterly assessment coming up in January 2020. The Dietitian saw residents every quarter, which was why some of the significant weight changes were not addressed. The Dietitian acknowledged R114's weekly weights were not implemented following significant weight changes weekly weights were not completed for four weeks following readmission.
F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to communicate with the [MEDICAL TREATMENT] center [MEDICATION NAME] (a medication used to help prevent low calcium levels) was not given with lunch on [MEDICAL TREATMENT] days for 1 of 35 sampled residents (Resident #70). Findings include: Resident #70 (R70) R70 was admitted on [DATE] and readmitted on [DATE], with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. A physician's orders [REDACTED]. On 03/11/2020 at 10:38 AM, R70 left the facility by 12:00 PM on [MEDICAL TREATMENT] days. R70 was provided with the [MEDICAL TREATMENT] Treatment Flowsheet and a sack lunch to take to the [MEDICAL TREATMENT] center. R70 indicated [MEDICATION NAME] was sent with the lunch meal. On 03/11/2020 at 11:40 AM, the Licensed Practical Nurse (LPN) confirmed R70 had an order to take [MEDICATION NAME] with meals. The LPN indicated R70 would be out of the facility by the time the [MEDICATION NAME] and the medication was not sent to the [MEDICAL TREATMENT] center for R70 to take with lunch. On 03/11/2020 at around 12:00 PM, R70 was in front of the nurses' station waiting for a sack lunch. R70 had not eaten lunch and would eat at the [MEDICAL TREATMENT] center. R70 indicated the LPN did give the [MEDICATION NAME] to take with lunch. The LPN confirmed R70 was not given the [MEDICATION NAME] to take with lunch. On 03/12/2020 at 1:22 PM, the Unit Manager indicated R70 ate very little and did not eat lunch at the facility on [MEDICAL TREATMENT] days due to transportation pick-up time of 12:00 PM. The Unit Manager conveyed, R70 was sent with a sack lunch and ate at the [MEDICAL TREATMENT] center. The Unit Manager confirmed R70 had an order for [REDACTED]. On 03/12/2020 at 12:52 PM, the [MEDICAL TREATMENT] Facility Administrator confirmed R70 had an order of [MEDICATION NAME] tablets to take with meals. R70 was scheduled to be dialyzed from 2:00 PM to 5:45 PM. The [MEDICAL TREATMENT] Facility Administrator would assume R70 had eaten lunch prior to arrival to the [MEDICAL TREATMENT] center. If a [MEDICAL TREATMENT] resident had not eaten their meal, had brought food with them to the [MEDICAL TREATMENT] center, the [MEDICAL TREATMENT] Facility Administrator would expect the facility to communicate with the [MEDICAL TREATMENT] center to remind the resident to take the [MEDICATION NAME] tablets with their food. The [MEDICAL TREATMENT] Facility Administrator explained [MEDICATION NAME] binders such as [MEDICATION NAME] were used to control the phosphorus levels in people with [MEDICAL CONDITION] who were on [MEDICAL TREATMENT]. The [MEDICATION NAME] binder would help prevent [DIAGNOSES REDACTED] caused by elevated phosphorus. The [MEDICAL TREATMENT] Facility Administrator explained [MEDICATION NAME] should be taken with meals and would not be effective if given before or after the [MEDICAL TREATMENT] resident had eaten their snack or meal. The medical record lacked documented evidence the facility communicated with the [MEDICAL TREATMENT] center R70's [MEDICATION NAME] was not provided at lunch time on [MEDICAL TREATMENT] days. The [MEDICAL TREATMENT] Policy was requested from the facility but was not provided.
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and documentation review, the facility failed to ensure an employee renewed their nursing license prior to providing care to residents for 1 of 36 sampled employees (Employee #36). Findings include: Employee #36 (E36) E36 was hired on ,[DATE] and employment was terminated on [DATE]. A License Verification Report documented E36 had a nursing license with an issue date of [DATE] with an expiration date of [DATE]. Nurse Staffing Schedules dated [DATE], [DATE], [DATE] and [DATE], documented E36 had worked various shifts from [DATE] through [DATE]. A Time-Card Differential Category Report indicated E36 had been compensated bi-weekly from [DATE] through [DATE]. A Corrective Action Form dated [DATE] indicated E36 was counseled for a medication error, timeliness in providing medications and documentation. On [DATE] in the morning, the Director of Human Resources (HR) indicated nurses were not to provide nursing care or pass medications to residents with an expired nursing license. The Director of HR terminated E36 because E36 had an expired nursing license. The Director of HR was unsure what tracking method was used to keep track of nurse license renewals prior to the Director of HR's employment. The Director of HR acknowledged E36 worked from [DATE] through [DATE] and provided care to residents without a current nursing license. The Director of HR indicated the Nurse Staffing Schedule for [DATE], [DATE], [DATE] and [DATE] reflected E36 worked various shifts and provided nursing services. The Director of HR indicated E36 was paid on a bi-weekly basis from [DATE] through [DATE]. On [DATE] in the morning, the Director of Nursing (DON) indicated nurses were not supposed to provide nursing care or pass medications to residents with an expired nursing license. The DON recalled, in [DATE], E36's license was expired and E36 was provided time to renew the license. The DON indicated when E36 did not renew the license, E36's employment was terminated. The DON acknowledged E36 worked from [DATE] through [DATE] and provided care to residents without a current nursing license. The DON indicated the Nurse Staffing Schedule for [DATE], [DATE], [DATE] and [DATE] reflected E36 worked various shifts and provided nursing services. A facility policy entitled Standard of Practice Statement revised [DATE], documented the facility required all associates were required to have a professional license and maintained their license per the licensing authority.

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 document review and interview, the facility failed to ensure fire door assemblies were inspected, tested and maintained as required. Findings include: 1) On 0[DATE], document review revealed the facility failed to ensure fire door assemblies were inspected and tested annually as required. The facility provided an annual door report that indicated a 3-hour fire door located in the kitchen was inspected on 07/31/2020. During an interview, the Maintenance Director indicated that 14 fire door assemblies were installed throughout the facility. The Maintenance Director and Maintenance Assistant indicated that the documentation was used to show all doors that were inspected on 07/31/2020. 2) During the facility tours conducted 0[DATE] and 03/13/2020, observation revealed the facility failed to maintain fire door assemblies as required, in the following locations: a) Kitchen - The 3-hour fire door between the kitchen and the south dining hall was missing several pieces of hardware on the latching mechanism and push bar. b) South Dining - The latching mechanisms, self-closer, and associated hardware was removed from the 90-minute fire doors at both entrances to the south dining hall.

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	29E037	A. BUILDING _____ B. WING _____	03/12/2020

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) Additionally, the south hall dining entrance doors (Double doors, 90-minute fire doors) across from the receptionist desk were observed with a inch to inch gap between the doors when they were closed. All observations were made in the presence of and acknowledged by the Maintenance Director and Maintenance Assistant.
F 0800 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure a dietary recommendation was followed for 1 of 35 residents (Resident #54). Findings include: Resident #54 (R54) R54 was admitted on [DATE], with [DIAGNOSES REDACTED]. On 03/10/2020 at 12:40 PM, R54's meal did not include ice cream. On 03/11/2020 at 12:15 PM, R54's meal did not include ice cream. R54's meal ticket documented the resident was to have ice cream with all meals. A Registered Dietitian note dated 03/6/2020, documented R54 was to get house shakes three times a day, large portions and ice cream with meals to help promote weight gain. On 03/11/2020 at 12:20 PM, a Certified Nursing Assistant (CNA), reported R54 did get ice cream at breakfast but not lunch. The ice cream came from the kitchen staff who placed the ice cream on the cart prior to transporting to the units. The CNA's served what was on the tray to R54. The CNA was not aware if the ice cream was given at dinner. R54 did not like to eat meals without a lot of coaxing from staff and ate all the ice cream when it was served. On 03/11/2020 at 12:50 PM, the Dietitian reported R54 had lost some weight. R54 was on a regular diet, house shakes and ice cream with all meals to assist in weight gain. The Dietitian was not aware the resident had not been given the ice cream at all meals. The Dietitian explained the kitchen staff provided the ice cream for the Memory Care staff to give to R54 and the ice cream was not available on the units. The Dietitian's expectation was for the meal ticket and recommendations to be followed by all staff. On 03/12/20 at 7:35 AM, the Dietary Manager explained the dietary staff put the ice cream on the trays per the ticket. The staff stocked the freezer's on the units with ice cream and snacks. The CNA's had access to the ice cream and were able to put the ice cream on the trays.
F 0808 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow a physician order [REDACTED].#85 (R85) R85 was admitted on [DATE], with [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) assessment dated [DATE], documented R85 with a Brief Interview for Mental Status (BIMS) score of 4, which indicated R85 had severe impaired cognition. R85 required supervision with one-person physical assist with eating. The Medical Nutrition Therapy assessment dated [DATE], documented R85 was receiving a regular, dysphagia mechanical texture diet. On 0[DATE]20 at 8:46 AM, R85's meal ticket indicated dysphagia mechanical texture with pureed bread, pureed scrambled eggs with cheese, and pureed hot cereal. R85's plate consisted of two halves of regular toast, scrambled eggs, and oatmeal, which were different food textures listed on the meal ticket. On 0[DATE]20 at 1:46 PM, R85's meal ticket indicated dysphagia mechanical texture with pureed lemon bar, pureed breadstick, pureed vegetable salad, and lasagna. R85's plate consisted of lasagna, dinner roll, lemon bar, and lettuce salad with dressing. R85 verbalized they were able to eat the dinner roll. On 03/11/2020 at 1:29 PM, R85's meal ticket indicated dysphagia mechanical texture with dysphagia crossed out in black pen. The meal ticket listed ground chicken, pinto beans, puree cornbread, and harvest baked apples. R85's lunch tray consisted of cornbread, sliced peaches, pinto beans, ground chicken, and coleslaw, which were different food textures listed on the meal ticket. On 03/11/2020 at 10:01 AM, the Dietary Manager (DM) indicated the facility had regular, mechanical, dysphagia mechanical and dysphagia pureed texture diets. The DM indicated the facility did not have any residents on the dysphagia mechanical texture diet. On 03/11/2020 at 12:05 PM, the Registered Dietitian indicated the dysphagia mechanical diets were not allowed to have toast, cornbread, dinner rolls, lettuce salads, coleslaw and lemon bars. The dietitian indicated the dysphagia mechanical textures needed to be soft and similar to a pureed consistency. The dietitian indicated the kitchen staff would serve everything listed on the meal ticket and follow the textures as indicated. The dietitian indicated the resident should have received pureed bread if the ticket listed puree bread. The dietitian acknowledged R85 meal ticket revealed dysphagia mechanical texture diet and was served the mechanical soft diet. On 0[DATE] at 1:27 PM, a Certified Nursing Assistant (CNA) verbalized R85's appetite was good and ate all meals in the room. The CNA verbalized R85 was on the dysphagia mechanical diet prior and the diet was changed to mechanical texture. Resident #114 (R114) R114 was admitted on [DATE] and readmitted on [DATE], with [DIAGNOSES REDACTED]. The Admission MDS assessment dated [DATE], revealed R144 with a BIMS score of 13, which indicated R114 was cognitively intact. The Admission Order and Plan of Care dated 01/22/2020, revealed R114 was on a regular diet, pureed texture, nectar-like thickened liquid. On 0[DATE]20 at 9:59 AM, R114 had a cup of thickened juice and a water pitcher with water and ice on the bedside table. R114 verbalized the ice water was not thickened and liked ice-cold beverages. On 0[DATE]20 at 1:29 PM, R114 had a cup of thickened juice and thickened water on the lunch tray. R114's meal ticket indicated nectar, fortified, and pureed diet. R114's water pitcher was next to the lunch tray filled with ice and thin water. On 03/11/2020 at 11:40 AM, R114 had a cup of thickened cranberry juice and a full water pitcher with thin ice water on the bedside table. On 03/11/2020 at 1:35 PM, R114 had two cups of thickened water and two cups of thickened juice on the lunch tray. R114's water pitcher on the bedside table was empty. On 03/11/2020 at 11:56 AM, a Restorative Nursing Assistant (RNA) verbalized R114 was on a pureed diet with nectar thickened liquids. The RNA acknowledged R114's water pitcher contained thin liquids and not nectar thickened liquids. The RNA verbalized thin liquids may cause the resident to choke or aspirate. The RNA indicated ice should not have been added to thicken liquids to make the thicken liquids cold because it would thin out the beverage. On 03/11/20 at 12:05 PM, the Registered Dietitian verbalized R114 was on a regular, pureed, nectar thickened liquid diet. The dietitian indicated the nursing staff was responsible for pouring the pre-packaged thickened beverages during meals and refilling the water pitchers in the rooms. The dietitian verbalized ice was not allowed in the thickened liquids to chill the beverage. Complaint #NV 521
F 0813 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Have a policy regarding use and storage of foods brought to residents by family and other visitors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure a resident's personal food from home was properly labeled and stored for 1 of 35 residents (Resident #47). Findings Include: Resident #47 (R47) R47 was admitted on [DATE] and readmitted on [DATE], with [DIAGNOSES REDACTED]. On 03/10/2020 at 12:10 PM, R47 had two plastic food containers on the floor, three containers on the bedside table, and one container filled with food on the ledge of the window. The bedside table had half a jar of pickle sauce and one opened bag of cereal. The plastic containers and food did not have labels and dates to indicate when the food was brought in. R47 indicated their family brought in the home cooked food in the containers and the cereal on the table. On 03/11/2020 at 1:37 PM, R47 had three plastic containers of food, a jar of pickle sauce, and a bag of opened cereal on the bedside table with no labels and dates. On 03/12/2020 at 12:43 PM, R47 had three plastic containers of food, a jar of pickle sauce, and a bag of opened cereal on the bedside table with no labels and dates. On 03/12/2020 at 12:45 PM, a Certified Nursing Assistant (CNA) verbalized food brought from home or outside restaurants should have been labeled and dated by the staff. The CNA indicated the food was tossed out after the meal or stored in the storage refrigerator located near the 500 hall storage room. On 03/12/2020 at 12:50 PM, the Registered Dietitian verbalized R47's family brought home cooked foods. The Dietitian indicated the nursing staff monitored and labeled the food brought in. On 03/12/2020 at 12:55 PM, the Infection Control Nurse verbalized the food brought in from home needed verification by the nursing staff. The Infection Control Nurse indicated it was the responsibility of the staff to label and date the food. The food should have been thrown out after the meal or placed in the medicine room refrigerator labeled and dated. The Infection Control Nurse indicated food should not have been left in the room after the meal. On 3/12/2020 at 2:11 PM, the Unit Manager indicated families would bring the food brought from home to the nurses for labeling and dating. The Unit Manager indicated the foods must be in airtight bags or containers. The Unit Manager indicated left over foods must be labeled and placed in the refrigerator in the 500 hall storage room. The Unit Manager confirmed the

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