STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295068	A. BUILDING _____ B. WING _____	**03/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIGHLAND MANOR OF MESQUITE	**272 PIONEER BLVD MESQUITE, NV 89027**

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 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to notify the physician and update the care plan following the refusal to wear a foot brace for 1 of 15 sampled residents (Resident #32). Findings include: Resident #32 (R32) R32 was re-admitted on [DATE], with [DIAGNOSES REDACTED]. R32 was aphasic and had a BIMS score of 15, which indicated the resident was cognitively intact. On 03/03/20 at 12:17 PM, R32 was observed in bed with a left leg brace in place. At 4:20 PM, R32 had the left leg brace off. On 03/04/20 at 9:15 AM, R32 was not wearing the left leg brace. A Physician order [REDACTED]. Monitor for signs and symptoms of infection and report to Physician. A care plan dated 10/18/2019, documented R32 had a left foot brace for foot drop. Approaches included: Apply and secure the foot brace. The discipline included in the care plan are Nurses, Certified Nursing Assistants (CNA) and Restorative Nursing Assistants (RNA). On 03/05/20 at 11:29 AM, R32 was observed not wearing the foot brace. The CNA working the area acknowledged not being aware R32 was supposed to wear a brace. The CNA indicated as per other CNA's, R32 had been refusing to wear the foot brace and that was the reason the CNA's were not consistently applying the brace. On 03/05/20 at 11:40 AM, R32 when asked why the left foot brace was not applied. R32 wrote the name of the RNA on a piece of paper. R32 acknowledged the brace was not consistently in place and the RNA was the only one applying the brace. On 03/05/20 at 1:33 PM, R32 was not wearing the foot brace. On 03/05/20 at 1:40 PM, two CNA's indicated R32 at times would let the staff apply the brace and at times would refuse. The CNA's indicated if the resident refused the application of the brace, the nurse should had been informed. On 03/05/20 at 1:50 PM, the RNA indicated R32 at most times would allow the brace to applied and would only want it on for a couple of hours. The RNA was not aware the brace should always be in place. The RNA verbalized the nurses, or the Director of Nursing (DON) should had been informed if a resident was refusing care. Review of R 32's Progress Notes from December 2019 to current lacked documented evidence of any refusal to wear the foot brace. Review of the Treatment Administration Record (TAR) from December to current reflected the resident consistently wears the brace. The TAR reflected R32 wore the brace consistently on 03/03/2020 and 03/04/2020, when it was observed to be off. On 03/05/20 at 2:06 PM, the Director of Nursing (DON) confirmed the progress notes lacked documented evidence R32 was refusing the brace. The DON indicated the importance of notifying the nurse for treatment refusals so the nurse could inform the physician and allowing the interdisciplinary team to adjust the care plan. The facility policy titled care Plan Policy revised 11/28/19, documented all qualified staff are responsible for carrying out interventions specified in the care plan. The staff will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure an accurate reconciliation between the Controlled Drug Record and the actual narcotic count for 2 of 18 sampled residents (Resident #13 and #48). Findings include: On 03/05/2020 at 3:15 PM, a narcotic medication reconciliation audit was performed which revealed the following: Resident #13 (R13) was re-admitted on [DATE], with [DIAGNOSES REDACTED]. A Physician order [REDACTED]. The medication blister pack for R13's [MEDICATION NAME] contained 23 tablets. The Controlled Drug Record for R13's [MEDICATION NAME] documented a balance of 24 tablets. The last documented administered dose was 03/04/2020 at 7:00 PM. R13's Medication Administration Record [REDACTED]. R13's Controlled Drug Record lacked documented evidence the medication was signed off by the nurse upon administering on 03/05/2020 at 7:00 AM. Resident #48 (R48) was admitted on [DATE], with [DIAGNOSES REDACTED]. A Physician order [REDACTED]. The medication blister pack for R48's [MEDICATION NAME] contained 60 tablets. The Controlled Drug Record for R48's [MEDICATION NAME] documented a balance of 1 tablet. The last documented administered dose was 03/04/2020 at 6:40 PM. R48's MAR indicated [REDACTED]. R48's Controlled Drug Record lacked documented evidence the medication was signed off by the nurse upon administering on 03/05/2020 at 9:00 AM. On 03/05/2020 at 3:20 PM, the Licensed Practical Nurse (LPN) acknowledged the discrepancies and indicated the nurse should have signed off the narcotic medication from the Controlled Drug Record upon administration. The LPN verbalized the medication blister pack and Controlled Drug Record must tally at all times. On 03/05/2020 at 4:20 PM, the Director of Nursing (DON) confirmed the findings and acknowledged the nurse should have signed off narcotic medication from the Narcotic Log upon administration. The DON indicated the expectation was for the medication count, Controlled Drug Record and MAR indicated [REDACTED].
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 medications stored in the treatment cart were dated as to the date when opened for use. Findings include: On 03/05/2020 at 3:00 PM, two partially used bottles of PVP Scrub solution 10 percent (%) Providone Iodine, 3 fluid (fl) ounce (oz), were stored inside the treatment cart. The two bottles of medications were not dated. The License Practical Nurse (LPN) confirmed the observation and indicated the bottles of skin preps are considered as medications and should have been dated upon opening. The LPN was not able to remember the last time the facility had used the Providine Iodine solutions for resident treatments. On 03/05/2020 at 3:30 PM, the Director of Nursing acknowledged the bottles of skin prep medications should have been dated when opened. The facility policy titled Pharmaceutical Procedures revised 10/18/19, documented each floor stock container shall bear the name and strength of the medication, lot and control number, expiration date (when applicable), and any other appropriate accessory or cautionary.

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.