STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN STREET FALLON, NV 89406

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 0604 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and document review, the facility failed to ensure a restraint device was not used prior to completing an assessment, to obtain an informed consent, and a physician order [REDACTED].#32 Resident #32 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Clinical record review revealed a Certified Nursing Assistant (CNA) found Resident #32 on the floor next to the bed in the early morning of 03/10/20, noting no new injuries. Messages were left with the physician and son. Clinical records updated 03/10/2020 at 11:55 AM, documented the fall was reviewed by the Interdisciplinary Team (IDT). Resident #32 has had an increase in falls recently. No noted injury with this last roll out of bed. Mats have been placed at bedside for when resident was in bed. Resident currently not self transferable . Mats will not pose a tripping hazard because the resident was not transferring independently. Due to the increase in falls, labs were being ordered to check for acute illness or infection. Care plan reviewed. Changes: Mats to floor when in bed. On 03/10/20 at 3:11 PM, a scoop mattress was on Resident #32's bed. On 03/10/20 at 3:42 PM, Resident #32's medical record lacked documented evidence of an updated Care Plan, Progress Notes or physician's orders [REDACTED]. On 03/11/20 at 8:23 AM, the scoop mattress was on Resident #32's bed. On 03/11/20 at 8:34 AM, the Director of Nursing (DON) explained the resident had rolled out of the side of the bed without the side rail, so it was replaced with a scoop mattress. The DON was unable to provide documentation of an assessment as evidence the scoop mattress was not used as a restraint. The DON confirmed the Care Plan lacked documentation of use of a scoop mattress. The DON verbalized a physician's orders [REDACTED]. On 03/11/20 at 9:43 AM, the DON confirmed the scoop mattress was used for one night on 03/10/20 for Resident #32. The scoop mattress was removed on 03/11/20 due to resident's alert status. The DON also verbalized neither an assessment, nor a consent could be found for the use of a scoop mattress. The facility policy titled Restraints, last revised 11/28/17, documented the facility was to control the use of physical restraints including, but not limited to leg restraints, arm restraints, hand mitts, soft ties or vests, wheelchair safety bars and lap trays. The policy indicated some facility practices meet the definition of a restrain such as: Bedrails keeping the resident from getting out of bed or placing a resident on a concave mattress so the resident could not get out of bed. Procedures for the use of device were documented as follows: 1. An assessment will be completed by licensed staff prior to use and reassessment will be completed at least every 90 days with the least restrictive restraint method to be used. This assessment shall include the resident's medical symptoms requiring the use of restraint and the less restrictive alternatives attempted but ineffective. 2. A signed consent was to be obtained by the resident, resident representative, or guardian prior to use. The consent form shall include any potential negative outcomes of physical restraint use. The consent form shall be used for a specified period of time. Signed consent will be obtained following the initial period of time if the restraint use continues to be appropriate. 3. A physician's orders [REDACTED]. The order should include a reason for the restraint, type of restraint to be used, and the length of time the restraint is to be used.
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, clinical record review, and document review the facility failed to accurately complete the MDS assessment to include a resident's pressure ulcers and a resident's [MEDICAL TREATMENT] treatments for 2 of 18 residents (Resident #40 and #57). Findings include: Resident #40 Resident #40 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 03/09/20 at 3:01 PM, the Registered Nurse (RN) for Resident #40 verbalized the resident had wounds present to the resident's sacrum and buttocks. The Minimum Data Set (MDS) 3.0 assessment for Resident #40, dated 03/05/20, documented, under Section M, the resident did not have one or more unhealed pressure ulcers/injuries and no selections were made for current number of pressure ulcers/injuries at each stage. The Wound Management documentation for Resident #40, dated 02/21/20, 02/27/20, and 03/05/20, all documented a Stage II pressure ulcer to the resident's left buttock. On 03/11/20 at 7:58 AM, the MDS Coordinator verbalized the MDS Coordinator would have looked at the Wound Management documentation to determine what to document on the MDS. The MDS Coordinator verbalized the MDS data was incorrect and there was a discrepancy concerning the number of pressure ulcers the resident had. Resident #57 Resident #57 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A physician order [REDACTED].#57, dated 11/07/18, documented the resident was a long-term resident with end stage [MEDICAL CONDITION] requiring [MEDICAL TREATMENT]. The MDS for Resident #57, dated 02/19/20, had no [MEDICAL TREATMENT] documented in Section O. On 03/11/20 at 7:52 AM, the MDS Coordinator verbalized Section O should indicate the resident was receiving [MEDICAL TREATMENT] but this information was not documented and was an MDS discrepancy. The facility policy, titled CMS's RAI Version 3.0 Manual, dated 10/2019, documented the RAI had multiple regulatory requirements including the assessment accurately reflected the resident's status.
F 0642 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Ensure a qualified health professional conducts resident assessments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and document review, the facility failed to ensure the Minimum Data Set (MDS) 3.0 assessments, completed by a Licensed Practical Nurse (LPN), were reviewed for accuracy by a Registered Nurse (RN) for 18 of 18 sampled residents (Resident's #2, #8, #13, #21, #24, #25, #27, #30, #31, #32, #36, #40, #44, #50, #51, #56, #57, and #59). Findings Include: On 03/11/20 at 7:58 AM, the MDS Coordinator verbalized the MDS Coordinator was an LPN and there was no quality review completed for the MDS assessments. The LPN verbalized the Director of Nursing (DON) signed the assessments as the RN but did not review the assessments for accuracy or completion. On 03/11/20 at 8:52 AM, the DON verbalized there was not a review completed to ensure accuracy of the MDS assessment after the assessment was filled out by the LPN. The DON verbalized the DON signed the MDS prior to submission but did not review the assessment for accuracy or completion. Resident #2 Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS for Resident #2, dated 01/15/20, was completed by the MDS LPN and signed by the DON on 03/10/20. Resident #8 Resident #8 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS for Resident #8, dated 02/26/20, was completed by the MDS LPN and signed by the DON on 03/03/20. Resident #13 Resident #13 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS for Resident #13, dated 03/04/20, was completed by the MDS LPN and signed by the DON on 03/10/20. Resident #21 Resident #21 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].#21, dated 03/06/20, was completed by the MDS LPN and signed by the DON on 03/10/20. Resident #24 Resident #24 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS for Resident #24, dated 01/02/20, was completed by the MDS LPN and signed by the DON on 01/06/20. Resident #25 Resident #25 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS for Resident #25, dated 01/28/20, was completed by the MDS LPN and signed by the DON on 02/05/20. Resident #27 Resident #27 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS for Resident #27, dated 01/08/20, was completed by the MDS LPN and

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 0642 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) signed by the DON on 01/14/20. Resident #30 Resident #30 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS for Resident #30, dated 01/22/20, was completed by the MDS LPN and signed by the DON on 01/25/20. Resident #31 Resident #31 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS for Resident #31, dated 01/15/20, was completed by the MDS LPN and signed by the DON on 01/23/20. Resident #32 Resident #32 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS for Resident #32, dated 01/15/20, was completed by the MDS LPN and signed by the DON on 01/23/20. Resident #36 Resident #36 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS for Resident #36, dated 01/29/20, was completed by the MDS LPN and signed by the DON on 02/05/20. Resident #40 Resident #40 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS for Resident #40, dated 02/05/20, was completed by the MDS LPN and signed by DON on 02/10/20. Resident #44 Resident #44 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS for Resident #44, dated 02/05/20, was completed by the MDS LPN and signed by the DON on 02/10/20. Resident #50 Resident #50 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS for Resident #50, dated 02/12/20, was completed by the MDS LPN and signed by the DON on 02/17/20. Resident #51 Resident #51 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS for Resident #51, dated 02/12/20, was completed by the MDS LPN and signed by the DON on 02/17/20. Resident #56 Resident #56 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS for Resident #56, dated 02/19/20, was completed by the MDS LPN and signed by the DON on 02/25/20. Resident #57 Resident #57 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS for Resident #57, dated 02/19/20, was completed by the MDS LPN and signed by the DON on 02/25/20. Resident #59 Resident #59 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS for Resident #59, dated 02/19/20, was completed by the MDS LPN and signed by the DON on 02/25/20. The facility Job Description, titled Director of Nursing, revised 11/28/18, documented the DON was to monitor the completion of the entire MDS care plan program and sign the MDS as the RN Assessment Coordinator. The nursing roles and responsibilities as specified in Nevada Revised Statutes (NRS 632) and Nevada Administrative Code (NAC 632), approved 12/17/01, documented the LPN contributes to assessment by collecting, reporting, and recording objective and subjective data and the RN validates, refines, and modifies data.
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.** Based on observation, interview, clinical record review and document review, the facility failed to develop an activity care plan to address the resident's stated activities goals and preferences for 1 of 17 residents (Resident #36). Findings include: Resident #36 On 03/09/20 at 9:14 AM, Resident #36 verbalized the resident would like to have been able to go outside when the weather was nice but the resident was unable to get out of bed without assistance and staff did not get him out of bed to take him outside when the weather was nice. The resident verbalized the resident did not enjoy the larger group activities, but the group activities were the activities most often offered to the resident. A Minimum Date Set (MDS) 3.0 assessment, dated 01/29/20, documented the resident had answered it was very important to the resident to go outside to get fresh air when the weather was good. An activities Care Plan for Resident #36, last revised on 01/16/20, did not address the resident's goal of being able to go outside. On 03/11/20 at 8:18 AM, the Activities Director verbalized the resident was invited to group activities two to three times per day and should have been offered to go outside at least twice a week. The Activities Director verbalized there were no interventions on the resident's Care Plan to address the resident's goal of going outside when the weather was nice. The facility policy, titled How to Write an Activity Care Plan, revised 11/2017, documented the activity care plan should have included all interests identified through the interview for activity preferences (Section F of the MDS).
F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and document review the facility failed to provide a resident with individual activities to meet the resident's stated interests for 1 of 18 residents (Resident #36). Findings include: Resident #36 Resident #36 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 03/09/20 at 9:14 AM, Resident #36 verbalized the resident would like to have been able to go outside when the weather was nice but the resident was unable to get out of bed without assistance and staff do not get him out of bed to take him outside when the weather was nice. The resident verbalized the resident did not enjoy the larger group activities, but the group activities were the activities most often offered to the resident. On 03/10/20 at 10:26 AM, the resident verbalized the resident wished someone would assist the resident up to the resident's wheelchair to go outside. The resident verbalized the resident felt sad because the resident had been looking out the window over the past few days and wanted to go outside because the weather looked nice. A Minimum Date Set (MDS) 3.0 assessment, dated 01/29/20, documented the resident had answered it was very important to the resident to go outside to get fresh air when the weather was good. An activities Care Plan for Resident #36, last revised on 01/16/20, did not address the resident's goal of being able to go outside. Activity Participation Forms, dated 09/2019 through 02/2020, did not document the resident had been offered to be taken outside. On 03/11/20 at 8:18 AM, the Activities Director verbalized the resident was invited to group activities two to three times per day and should have been offered to go outside at least twice a week. The Activities Director verbalized there were no interventions on the resident's Care Plan to address the resident's goal of going outside when the weather was nice. The facility policy, titled Activities, revised on 10/23/19, documented the facility would provide an ongoing program to support residents in their choice of activities, including independent activities, designed to meet the interest of, and support the mental and psychosocial wellbeing of each 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 interviews and document review, the facility failed to ensure medications were properly administered to 1 of 17 residents (Resident #25). Findings include: Resident #25 Resident #25 admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #25's physician order [REDACTED]. Resident #25's Medical Administration Record (MAR) dated 03/2020, documented the following: -[MED], 0.4 mg capsule was not administered on 03/01/20 at 8:00 PM due to drug/item being unavailable. -[MED], 0.4mg capsule was not administered on 03/02/20 at 8:00 PM due to drug/item being unavailable. -[MED], 0.4mg capsule was not administered on 03/04/20 at 8:00pm due to drug/item unavailable. On 03/11/20 at 9:40 AM, the Director of Nursing (DON) verbalized [MED] was available on the dates Resident #25 was not administered the medicine. Each Licensed Practical Nurse (LPN) has a personal code to access Omnicell (a phamaceutical device holding back-up medication stock) and nurses should have pulled the medications from the Omnicell. The DON confirmed there was no staff designated to review the MAR. The DON was unaware Resident #25 had missed the medications until today. The facility policy titled Medication Administration using eMAR, dated 11/11, documented employees were to administer all medications to the resident in the manner and method prescribed by the physician and in the event a medication cannot be given, it must be marked as Not Administered on the eMAR and the reason must be documented. The physician will review all orders on a monthly basis and sign the order sheet, indicating renewal of the orders.
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, clinical record review, and document review, the facility failed to ensure a resident was adequately supervised to prevent the resident from smoking while wearing Oxygen for 1 of 18 residents (Resident #8); to provide protective supervision to prevent an elopement for 1 of 4 unsampled residents (Resident #112). Findings include: Resident #8 Resident #8 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 03/09/20 at 1:52 PM, Resident #8 verbalized the resident was a smoker and went outside to smoke alone without staff supervision. Resident had 2 liters per minute of Oxygen being administered via nasal cannula from a portable concentrator attached to the back of the

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) resident's wheelchair. On 03/10/20 at 8:26 AM, the resident went outside to the smoking area. Resident had cigarettes and lighter and was preparing to light a cigarette. The resident realized the resident's Oxygen was still on and went back into the building and requested for a staff member to remove the Oxygen. A Care Plan for Resident #8, dated 11/27/19, documented the staff would ensure the resident removed Oxygen prior to going outside to the smoking area. On 03/11/20 at 7:32 AM, the Registered Nurse (RN) for Resident #8 verbalized when the resident requested smoking supplies from the med cart, it was the nurse's responsibility to remove the Oxygen from the resident's wheelchair and place the Oxygen in the resident's room. On 03/11/20 at 8:58 AM, the Director of Nursing (DON) verbalized the resident should not have been able to go outside to the smoking area with Oxygen on as this would create a safety hazard. The facility policy, titled Non-Smoking Facility, revised on 02/25/19, documented the purpose of resident protection procedures was to promote the health and assure safety for all residents. Resident #112 Resident #112 was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. The facility submitted an initial and final Facility Reported Incident (FRI) report for a resident elopement to the State on 01/06/20. The FRI documented on 01/04/20 Resident #112 was found by the Police at a intersection. A Certified Nursing Assistant (CNA) coming to work saw Resident #112 with the police and stopped and identified Resident #112. The police had the CNA call the facility and have a Charge Nurse identify him and take him back to the facility. When Resident #112 was asked where the resident was going the resident stated to the grocery store. Resident #112's progress notes dated 01/04/20, recorded as late entry on 01/05/20, documented at 4:40 PM, a Registered Nurse (RN) received a call from a CNA who was coming to work. The CNA verbalized Resident #112 was on the street in a wheelchair, 2 blocks away from the facility. The RN went outside to take Resident #112 back to the facility. Upon arriving to the scene, Resident #112 was with the CNA and a Police officer. The Officer released the resident to the RN. When the resident was asked where the resident was going, Resident #112 verbalized going to the grocery store. Daughter was notified about the incident. On 03/10/20 at 3:16 PM, the Administrator verbalized Resident #112 eloped in a self-propel wheelchair. The Administrator believed Resident #112 went out the door by the 200 hall. A CNA acknowledged the CNA heard the door alarm and when looking out did not see the resident. The Administrator verbalized the CNA did not go outside to search for a resident. Another CNA was on their way to work at the facility around 2:00 PM and saw Resident #112 with a Police officer. The Administrator verbalized being informed that a bystander called the police regarding the resident. The RN Charge Nurse was contacted by the CNA and went to Resident #112 and brought the resident back into the facility. The facility policy titled Missing Resident, revised 02/25/19 documented the purpose is to provide 24-hour supervision of the resident's safety.
F 0712 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that the resident and his/her doctor meet face-to-face at all required visits.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and interview, the facility failed to complete physician visits within the required timeframes for 1 of 17 sampled residents (Resident #44). Findings include: Resident #44 Resident #44 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #44's clinical record documented an initial physician visit on 12/16/19, a 60-day physician visit on 01/15/20, and a 90-day physician visit on 0[DATE]. On 03/11/20 at 1:36 PM, the Director of Nursing (DON), verbalized physician visits were required to be completed every 30 days for the first 90 days of a resident's admission. The DON verbalized the timeframes for the physician visits would start from the resident's admitted . The DON confirmed Resident #44's initial, 60-day, and 90-day physician visits were not completed within the required timeframes. The DON verbalized the DON was unsure if the facility had a policy on the timeliness of physician visits.
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**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 observation, interview and document review the facility failed to ensure the Interim Director of Nursing (IDON) had the competency, tools, and knowledge to train staff in the standard of practice used for providing care in the facility. On 03/10/20 at 11:47 AM, the IDON verbalized being the IDON for approximately 3 months and did not know what standard of practice was used in the facility to guide nursing procedures, skills, or tasks. The IDON verbalized the IDON was unaware of a facility specific or corporate standard of practice. On 03/10/20 at 12:19 PM, the Corporate Nurse Consultant (CNS) verbalized the standard of practice was an online resource nursing staff could access at any time for policies, procedures, and skills. On 03/10/20 at 12:33 PM, a Licensed Practical Nurse (LPN#1) verbalized the LPN worked at the facility for five years. The LPN #1 attempted to locate the policies and procedures online. The LPN #1 could not access the information and verbalized the LPN had been unable to access the information online for a long time. The LPN #1 located a binder labeled Nursing Procedures at the back of a nursing station. The Nursing Policy and Procedures binder was revised 02/2004 and 03/2004. On 03/10/20 at 12:40 PM, the CNS verbalized the Nursing Policy and Procedure binder found at the nursing station dated 02/2004 and 03/2004 was outdated and should have been removed. Current policies/procedures for nursing were dated/updated 2019. On 03/10/20 at 12:44 PM, the IDON verbalized the IDON was unaware the Nursing Policy and Procedure binder was at the nursing station. On 03/10/20 at 12:38 PM, the CNS requested a Licensed Practical Nurse (LPN #2) to access the online corporate resources. The LPN #2 attempted to access the information and was denied access to the site. The CNS verbalized all nursing staff needed to have access to the website and should have had IT authorization to access it upon hire. On 03/10/20 at 4:11 PM, the CNS verbalized the standard of practice used for facility staff included the Medical Association guidelines, National Pressure Ulcer Advisory Panel (NPUAP) guidelines, and Federal Regulations. On 03/12/20 at 8:11 AM, the CNS supplied a typed list of the facility standards of practice which included federal regulations, RAI manual, Medical director association and NPUAP. The CNS verbalized the standards of practice had been given to the CNS by corporate leadership. The CNS lacked documented evidence of the online access for facility staff to policies and procedures or standards of practice. The facility job description titled Director of Nursing, revised 04/03/18, documented the DON would train and supervise all employees. The facility form titled OJT Checklist - Director of Nursing/Assistant Director of Nursing, dated 12/16/19, documented the IDON had received training on the policies and procedures for resident isolation, pharmacy, and radiology, but lacked documented evidence of training for facility policy and procedures or standards of practice. On 03/11/20 at 3:56 PM, the MDS Coordinator verbalized the MDS Coordinator was receiving training via phone on Friday's from other MDS Coordinator's in the same organization. Two skills checklists were provided for the MDS Coordinator. One checklist with a start date of 11/11/19, was incomplete. The other checklist, with a start date of 01/27/20, was also incomplete. On 03/11/20 at 3:56 PM, the MDS coordinator verbalized the checklist was started over on 01/27/20 because the MDS Coordinator had been inadequately trained by the original trainer and the facility had made the decision to start the training over on 01/27/20. The MDS Coordinator verbalized the MDS Coordinator had not yet been fully trained on the MDS Coordinator role and process and was independently completing the MDS assessments.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure medications in 1 of 4 medication carts were secured and a resident in a secured unit was not self-administering medication for 1 of 1 unsampled residents (Resident #361). On 03/09/20 at 3:41 PM, the 200-hall medication cart parked at nursing station in front of Liberty Lane was left unlocked. There were no licensed nurses within sight of the cart. The medications on the cart were easily accessible to residents, visitors, and staff. On 03/09/20 at 3:43 PM, the DON verbalized medication carts were to be locked at all times. THe ADministrator acknowledged the cart was unlocked, anyone could access the medications in the cart, and the nurse assigned to the cart was not at the nursing station, or in the hallway. Resident #361 Resident #361 was admitted to the facility's secure unit on 01/27/20 with [DIAGNOSES REDACTED]. On 03/11/20 at 9:10 AM, Resident #361 was seated

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) alone in Resident #361's room using a nebulizer. Resident #361 was self-administering a breathing treatment. There were no staff members in the room or the hallway. On 03/11/20 at 9:12 AM, Resident #361 verbalized it was Resident #361's room, nebulizer, and medication. Resident #361 verbalized being alone in the room, using a nebulizer every 4-5 hours routinely, and being left alone frequently when using the nebulizer for a treatment. On 03/11/20 at 9:14 AM, a Certified Nurses (CNA) entered the room and verbalized a Licensed Practical Nurse (LPN #1 and LPN #2) had requested the CNA sit with Resident #361 while the resident received the breathing treatment. The CNA confirmed the CNA was not a licensed medication technician and was not qualified in medication administration. On 03/11/20 at 9:19 AM, LPN #1 verbalized LPN #2 set up and started Resident #361's breathing treatment, notified LPN #2 it was started and left the unit. LPN #2 was aware Resident #361 was unattended during the breathing treatment and was self-monitoring and administering the breathing treatment. LPN #2 confirmed the CNA was not qualified to monitor the resident or administer medications. LPN #1 verbalized Resident #361 did not have a physician order [REDACTED]. The ADON confirmed Resident #361 had not been evaluated by the interdisciplinary team for self-administration of medications and did not have a physician order [REDACTED].#2 verbalized LPN #2 had set up and started Resident #361's breathing treatment then notified LPN #1 the treatment was started. LPN #2 confirmed Resident #361 was left alone to self-administer the breathing treatment. The facility policy titled Pharmaceutical Procedures, revised 10/18/19, documented all resident medications would be stored in a locked cabinet, locked medication room, or locked medication cart. All medication carts would be under visual control of a nurse when the cart was not stored securely. The policy also documented resident self-administration of medications would not be permitted without the written order of a physician.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview and document review, the facility failed to ensure sanitary requirements in the kitchen wash line, proper hand hygiene was followed during tray line, food equipment was properly cleaned and sanitized, food temperatures and reheating procedures were followed, and jewelry was not worn by staff in the kitchen, with the potential to affect 63 of 63 resident census. Findings include: Kitchen Wash Line On 03/09/20 at 8:48 AM, a crack at the handle of the dishwasher was leaking water when in operation. The backflow pipe at the top of the dishwasher was also leaking. Mineral deposit was built up around both leaks. The Dietary Director confirmed both leaks and repairs were needed. On 03/09/20 at 9:01 AM, there was a missing tile on the wall behind the dishwasher line. The tile was approximately 4x4 inches. The missing tile exposed a permeable wall and lacked the ability to be sanitized. The Dietary Director confirmed the tile was missing and explained the wall had been exposed when a shelf had been removed and the tile fell off. The facility work history report documented the monthly dishwasher inspection, confirming there were no water leaks, and was marked on-time on 0[DATE]. Food Equipment Cleanliness On 03/09/20 at 9:27 AM, the satellite kitchen in Unit Three revealed stains and water under the cutting board of the steam table. The Dietary Director confirmed it remained wet and the staff needed additional training for proper cleaning and drying. The facility policy titled Cleaning and Sanitizing Work Surfaces & Equipment Procedure, adopted 08/19, documented employees were expected to clear equipment of food and food crumbs using cleaning and sanitizing procedures and to allow the equipment to air dry completely before using. Hand Hygiene On 03/10/20 at 11:40 AM, the tray line in Unit Three had food transported by a Dietary Aide (DA) cart into the satellite kitchen. On 03/10/20 at 11:54 AM, the steam table was opened and an old dried food stain was located between the tray wells. The DA placed gloves on hands to handle the hot trays, without washing hands. On 03/10/20 at 11:57 AM, the DA began moving the hot trays to the steam table. The DA verbalized the DA preferred to use gloves to move the trays prior to hand washing because the DA did not want to wash her hands. The DA verbalized it was not how the DA was trained for proper hand hygiene however, it was how the DA did it. On 03/10/20 at 11:59 AM, the DA stepped away from the steam table and discarded her gloves. The DA pulled paper towels from a dispenser and placed the towels on top of a trash can lid. The DA washed the DA's hands and retrieved the paper towels from the top of the trash can and dried her hands. On 03/10/20 at 12:01 the DA began taking the temperature of the remaining food. On 03/10/20 at 12:12 PM, the DA discarded her old gloves and donned new gloves without washing her hands. The DA continued to complete the tray line for Unit Three. On 03/10/20 at 12:20 PM, the Dietary Director verbalized it was okay to move the covered food to the steam table prior to hand washing but hands must be washed and gloved before uncovering the food and taking temperatures. The Dietary Director confirmed hands were to be washed prior to donning gloves. The facility policy titled Hand Washing Technique documented employees were to wet hands with clean, running water and apply soap, to lather hands by rubbing them together for at least 20 seconds, to rinse hands well under running water, and to dry hands thoroughly with paper towels then turn off faucets with a clean, dry paper towels, and to discard towels into trash. Food Temperature (Reheating) On 03/10/20 at 12:04 PM, the pureed meatloaf was temped at 134 degrees Fahrenheit (F). The DA verbalized it was below proper holding temperature and placed it in the microwave to reheat. On 03/10/20 at 12:06 PM, the DA took the temperature of the reheated meatloaf; It was 150 degrees . The DA verbalized it was okay because it was above 135 degrees F. The DA returned the pureed meatloaf container to the steam table. On 03/10/20 at 12:20 PM, the Dietary Director verbalized that meatloaf needed to be reheated to 165 degrees for 2 minutes and confirmed the Dietary Director would reheat the pureed meatloaf to proper cooking temperature for reheating. The facility procedure titled Measuring Food Temperatures documented employees were expected to send any item not at the correct temperature back to the kitchen for the Dietary Manager or Head Cook to decide if it should be discarded or reheated. Previously heated foods cooked in the microwave to be reheated to a minimum temperature of 165 degrees for 15 seconds with a rotation or stir midway through cooking, and to let sit for 2 minutes before serving. Jewelry On 03/10/20 between 11:40 AM and 12:20 PM, during tray line of Unit Three satellite kitchen, the DA wore dangling earrings, multiple dangling necklaces and unsecured eyeglasses placed on top of her head (on top of a baseball cap). The Dietary Director verbalized wearing those items was against policy while working on the tray line. The facility policy Jewelry in the Food Service Kitchen, documented employees were prohibited from wearing earrings, watches & smart watches, bracelets, necklaces, lanyards, pins, gauges or any other facial or ear piercings.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review and document review, the facility failed to document a resident's blood sugars and medication administration for InstaGlucose for 1 of 17 sampled residents (Resident #27). Findings include: Resident #27 Resident #27 was admitted to the facility on [DATE] and readmitted on [DATE], with [DIAGNOSES REDACTED]. On 03/09/19 at 9:21 AM, Resident #27 explained they had fallen on 01/08/20, and had a fractured clavicle. Resident #27 was attempting to transfer from the bed to the wheelchair. The locks on the wheelchair were not locked and the wheelchair slid away from the resident causing the resident to fall. In addition, the resident verbalized having low blood sugar levels at times and it may have been a cause for the fall. Resident #27's blood sugar level was checked immediately and glucose was administered as a result. A physician order [REDACTED]. Give one tube if blood sugar level was less than 60 and resident was able to safely swallow. Recheck the blood sugars after ten minutes, give a second tube if blood sugar was still below 60 or if the resident was unable to safely swallow, then inform the medical provider. Resident #27's progress notes dated 01/08/20, documented the resident had fallen and was found on the floor in the resident's room. The resident was confused, as a result, the resident's blood sugars were checked and documented at 48. InstaGlucose was administered and blood sugars were checked again and were at 135. Resident #27's Medication Administration Record (MAR) dated January 2020, lacked documented evidence InstaGlucose was administered on 01/08/20. Resident #27's Vitals record, located in the electronic hard chart, lacked documented evidence of the resident's blood sugar levels before and after the administration of InstaGlucose on 01/08/20. On 03/10/20 at 2:40 PM, the Administrator verbalized the resident had fallen on 01/08/20. Staff had heard a loud bangs, went into the residents room and found the resident on the floor. The resident seemed confused so their blood sugars were checked immediately. Resident #27's blood sugar was at 48. Staff then administered Instaglucose and checked the blood sugars again and were at 135. The resident was taken to the hospital to be evaluated and the hospital determined the resident had broken their clavicle. The Administrator verbalized the resident's blood sugars were to be documented under

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIGHLAND MANOR OF FALLON	**550 NORTH SHERMAN STREET FALLON, NV 89406**

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) vitals in the electronic chart and confirmed no blood sugars were documented in the vitals section of the resident's electronic chart. The Administrator verbalized all medications were to be documented if they were administered on the electronic MAR and confirmed the resident's InstaGlucose administration was not documented on the electronic MAR. On 03/10/20 at 2:40 PM, the Regional Nurse Consultant confirmed InstaGlucose was not documented on the resident's MAR to indicate the medication was administered and the blood sugar levels were not documented under the vitals section in the electronic chart. However, the blood sugars and the administration of InstaGlucose were documented in the residents progress notes. The Regional Nurse Consultant explained if as needed medications were not input into the tasks section of the electronic chart and the medication was administered, then the administration of the medication would not carry over to the resident's MAR. On 03/10/20 at 4:14 PM, the Regional Nurse Consultant verbalized the expectation was to see the blood sugars documented under vitals in the electronic hard chart and the administration of InstaGlucose should be documented on the resident's electronic MAR. The Regional Nurse Consultant explained the information being documented under progress notes was inappropriate and staff were not aware to check for vitals or medication administration for residents under the progress notes. The facility policy titled, Medication Administration, last revised 02/04, documented whenever an as needed medication was administered, the administration of the medication must be documented on the MAR to include the response to the medication and documentation of medication administration would be done immediately by the staff member responsible. The facility policy titled, Medication Administration using eMAR, last revised 11/11, documented whenever an as needed medication was administered, the administration of the medication must be documented on the eMAR to include the response to the medication and documentation of medication administration would be done immediately by the staff member responsible. Documentation of medications being administered would be done in a consistent manner by the nurse documenting the preparation and administration of the medicine on the eMAR. The nurse would then put their initials in the appropriate space on the electronic MAR.