STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295029	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WHITE PINE CARE CENTER	1500 AVENUE G ELY, NV 89301

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 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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review and document review, the facility failed to ensure a resident's sexually inappropriate behaviors were reported to the Abuse Coordinator within 24 hours, an investigation was initiated and completed for the alleged incidents, and was reported to the State for 1 of 9 sampled residents (Resident #1); and a pre-employment reference check was completed for 1 of 6 sampled employees (Employee #6). Findings include: Resident #1 (R1) R1 was readmitted on [DATE], with [DIAGNOSES REDACTED]. The Licensed Nurses documented R1's behavior in the following Behavior Note on the dates and times indicated: 01/08/2020 at 8:37 AM, Certified Nursing Assistant (CNA) just informed the Licensed Practical Nurse (LPN) R1 made inappropriate sexual hand movements to other residents in the dining room. 0[DATE] at 7:03 AM, R1 turned to another resident and made masturbating hand gestures towards the resident. 02/16/2020 at 2:44 AM, R1 had sexual behaviors as evidenced by rubbing self while naked in the dining room and in front of others. R1 was verbally aggressive with staff while trying to be redirected. 03/06/2020 at 1:51 AM, R1 wandered in hallways and went into other resident rooms. R1 was verbally aggressive and cussed at the staff when redirected. On 03/11/2020 at 1:51 PM, the Abuse Coordinator confirmed she/he was aware of the incident documented in the Behavior Note dated 01/08/2020 at 8:37 AM. R1 made inappropriate sexual hand movements to other residents in the dining room. The Abuse Coordinator confirmed there was no investigation initiated or completed regarding the incident. The Abuse Coordinator acknowledged an investigation should have been completed to determine the cause and prevent further occurrence of the same incident. The Abuse Coordinator indicated she/he was not aware of the other incidents which involved R1 as documented in the above-mentioned Behavior Note. The nurses should have reported R1's inappropriate sexual behaviors to the Abuse Coordinator within 24 hours. The resident's sexual behaviors should have been investigated. The Abuse Coordinator confirmed there was no investigation completed for the incidents documented in the above-mentioned Behavior Note. The incidents should have been reported to the State. On 03/11/2020 at 3:17 PM, an LPN confirmed R1's sexually inappropriate behaviors towards other residents were allegations of sexual abuse. The LPN acknowledged the incidents were not reported to the Abuse Coordinator. R1's sexually inappropriate behaviors should have been reported immediately to the Abuse Coordinator or within the shift. The incidents should have been reported to the State. The facility Abuse Prohibition Notification Form dated March 2012, documented alleged violations including mistreatment, neglect or abuse should have been reported immediately to the Executive Director (Administrator/Abuse Coordinator) and to other officials in accordance with Federal and State law. At the time of the alleged violation, an investigation was initiated. The results of all investigations must have been reported to the administrator or designated representative and to other officials in accordance with Federal and State law, not to exceed five working days of the incident. Employee #6 was a Licensed Practical Nurse (LPN) hired on 07/29/19. Employee #6's personnel file lacked documented evidence of a completed reference check. On 0[DATE] in the afternoon, the Administrator indicated being responsible for completing an employee background or reference checks on new employees. The Administrator indicated two employee reference checks for each applicant would have been completed prior to being hired. The Administrator confirmed reference checks were not completed for Employee #6. The facility Seven Components of Abuse policy (undated), documented the facility would not knowingly hire any individual who had a history of [REDACTED]. Facility Reported Incident #NV 408 and #NV 476
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 and clinical record review and document review, the facility failed to ensure a Baseline Care Plan was completed for 2 of 9 sampled residents (Resident #5 and #8). Findings include: Resident #5 (R5) R5 was admitted on [DATE], with [DIAGNOSES REDACTED]. On 03/11/2020 in the afternoon, R5's clinical record lacked documented evidence of a Baseline Care Plan for medical [DIAGNOSES REDACTED]. Resident #8 (R8) R8 was admitted on [DATE], with [DIAGNOSES REDACTED]. The clinical record lacked documented evidence of a Baseline Care Plans. On 0[DATE] at 11:47 AM, the MDS Coordinator revealed due to a turnover in MDS Coordinators, R8's baseline care plan was not developed and completed. The MDS Coordinator confirmed a baseline care plan should have been developed and completed by the Interdisciplinary Team within 48 hours from the admitted . The facility Care Plan policy revised 12/03/19, documented the staff would prepare an initial care plan. The care plan would include kind of service, health goals, equipment needed, dietary needs, [MEDICAL CONDITION] drugs, rehabilitative goals, physician's orders [REDACTED].
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review and document review, the facility failed to ensure comprehensive care plans were completed for inappropriate sexual behaviors and antianxiety medications for 1 of 9 sampled residents (Resident #1) for the care and services required 1 of 9 sampled residents (Resident #8). Findings include: Resident #8 (R8) R8 was admitted on [DATE], with [DIAGNOSES REDACTED]. A Comprehensive Minimum Data Set (MDS) assessment dated [DATE], revealed R8 required nursing, rehabilitative, dietary, and social services. The clinical record lacked documented evidence of a comprehensive care plan. On 0[DATE] at 11:47 AM, the MDS Coordinator revealed due to a turnover in MDS Coordinators, R8's comprehensive care plan was not developed and completed. The MDS Coordinator confirmed a comprehensive care plan should have been developed and completed by the Interdisciplinary Team within seven days from the date of the last comprehensive MDS assessment. The Center for Medicare and Medicaid Services (C[CONDITION]) Resident Assessment Instrument Manual revised October 2019, documented comprehensive care plans should be completed within seven calendar days from the date of the comprehensive MDS. Resident #1 (R1) R1 was readmitted on [DATE], with [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set ((MDS) dated [DATE], documented R1 had a Brief Interview for Mental Status (BI[CONDITION]) score of 4 which indicated severe cognitive impairment. The physician's orders [REDACTED]. The medication was discontinued on 03/05/2020 as ordered. The physician's orders [REDACTED]. The Medication Administration Record [REDACTED]. The Minimum Data Set (MDS) Coordinator indicated a care

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) plan should have been developed for the administration of R1's [MEDICATION NAME]. The care plan should have included the interventions such as to monitor the target behavior, side-effects, and efficacy of the medication. The Quarterly Minimum Data Set ((MDS) dated [DATE], documented R1 had a Brief Interview for Mental Status (BI[CONDITION]) score of 4 which indicated severe cognitive impairment. The following behavioral symptoms were present: - Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing) - Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, disrobing in public, or verbal/vocal symptoms like screaming, disruptive sounds) The Behavior Medication Review Form dated 09/10/19 and 01/14/2020, documented the resident was on [MEDICATION NAME] for dementia with behavioral disturbance. The target behaviors included sexualized behaviors towards female staff and history of sexual inappropriateness with female residents. The licensed nurses documented R1's behavior in the following Behavior Note on the dates and times indicated: - 01/08/2020 at 8:37 AM, Certified Nursing Assistant (CNA) just informed the Licensed Practical Nurse (LPN) R1 made inappropriate sexual hand movements to other residents in the dining room. - 0[DATE] at 7:03 AM, R1 turned to another resident and made masturbating hand gestures towards the resident. - 02/16/2020 at 2:44 AM, R1 had sexual behaviors as evidenced by rubbing self while naked in the dining room and in front of others. R1 was verbally aggressive with staff while trying to be redirected. - 03/06/2020 at 1:51 AM, R1 wandered in hallways and went into other resident rooms. R1 was verbally aggressive and cussed at the staff when redirected. R1's clinical record lacked documented evidence a comprehensive care plan was developed for the resident's inappropriate sexual behaviors. On 03/11/2020 at 3:17 PM, the MDS Coordinator confirmed the findings and acknowledged a care plan for R1's inappropriate sexual behaviors should have been developed. The interventions should have included to redirect the resident, explain to the resident why it was not appropriate, and removed the resident from the situation. The MDS Coordinator revealed R1 made sexually inappropriate comments towards staff and sexually inappropriate behaviors towards residents and staff as documented in the Behavior Note. The facility Care Plan policy dated 12/03/19, documented when a resident's health condition was assessed, the staff would have prepared or updated the resident's care plan. The care plans would have included resident behaviors, [MEDICAL CONDITION] drugs and what kind of services needed for the resident.
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, clinical record review and document review, the facility failed to ensure a physician's order was obtained for a resident to be transferred to the hospital for 1 of 9 sampled residents (Resident #7). Findings include: Resident #7 (R7) R7 was admitted on [DATE], with [DIAGNOSES REDACTED]. A Situation Background Assessment Recommendation form dated 01/09/2020, indicated R7 had an unwitnessed fall and was transferred to the emergency room (ER) for further evaluation per the former Director of Nursing's instruction. The clinical record lacked documented evidence of a physician's order to transfer R7 to the ER. On 03/11/2020 at 10:37 AM, a Licensed Practical Nurse (LPN) indicated an ER transfer due to a fall would have been initiated, only if a physician had ordered the transfer. On 0[DATE] at 9:24 AM, the Charge Nurse indicated if a resident had a fall, the physician would be informed of any injuries. The Charge Nurse indicated the physician would determine if the injuries could be treated in the facility; if not, the physician would order an ER transfer for further evaluation. The Charge Nurse confirmed a physician's order to transfer to the ER should have been obtained and documented in R7's clinical record. The ER Transfer policy (undated), documented when transferring a resident to the ER, the nurse would print the current physician's orders, inform the physician, and call the ER and provide the transfer details.
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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.** Based on interview, record review and document review, the facility ensure an initial competency evaluation was documented for 5 of 6 personnel files review (Employee #1, #3, #4, #5 and #6), and annual competency evaluation for 3 of 6 personnel files review (Employee #1, #4 and #5). Findings include: Employee #1 was hired as a Certified Nursing Assistant (CNA) on 01/16/19. Employee #1's personnel file lacked documented evidence of a completed initial and annual competency evaluation. Employee #3 was hired as a Licensed Practical Nurse (LPN) on 02/04/2020. Employee #3's personnel file lacked documented evidence of a completed initial competency evaluation. Employee #4 was hired as an LPN on 03/05/18. Employee #4's personnel file lacked documented evidence of a completed initial and annual competency evaluation. Employee #5 was hired as a CNA on 03/01/19. Employee #5's personnel file lacked documented evidence of a completed initial and annual competency evaluation. Employee #6 was hired as an LPN on 07/29/19. Employee #6's personnel file lacked documented evidence of a completed initial competency evaluation. On 0[DATE] at 9:24 AM, the Charge Nurse confirmed CNAs, LPNs, and registered nurses (RN), would receive training on orientation, and a competency evaluation would be documented in a checklist. The LPN indicated the checklist would be signed off by a preceptor and would have been completed within 30 days. The LPN revealed an annual competency evaluation would be completed to ensure the staff's skills were aligned with the facility's standards of practice. On 0[DATE] at 11:11 AM, the Charge Nurse confirmed the personnel files lacked documented evidence of completed initial and annual competency evaluations. The Orientation and Skills Competency Log (undated) for CNAs, LPNs, and RNs, documented the skills checklist should have been completed within 30 days from the receipt of this form. An Annual Competency Skills Assessment form (undated) for CNAs, LPNs, and RNs, revealed a supervisor would rate and review the staff's performance annually. Each staff performance would be rated as exceeds performance, expected performance, or needs improvement. The form would be reviewed and signed by the employee and supervisor.
F 0740 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident must receive and the facility must provide necessary behavioral health care and services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review and document review, the facility failed to ensure a psychiatric consultation was provided to a resident who was diagnosed , assessed and care planned, for behavioral problems for 1 of 9 sampled residents (Resident #1). Findings include: Resident #1 (R1) R1 was readmitted on [DATE], with [DIAGNOSES REDACTED]. The active physician's orders [REDACTED]. The order was dated 03/26/17. The Quarterly Minimum Data Set ((MDS) dated [DATE], documented R1 had a Brief Interview for Mental Status (BI[CONDITION]) score of 4 which indicated severe cognitive impairment. The following behavioral symptoms were present: - Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing) - Verbal behavioral symptoms directed toward others (e.g., screaming at others, cursing at others) - Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, disrobing in public, or verbal/vocal symptoms like screaming, disruptive sounds) - Rejection of care - Wandering R1's Care Plan documented the following: - The resident had a behavioral problem related to dementia as evidenced by refusal of care, physical aggression, continuous elopement, and resident to resident confrontations and altercations. The care plan was initiated on 11/28/18 and revised on 05/03/19. - The resident had a potential to be physically aggressive toward residents and staff related to dementia. The care plan was initiated on 07/26/19. - The resident had impaired cognitive function or impaired thought processes related to dementia. The care plan was initiated on 12/08/17 and revised on 05/03/19. - The interventions included staff/provider to implement and reinforce cognitive and psychosocial interventions as a means of behavioral management and psychosocial rehabilitation. The intervention was initiated on 05/03/19. The licensed nurses documented R1's behavior in the following Behavior Note on the dates and times indicated: - 01/08/2020 at 8:37 AM, Certified Nurse Assistant (CNA) just informed the Licensed Practical Nurse (LPN) R1 made inappropriate sexual hand movements to other residents in the dining room. - 01/19/2020 at 5:35 PM, R1 was being physically aggressive as evidenced by going after another resident. R1 tried to hit the other resident and ran him over R1's wheelchair. - 01/19/2020 at 6:26 PM, LPN saw R1 touch another staff member's buttocks. R1 stated you have a nice butt. - 0[DATE] at 7:03 AM,, R1 turned to another resident and made masturbating hand gestures towards the resident. -

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F 0740 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) 02/16/2020 at 2:44 AM ,R1 had sexual behaviors as evidenced by rubbing self while naked in the dining room and in front of others. R1 was verbally aggressive with staff while trying to be redirected. - 0[DATE]20 at 10:48 AM, LPN was informed R1 hit another resident. - [DATE]20 at 6:09 PM, R3 punched R1's right arm. R3 was tired of R1's nasty mouth. - 03/06/2020 at 1:51 AM, R1 wandered in hallways and went into other resident rooms. R1 was verbally aggressive and cussed at the staff when redirected. On 03/11/2020 at 1:51 PM, the Administrator acknowledged R1 should have had a psychiatric consultation due to the behaviors manifested. On 03/11/2020 at 3:17 PM, an LPN confirmed R1 was physically and verbally aggressive to the staff during provision of care. The resident had bitten, kicked, and pinched the staff during showers and when changing the resident. R1 also made inappropriate sexual comments and behaviors towards staff and other residents. The resident had been involved in resident to resident altercations. The LPN indicated the last psychiatric consultation R1 received was in May 2018 and June 2018. The LPN acknowledged R1 should have received another psychiatric consultation in 2019 due to the behaviors manifested. The psychiatric consultation could have assessed the effectiveness of current interventions and provided different therapeutic interventions to address the resident's behavioral problems. On 0[DATE] at 10:11 AM, another LPN revealed R1 was physically and verbally aggressive towards the staff. The resident was involved in resident to resident altercations. R1 wandered in the hallways and entered other resident rooms. The resident made inappropriate sexual gestures and comments towards the staff and other residents. On 0[DATE] at 2:52 PM, the Administrator acknowledged a psychiatric consultation should have been provided to R1 in 2019. The nurses were expected to initiate the process of obtaining a psychiatric consultation for the resident. The physician should have been informed then contracted behavioral services should have been notified when ordered. The Facility Reported Incident dated 0[DATE]20, documented R1 and R2 were in the dining room and waited for an activity to begin. R1 bumped into R2's wheelchair, words were exchanged, and R1 hit R2. The alleged incident occurred on 02/23/2020 at 10:45 AM. Facility Reported Incident #NV 408 and #NV 476
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and clinical record review, the facility failed to ensure a laboratory test for an [MEDICATION NAME] level was obtained per the Interdisciplinary Team (IDT) and pharmacy recommendation for 1 of 9 sampled residents (Resident #1). Findings include: Resident #1 (R1) R1 was readmitted on [DATE], with [DIAGNOSES REDACTED]. The physician's orders [REDACTED]. The Behavior Medication Review Form dated 01/14/2020, documented the IDT recommended an [MEDICATION NAME] level for R1 was needed. R1's clinical record lacked documented evidence an [MEDICATION NAME] level was obtained per the IDT recommendation. On 0[DATE] at 9:24 AM, a Licensed Practical Nurse (LPN) confirmed the findings and revealed the LPN was one of the members of the IDT. The IDT recommended the laboratory test for an [MEDICATION NAME] level because the medication was a hormone supplement and to determine the therapeutic level of the medication. (The therapeutic level of a drug in the bloodstream was the range within which the drug was expected to be effective without causing any serious problems to the resident). The [MEDICATION NAME] level was also based on the pharmacy recommendation in January 2020. The LPN acknowledged R1's [MEDICATION NAME] level should have been obtained in January 2020. The resident could have refused the laboratory test. The LPN confirmed there was no documentation of the resident's refusal of the laboratory test. The test had not been done as of 0[DATE]. On 0[DATE] at 9:29 AM, the Pharmacy Consultant confirmed R1's [MEDICATION NAME] level was recommended in January 2020. The laboratory test for an [MEDICATION NAME] level was necessary to determine the therapeutic level of the medication. An elevated level of [MEDICATION NAME] could have caused more aggressive behaviors, increased confusion and anxiety.