

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

*Acceptable POC document*

PRINTED: 11/22/2023  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>295088</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>11/15/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WINGFIELD SKILLED NURSING AND REHABILITATION CENTE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2350 WINGFIELD HILLS RD SPARKS, NV 89436</b>
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>This Statement of Deficiencies was generated as a result of Facility Reported Incident (FRI) and complaint (CPT) investigations conducted in your facility from 10/09/23 to 10/10/23, and 11/15/23, in accordance with 42 Code of Federal Regulations (CFR) Chapter IV, Part 483-Requirements for Long Term Care Facilities.</p> <p>The census at the time of survey was 107.</p> <p>The sample size was 20.</p> <p>There were three CPTs and 15 FRIs investigated.</p> <p>CPT #NV00069059 with the allegation a resident was not given a prescribed medication resulting in death was substantiated (See tag F600 and F760).</p> <p>CPT #NV00069159 with the following allegations could not be substantiated due to a lack of evidence:</p> <p>Allegation #1: A resident had a cell phone and money stolen from the resident's room. Allegation #2: A resident had an unwitnessed fall and caused a prolonged facility stay.</p> <p>FRI #NV00068948 with an allegation a resident had an unwitnessed fall in a resident room could not be substantiated due to a lack of evidence.</p> <p>FRI #NV00069185 with the allegation an employee was verbally abusive to a resident could not be substantiated due to a lack of evidence.</p>	F 000	<p>This plan of correction is being submitted as a requirement of ongoing participation in the Medicare and Medicaid program, however, should in no way be construed as agreement with any of the deficiencies cited.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>,LNHA</b>	(X6) DATE <b>11/29/2023</b>
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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 000	<p>Continued From page 1</p> <p>FRI #NV00069269 with the allegation a resident was called a racial slur by another resident could not be substantiated due to a lack of evidence.</p> <p>The investigation into the allegations included:</p> <p>Observation of supervision of residents, resident to resident interactions, employee to resident interactions, fall precautions in resident rooms, and personal items in resident rooms.</p> <p>Interviews were conducted with a Certified Nursing Assistant (CNA), three Licensed Practical Nurses (LPN), two Licensed Social Workers (LSW), a Physical Therapist, the Director of Rehabilitation, the Director of Nursing (DON), the Administrator, and two residents.</p> <p>Document review included care plans, Minimum Data Set 3.0 (MDS) assessments, progress notes, behavioral progress notes, fall risk assessments, belongings inventory sheets, staff records, staff schedules, staff trainings, history and physicals, hospital admit and discharge summaries, social worker progress notes and Situation, Background, Assessment, Recommendations (SBAR).</p> <p>Policy review included Personal Property, Resident Belongings and Valuable Items, Resident Rights, Safety and Supervision of Residents, Falls and Fall Risk Management, Fall Risk Assessment, Fall Prevention Management, Abuse Investigating and Reporting, Abuse Prevention Program, Investigating Injuries, Protection of Residents During Abuse Investigations, Recognizing Signs and Symptoms of Abuse/Neglect, and Liberalized Medication Administration.</p>	F 000			

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F 000	<p>Continued From page 2</p> <p>FRI #NV00069197 with an allegation a CNA borrowed money from a resident and did not pay the resident back was substantiated (See Tag F602).</p> <p>FRI #NV00068977 with an allegation a resident had money stolen from a wallet could not be substantiated due to a lack of evidence.</p> <p>FRI #NV00069546 and FRI #NV00069206 with an allegation a resident had an unwitnessed fall in a resident room resulting in neglect could not be substantiated due to a lack of evidence.</p> <p>FRI #NV00068808 with an allegation a resident had fallen in the shower room could not be substantiated due to a lack of evidence.</p> <p>The investigation into the allegations included:</p> <p>Observation of resident to staff interactions, supervision of residents, fall precautions on residents and in resident rooms, obstructions in resident rooms, interventions in place for residents deemed a fall risk, and personal items in resident rooms.</p> <p>Interviews were conducted with a CNA, two Registered Nurses (RN), two LSWs, a Physical Therapist, the Director of Rehabilitation, the DON, the Administrator, and the Regional MDS Coordinator.</p> <p>Document review included care plans, MDS assessments, nursing progress notes, incident reports, behavioral progress notes, fall risk assessments, inventory sheets, police reports, grievances, employee records, State Board of Nursing investigation letters, staff trainings,</p>	F 000			

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F 000	<p>Continued From page 3</p> <p>in-service trainings for staff, history and physicals, hospital documentation, social worker progress notes, and SBARs.</p> <p>Policy review included Personal Property, Resident Belongings and Valuable Items, Emergency Procedure-Seizure Management, Resident Rights, Safety and Supervision of Residents, Falls and Fall Risk, Management, Fall Risk Assessment, Fall Prevention Management, Abuse Investigating and Reporting, Abuse Prevention Program, Investigating Injuries, Protection of Residents During Abuse Investigations, and Recognizing Signs and Symptoms of Abuse/Neglect.</p> <p>FRI #NV00069006 with the allegation a resident hit another resident was substantiated (See Tag F600).</p> <p>FRI #NV00069113 with the allegation a resident was observed yelling after another resident had thrown water at the first resident was substantiated (See Tag F600).</p> <p>FRI #NV00069356 with the allegation a resident reported striking another resident causing the resident to hit the floor resulting in a forehead laceration and a left rib abrasion was substantiated (See Tag F600).</p> <p>FRI #NV00068634 with the allegation a facility employee mistook a resident for a visitor and allowed the resident to exit the facility was substantiated (See Tag F689).</p> <p>FRI #NV00069007 with the allegation a resident was found in the parking lot of the facility next door was substantiated (See Tag F689).</p>	F 000			

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F 000	<p>Continued From page 4</p> <p>FRI #NV00069548 with the allegation a resident eloped from the facility was substantiated (See Tag F689).</p> <p>FRI #NV00069708 with the following allegations could not be substantiated:</p> <p>Allegation #1: an employee caused a resident to have a skin tear to the hand could not be substantiated for employee to resident abuse due to a lack of evidence.</p> <p>Allegation #2: a resident had yelled, lunged at and attempted to punch another resident could not be substantiated for resident to resident abuse due to a lack of evidence.</p> <p>Complaint #NV00069802 with the allegation a resident was not provided food preferences by the facility could not be substantiated for food preparation to meet a resident's individual needs due to a lack of evidence.</p> <p>The investigation into the allegations included:</p> <p>Observations of a resident exiting the facility, residents of concern in their rooms and in the Activities room.</p> <p>Interviews were conducted with three residents of concern, the receptionist, the Administrator, the Director of Nursing, a Licensed Social Worker, and the Food Services Director.</p> <p>Reviewed 11 resident records including 11 residents of concern to include care plans, elopement risk evaluations, physician orders, daily skilled charting progress notes, incident progress notes, alert progress notes, nursing</p>	F 000		

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F 000	Continued From page 5 progress notes, behavior progress notes, communication notes, social services progress notes, behavior psychoactive meeting notes, nutritional assessment, dehydration risk evaluation, and weights.  Reviewed the employee of concerns record to include background check, nursing license, and abuse training.  Reviewed the facility policies titled, Resident Rights, Emergency Procedures - Missing Resident, Elopements, Elopement Prevention - Policy and Procedure, Wandering and Elopements, Abuse Prevention Program, and Resident Food Preferences.  The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.	F 000			
F 600 SS=G	The following deficiencies were identified: Free from Abuse and Neglect CFR(s): 483.12(a)(1)  §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice (indicate specifically how the deficient practice cited in the Statement of Deficiencies (SOD) for each resident cited will be corrected.  Resident #1, #11, and #12 are no longer in the facility.  Resident #10, #13, and #14 are currently doing well. A trauma screen was immediately done to ensure that the residents did not have any negative effects from the incidents.  Resident #9 is currently in the facility. The resident remained stable. The resident is currently receiving psychiatric services.		

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F 600	<p>Continued From page 6</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and document review, the facility failed to prevent neglect of a resident when medication was not administered per a physician's order resulting in death for 1 of 31 residents sampled for medication review (Resident #1) and prevent resident to resident abuse for 8 of 8 residents sampled with documented resident to resident altercations (Resident #9, #10, #11, #12, #13, and #14).</p> <p>Findings include:</p> <p>Resident #1</p> <p>Resident #1 was admitted to the facility on 02/08/23, with diagnoses including cardiac arrest, cause unspecified, and non-ST elevation myocardial infarction (NSTEMI).</p> <p>A hospital Discharge Summary dated 02/08/23, documented Resident #1 was admitted to the hospital on 01/13/23 for cardiac arrest. The resident received a cardiac catheterization and suffered another brief arrest during the procedure. Resident #1's discharge medications included Brillinta (ticagrelor) 90 milligrams (mg), take one tablet by mouth two times a day for 30 days.</p> <p>A Nursing Progress Note dated 02/08/23, documented Resident #1 was admitted to the</p>	F 600	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>All the resident have the potential to be affected. An audit of medication administration was done by the nursing management team to ensure that medications are given timely. An audit of all residents were done to ensure that all residents are free from neglect. All staff were inserviced in recognizing resident to resident abuse.</p> <p>What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur.</p> <p>An inservice training was done to all licensed nurses (RN/LPNs) on how to enter medication orders to the electronic medical records. Additional training was done to the licensed nurses (RN/LPNs) on what to do when medications are unavailable. Medication unavailability will be reported to the director of nursing or designee.</p> <p>An inservice was done to all staff regarding abuse and neglect.</p> <p>How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program/processes will be put into place to monitor the continued effectiveness of the systemic change.</p> <p>The director of nursing or designee will audit new medication orders on a weekly basis to ensure that medications are given in a timely manner.</p> <p>The director of social work will audit 5 residents per month to ensure that residents are free from abuse and neglect.</p>	

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F 600	<p>Continued From page 7</p> <p>facility and did not have shortness of breath, breathing difficulties, or chest pain. The resident's heart rate and rhythm were regular. Resident #1 reported the hospital medication list was accurate and medication orders were verified with the provider.</p> <p>A physician's order dated 02/08/23, documented the following:</p> <p>Brillinta (ticagrelor) oral tablet, give 90 mg by mouth two times a day for NSTEMI.</p> <p>The Medication Administration Record (MAR) dated 02/01/23-02/28/23, documented Resident #1 did not receive Brillinta on the following dates and administration times:</p> <p>-02/08/23: 8:00 PM -02/09/23: 8:00 AM -02/09/23: 8:00 PM -02/10/23: 8:00 AM -02/10/23: 8:00 PM -02/11/23: 8:00 AM -02/11/23: 8:00 PM -02/12/23: 8:00 AM -02/12/23: 8:00 PM</p> <p>Nursing Progress Notes documented the following for the Brillinta medication:</p> <p>-02/08/23 9:05 PM: Brillinta oral tablet, awaiting delivery -02/09/23 8:54 AM: Brillinta oral tablet, newly admitted, awaiting delivery from pharmacy -02/09/23 10:27 PM: Brillinta oral tablet, awaiting delivery -02/10/23 7:32 AM: Brillinta oral tablet, awaiting delivery from pharmacy</p>	F 600	<p>The results of the audit will be submitted to the QAPI Committee in a period of three months. At the end of the three month period, the QAPI Committee will determine if additional interventions are necessary.</p> <p>The responsible party for accomplishing and/or monitoring compliance with the corrective action. If the corrective action involves more than one person, the party who maintains ultimate responsibility should be identified.</p> <p>The Director of Nursing</p> <p>Date of Compliance: 11/15/2023</p>		

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F 600	<p>Continued From page 8</p> <p>-02/10/23 7:15 PM: Brillinta oral tablet, awaiting delivery</p> <p>-02/11/23 10:57 AM: Brillinta oral tablet, waiting for delivery</p> <p>-02/11/23 10:38 PM: Brillinta oral tablet, awaiting delivery</p> <p>-02/12/23 8:08 AM: Brillinta oral tablet, awaiting for pharmacy delivery</p> <p>-02/12/23 7:08 PM: Brillinta oral tablet, awaiting delivery</p> <p>Resident #1 had not received the Brillinta medication for nine medication administrations.</p> <p>A Situation, Background, Assessment, and Recommendation (SBAR) Communication Form dated 02/13/23 at 2:35 AM, documented the following for Resident #1:</p> <p>-Change in condition, symptoms, or signs observed and evaluated were cardiac arrest, respiratory arrest, and unresponsiveness.</p> <p>-Mental status evaluation: unresponsiveness</p> <p>-Functional status evaluation: without pulse and respirations</p> <p>-Respiratory evaluation: respirations ceased</p> <p>-Cardiovascular evaluation: without pulse</p> <p>-Observation and evaluation summary: 2:30 AM Resident #1 was diaphoretic, pursed lipped breathing and unresponsive upon entering room. Eyes fixated. The resident's respirations and pulse ceased when the blood pressure cuff was applied. 2:35 AM, cardiopulmonary resuscitation (CPR) initiated per full code status, call placed to 911. Six rounds of compressions with oxygen at 15 liters per minute given until paramedics/fire took over code, intubated resident, administered epinephrine twice along with intravenous fluids, and transported resident to the hospital at 3:00</p>	F 600			

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F 600	<p>Continued From page 9</p> <p>AM with continued chest compressions.</p> <p>A Hospital Nursing Progress Note dated 02/13/23, documented Resident #1 arrived with pulseless electrical activity, had received CPR in the field for over 30 minutes, and did not have a pulse.</p> <p>An Emergency Department Physician Record dated 02/13/23, documented Resident #1 arrived in the Emergency Department at 3:15 AM. Resident #1 presented with cardiac arrest and CPR was in progress upon arrival. The resident was intubated to establish an airway. A total of 45 minutes of CPR was administered and Resident #1 never achieved a return of spontaneous circulation. The resident expired on 02/13/23 at 3:33 AM, with a high suspicion for an in-stent thrombosis leading to a fatal cardiac arrest.</p> <p>A Nursing Progress Note dated 02/13/23, at 4:14 AM, documented a call was placed to the hospital for a status update on Resident #1 and was informed by the hospital nurse the resident had expired.</p> <p>On 10/09/23 at 3:42 PM, a Licensed Practical Nurse (LPN) explained if a medication was missing, and not stocked in the automated medication dispensary (Passport), the nurse should call the pharmacy and find out why the medication was not sent. The LPN verbalized the facility pharmacy could send a prescription to a local pharmacy and have it delivered to the facility. The LPN explained missing medication, the follow up, and physician notification should be documented in the clinical record as a progress note. The LPN confirmed Brillinta was not stocked in Passport and would have to be</p>	F 600			

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NAME OF PROVIDER OR SUPPLIER  <b>WINGFIELD SKILLED NURSING AND REHABILITATION CENTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2350 WINGFIELD HILLS RD</b> <b>SPARKS, NV 89436</b>		
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F 600	<p>Continued From page 10 ordered through the pharmacy.</p> <p>On 10/09/23 at 3:57 PM, the Director of Nursing (DON) explained the expectation of nursing staff to follow up on missing medications was to call the pharmacy, find out where the medication was, what caused the delay, and notify both the physician and the Nurse Supervisor or DON. The DON verbalized it was the nurse's responsibility to follow up on any medication issues and would expect a missing medication to be available by the next scheduled administration. The DON confirmed the facility pharmacy was available seven days per week and for 24 hours per day.</p> <p>On 10/09/23 at 4:00 PM, the DON confirmed Resident #1 did not receive the prescribed medication Brillinta from 02/08/23-02/12/23. The DON verbalized the DON did not know the resident had not received the medication until the resident was transferred out to the hospital on 02/13/23, and should have been notified of any issues with obtaining the medication. The DON explained a resident with a cardiac diagnosis could experience cardiac arrest or a blood clot without the prescribed medication. The DON confirmed it was neglect when the facility did not administer the Brillinta to Resident #1.</p> <p>On 10/09/23 at 4:09 PM, the Administrator explained the expectation of nursing to follow up on a missing medication by calling the pharmacy, the physician, and the Nurse Manager or DON. The Administrator verbalized the missing medication was expected to be present by the next administration time. The Administrator confirmed it was not acceptable for a resident to miss a critical medication for five days and explained the medication order transcribed by the</p>	F 600			

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F 600	<p>Continued From page 11</p> <p>nurse had indicated the medication was on hand and part of house stock, therefore it was not filled through the pharmacy. The Administrator confirmed it was neglect when the facility did not administer the Brillinta to Resident #1.</p> <p>On 10/10/23 at 10:09 AM, the Pharmacy Manager explained each new admission required an electronic notification to add the resident to the system. The nurse would enter all medication orders into the electronic system, the orders would go to the pharmacy, and the pharmacy would fill the orders. The nurse would have to indicate the status of each medication as on hand, house stock, or pharmacy fill. A medication indicated as on hand or house stock would not be filled by the pharmacy because it was not identified as a pharmacy fill. The Pharmacy Manager confirmed the Brillinta was not filled for Resident #1 until 02/13/23, as the fill request was not made until the evening of 02/12/23.</p> <p>An Order Audit Report, dated 10/10/23, documented Brillinta oral tablet 90 mg, give one tablet by mouth two times a day for NSTEMI and had an original status of "On Hand" with a source of "House Stock". On 02/13/23, the medication was auto-linked with a prescription number, had a source of "Pharmacy-Partners," and was dispensed on 02/13/23.</p> <p>The medication was not filled until 02/13/23, after the resident had transferred to the hospital and expired.</p> <p>The facility policy titled, "Recognizing Signs and Symptoms of Abuse/Neglect," revised January 2011, documented signs of actual physical neglect included improper use/administration of</p>	F 600			

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F 600	<p>Continued From page 12</p> <p>medication, inadequate provisions of care, and caregiver indifference to resident's personal care and needs.</p> <p>The facility policy titled, "Abuse Prevention Program," revised December 2016, documented residents had the right to be free from neglect and the facility would protect residents from abuse including abuse from facility staff.</p> <p>A facility policy titled "Liberalized Medication Administration Policy and Procedure," dated February 2023, documented it was the policy of the facility to administer medication to residents in a safe manner. Medications prescribed by the physician would be given as such. The medical director and pharmacist would provide direction for any concerns that arose in order to optimize the care and safety for medication administration effects for each individual resident based on their needs.</p> <p>A facility policy titled "Resident Rights," revised December 2019, documented the Resident had a right to receive treatment and support for daily living safely.</p> <p>Cross Reference to tag F760</p> <p>Complaint #NV00069059 Facility Reported Incident (FRI) #NV00069006 documented on 07/15/23 a resident hit another resident.</p> <p>Resident #9</p> <p>Resident #9 was admitted to the facility on 01/14/23, with diagnoses including hemiplegia and hemiparesis following cerebral infarction</p>	F 600		

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F 600	<p>Continued From page 13</p> <p>affecting right dominant side, aphasia, vascular dementia, and anxiety disorder.</p> <p>Resident #9's Care Plan dated 06/08/23, documented the resident had the potential to be verbally aggressive with inappropriate language and yelling.</p> <p>Resident #10</p> <p>Resident #10 was admitted to the facility on 03/14/22, with diagnoses including discitis, unspecified, thoracic region, hyperlipidemia, essential primary hypertension, and chronic pain.</p> <p>An Incident Progress Note dated 07/15/23, documented Resident #10 reported to staff Resident #9 had hit Resident #10 after asking to change the television channel.</p> <p>On 10/10/23 at 10:40 AM, Resident #10 was in bed watching television. The resident verbalized remembering the incident happening and reported it to staff.</p> <p>On 10/10/23 at 1:16 PM, the Director of Nursing (DON) confirmed Resident #10 had reported having been hit by Resident #9 after asking to change to television channel. The DON verbalized Resident #9 had documented behaviors and did not want to give up the television remote control and hit Resident #10.</p> <p>FRI #NV00069113 documented on 07/31/23, a resident was observed yelling and cursing at another resident who had thrown water at the first resident.</p> <p>Resident #11</p>	F 600			

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F 600	Continued From page 14  Resident #11 was admitted to the facility on 03/19/22, with diagnoses including unspecified sequelae of cerebral infarction, dysphagia and depression.  Resident #12  Resident #12 was admitted to the facility on 05/08/23, with diagnoses including discitis, unspecified, lumbar region, anxiety disorder, depression, and bi-polar disorder.  A Behavior Progress Note dated 07/31/23, documented Resident #11 had come out of the resident's room yelling the resident's roommate had thrown water at the resident.  A Social Services Progress Note dated 08/01/23, documented Resident #12 had reported Resident #11 would not stop singing and after asking Resident #11 to stop multiple times, Resident #12 threw water from a cup at Resident #11.  On 10/10/23 at 1:13 PM, the DON confirmed Resident #12 had thrown water at Resident #11 after asking multiple times for Resident #11 to stop singing.  FRI #NV00069356 documented on 09/03/23, a resident reported striking another resident causing the resident to hit the floor resulting in a forehead laceration and a left rib abrasion.  Resident #13  Resident #13 was admitted to the facility on 06/29/22, with diagnoses including malignant neoplasm of tongue, unspecified dementia, mood	F 600			

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F 600	<p>Continued From page 15 disturbance, and anxiety.</p> <p>Resident #14</p> <p>Resident #14 was admitted to the facility on 06/16/23 with diagnoses including acute cystitis without hematuria, cognitive communication deficit, dementia, psychotic disturbance, mood disturbance, and anxiety.</p> <p>An Incident Progress Note dated 09/03/23, documented Resident #13 had reported striking Resident #14 after Resident #14 would not stop going through Resident #13's personal property. Resident #14 was found in the resident's bathroom washing blood from the resident's face. Resident #14 reported arguing with Resident #13 and Resident #14 hit Resident #13 resulting in the resident falling to the floor causing a laceration to the forehead and redness and superficial abrasion to the left ribs. Resident #14 was transferred to the hospital for evaluation and treatment.</p> <p>Resident #14's Care Plan dated 09/03/23, documented the resident had an unwitnessed fall with minor injuries from a resident to resident altercation, neurological checks were initiated and the resident was sent out to the emergency department for further evaluation and treatment.</p> <p>On 10/10/23 at 1:08 PM, the DON confirmed Resident #13 had reported striking Resident #14 resulting in Resident #14 hitting the floor causing a laceration to the forehead and abrasion to the left ribs. The incident was unwitnessed and Resident #14 was transferred to the hospital for treatment and received several stitches.</p>	F 600			

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F 600	Continued From page 16 The facility policy titled, "Resident Rights," revised December 2019, documented the resident's had the right to a safe environment.  The facility policy titled, "Abuse Prevention Program," revised December 2016, documented residents had the right to be free from abuse, and the facility would protect residents from abuse including abuse from other residents.  FRI #NV00069006, FRI #NV00069113, FRI #NV00069356	F 600			
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12  §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and document review, the facility failed to ensure a resident was free from misappropriation of property when a Certified Nursing Assistant (CNA) borrowed money from a resident and failed to pay the money back to the resident for 1 of 17 sampled residents (Resident #7).  Findings include:  Resident #7  Resident #7 was admitted to the facility on	F 602	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice (indicate specifically how the deficient practice cited in the Statement of Deficiencies (SOD) for each resident cited will be corrected).  Resident #7 no longer resides in the facility.  How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.  All alert, oriented residents have the potential to be affected. An audit of all current alert, oriented residents will be done to ensure that staff did not borrow any money from them.  What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur.  An inservice training was done to all staff regarding abuse, neglect, and misappropriation of property.		

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F 602	<p>Continued From page 17</p> <p>05/21/23, and discharged on 09/22/23, with diagnoses including unspecified acquired deformity of right lower leg, dorsalgia, unspecified and other chronic pain.</p> <p>A Facility Reported Incident (FRI) dated 08/11/23, documented Resident #7 had reported to the facility, the resident had let a CNA borrow \$100.00 to go toward the CNA's nursing degree; however, the CNA failed to return the money to Resident #7.</p> <p>A Complaint Form dated 08/14/23, documented Resident #7 filed a grievance explaining the resident had let a CNA borrow \$100.00, however the CNA made no attempt to pay the money back to the resident. The employee was put on leave pending the investigation. In addition to the \$100.00 the CNA borrowed, there was an additional \$15.90 charged to the resident's bank card. The resident denied any knowledge of the additional \$15.90 withdrawn from the resident's bank account.</p> <p>A Police Department Summary Incident Report dated 08/14/23, documented Resident #7 filed a report with the police regarding petit larceny against the CNA. The resident had told police officers the CNA was talking about going to nursing school and the resident had offered to let the CNA borrow \$100.00. The resident's bank statements documented \$100.00 withdrawn from a nearby grocery store and a separate charge in the amount of \$15.90 on 07/18/23.</p> <p>A Disciplinary Action Form dated 08/14/23, documented the CNA was terminated by the facility for a substantiated allegation of misappropriation of resident funds.</p>	F 602	<p>How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program/processes will be put into place to monitor the continued effectiveness of the systemic change.</p> <p>The social work department will audit 5 residents a month to ensure that residents are free of abuse, neglect, and misappropriation of property. The results of the audit will be submitted to the QAPI Committee on a monthly basis for a period of three months. At the end of the three month period, the QAPI Committee will determine if additional interventions are necessary.</p> <p>The responsible party for accomplishing and/or monitoring compliance with the corrective action. If the corrective action involves more than one person, the party who maintains ultimate responsibility should be identified.</p> <p>Licensed Social Worker</p> <p>Date of Compliance: 11/15/2023</p>		

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F 602	Continued From page 18  On 10/10/23 at 11:58 AM, the Administrator explained a CNA had borrowed \$100.00 from Resident #7 to help with the CNA's schooling. The resident had asked for the money back several times, however, the CNA made no attempt to pay the money back to the resident. During the investigation, it was discovered the employee did not clock out when leaving the facility to withdraw money from the resident's bank account. The CNA left the facility, went to a nearby grocery store, withdrew money from the resident's bank account and made an additional purchase that was not authorized by the resident. As a result, a police report was filed and the CNA was suspended pending an internal investigation. After investigating the grievance filed by Resident #7, the facility determined the CNA abused the resident's funds. The Administrator confirmed the CNA took advantage of a resident's funds and was considered abuse.  The facility policy titled "Abuse Prevention Program," last revised 12/2016, documented all residents had the right to be free from abuse, neglect, misappropriation of resident property and exploitation.	F 602			
F 689 SS=D	FRI #NV00069197 Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and  §483.25(d)(2)Each resident receives adequate	F 689			

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F 689	<p>Continued From page 19</p> <p>supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on clinical record review, interview and document review, the facility failed to provide supervision to prevent two residents (Resident #8 and #9) from elopement from the facility.</p> <p>Findings include:</p> <p>FRI #NV00068634 documented on 05/21/23, a resident was found at a hardware store across the street from the facility.</p> <p>Resident #8</p> <p>Resident #8 was admitted to the facility on 05/12/23, with diagnoses including traumatic subdural hemorrhage with loss of consciousness of unspecified duration, cognitive communication deficit, and impulsiveness.</p> <p>An Elopement Risk Evaluation dated 05/12/23, document the resident was at low risk for wandering.</p> <p>A Brief Interview for Mental Status dated 05/15/23, documented the resident was severely impaired, with a score of two.</p> <p>A Daily Skilled Charting Progress Note dated 05/16/23, documented the resident had multiple episodes of confusion and was attempting to open exit doors in hallways.</p> <p>An Incident Progress Note dated 05/21/23, documented the resident's family member had called the facility at approximately 12:15 PM and</p>	F 689	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice (indicate specifically how the deficient practice cited in the Statement of Deficiencies (SOD) for each resident cited will be corrected).</p> <p>Resident #8 no longer resides in the facility. Resident #9 is doing well. Careplan has been updated to ensure that resident is free from accidents. Resident is currently receiving psychiatric services.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>All mobile and cognitively impaired residents have the potential to be affected. Careplan for all mobile cognitively impaired residents were audited to ensure that they remain free of accidents and incidents.</p> <p>What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur.</p> <p>An inservice was done to all staff regarding elopements, and the interventions for residents at risk of elopement.</p> <p>How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program/processes will be put into place to monitor the continued effectiveness of the systemic change.</p> <p>An elopement drill will be done on a monthly basis for a period of three months. The result of the drill will be submitted to the QAPI Committee. At the end of the three month period, the QAPI committee will determine if additional interventions are necessary.</p>		

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F 689	<p>Continued From page 20</p> <p>reported the resident was found at a hardware store across the street from the facility. The resident was last seen in the facility before 12:00 PM. The resident was returned to the facility at 12:30 PM.</p> <p>On 10/10/23 at 1:29 PM, the Director of Nursing (DON) confirmed Resident #8 had eloped from the facility and verbalized the receptionist on duty on 05/21/23, believed Resident #8 was a visitor and let the resident exit the facility through the front door. The DON verbalized after this incident the facility updated their process to include a phone call from the receptionist to the nursing stations to check with nursing staff to ensure a resident may leave the facility and had been signed out to exit.</p> <p>FRI #NV00069007 documented on 07/16/23 a resident was found in the parking lot of the facility next door.</p> <p>Resident #9</p> <p>Resident #9 was admitted to the facility on 01/14/23, with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, aphasia, vascular dementia, and anxiety disorder.</p> <p>An Elopement Risk Evaluation dated 06/09/23, document the resident was at moderate risk for wandering due to forgetfulness, short attention span and dementia.</p> <p>An Alert Progress Note dated 07/16/23, documented the resident was found in the parking lot of the facility next door at approximately 11:00 PM and the resident was</p>	F 689	<p>The responsible party for accomplishing and/or monitoring compliance with the corrective action. If the corrective action involves more than one person, the party who maintains ultimate responsibility should be identified.</p> <p>Administrator</p> <p>Date of Compliance: 11/15/2023</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>295088</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/15/2023</b>
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F 689	<p>Continued From page 21</p> <p>transported to the hospital for evaluation.</p> <p>On 10/10/23 at 1:18 PM, the DON confirmed Resident #9 had eloped from the facility and was found in the parking lot of the facility next door. The resident was last seen at approximately 9:00 PM in the facility. The facility only became aware of the resident missing when hospital staff called the facility and was informed the resident had been found in the parking lot and had been admitted for evaluation. The DON verbalized the resident was aware to push and hold the front door for it to open. The DON verbalized having been unsure if a staff member had checked the front door alarm after the resident had exited the facility.</p> <p>FRI #NV00069548 documented on 09/29/23 a resident had eloped from the facility.</p> <p>A Nursing Progress Note dated 09/29/23, documented the resident was not in the resident's room and was unable to be found at approximately 10:00 PM. The resident was last seen during the 7:00 PM hour for medication pass. The facility had received a call from the resident's family member informing the facility the resident was at the hospital.</p> <p>A Nursing Progress Note dated 09/30/23, documented the hospital had called and informed the facility the resident was found at the grocery store across the street and had been admitted for evaluation at approximately 8:30 PM.</p> <p>On 10/10/23 at 1:24 PM, the DON confirmed Resident #9 had eloped from the facility and was found at the grocery store across the street. The resident was last seen at approximately 7:00 PM</p>	F 689			

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F 689	Continued From page 22 during medication pass. The facility staff was unable to locate the resident at 10:00 PM and was later notified by the hospital the resident had been admitted for evaluation. The DON verbalized the resident was aware to push and hold the front door for it to open. The DON verbalized having been unsure if a staff member had checked the front door alarm after the resident had exited the facility.  The facility policy titled, "Resident Rights," revised December 2019, documented the resident's had the right to a safe environment.  FRI #NV00068634, FRI #NV00069007, FRI #NV00069548	F 689			
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)  The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and document review, the facility failed to administer significant medications per physician order resulting in death for 1 of 31 sampled residents (Resident #1).  Findings include:  Resident #1  Resident #1 was admitted to the facility on 02/08/23, with diagnoses including cardiac arrest, cause unspecified, and non-ST elevation myocardial infarction (NSTEMI).	F 760	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice (indicate specifically how the deficient practice cited in the Statement of Deficiencies (SOD) for each resident cited will be corrected.  Resident #1 is no longer in the facility.  How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.  All the resident have the potential to be affected. An audit of medication administration was done by the nursing management team to ensure that medications are given timely.  What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur.		

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F 760	<p>Continued From page 23</p> <p>A hospital Discharge Summary dated 02/08/23, documented Resident #1 was admitted to the hospital on 01/13/23 for cardiac arrest. The resident received a cardiac catheterization and suffered another brief arrest during the procedure. Resident #1's discharge medications included Brillinta (ticagrelor) 90 milligrams (mg), take one tablet by mouth two times a day for 30 days.</p> <p>A Nursing Progress Note dated 02/08/23, documented Resident #1 was admitted to the facility and did not have shortness of breath, breathing difficulties, or chest pain. The resident's heart rate and rhythm were regular. Resident #1 reported the hospital medication list was accurate and medication orders were verified with the provider.</p> <p>A physician's order dated 02/08/23, documented the following:</p> <p>Brillinta (ticagrelor) oral tablet, give 90 mg by mouth two times a day for NSTEMI.</p> <p>The Medication Administration Record (MAR) dated 02/01/23-02/28/23, documented Resident #1 did not receive Brillinta on the following dates and administration times:</p> <p>-02/08/23: 8:00 PM -02/09/23: 8:00 AM -02/09/23: 8:00 PM -02/10/23: 8:00 AM -02/10/23: 8:00 PM -02/11/23: 8:00 AM -02/11/23: 8:00 PM -02/12/23: 8:00 AM</p>	F 760	<p>An inservice training was done to all licensed nurses (RN/LPNs) on how to enter medication orders to the electronic medical records. Medication Pass Administration was a part of the inservice training. Additional training was done to the licensed nurses (RN/LPNs) on what to do when medications are unavailable. Medication unavailability will be reported to the director of nursing or designee.</p> <p>How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program/processes will be put into place to monitor the continued effectiveness of the systemic change.</p> <p>The director of nursing or designee will audit new medication orders on a weekly basis to ensure that medications are given in a timely manner. The results of the audit will be submitted to the QAPI Committee on a monthly basis for a period of three months. At the end of the three month period, the QAPI Committee will determine if additional interventions are necessary.</p> <p>The responsible party for accomplishing and/or monitoring compliance with the corrective action. If the corrective action involves more than one person, the party who maintains ultimate responsibility should be identified.</p> <p>The Director of Nursing</p> <p>Date of Compliance: 11/15/2023</p>		

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F 760	<p>Continued From page 24 -02/12/23: 8:00 PM</p> <p>Nursing Progress Notes documented the following for the Brillinta medication:</p> <p>-02/08/23 9:05 PM: Brillinta oral tablet, awaiting delivery -02/09/23 8:54 AM: Brillinta oral tablet, newly admitted, awaiting delivery from pharmacy -02/09/23 10:27 PM: Brillinta oral tablet, awaiting delivery -02/10/23 7:32 AM: Brillinta oral tablet, awaiting delivery from pharmacy -02/10/23 7:15 PM: Brillinta oral tablet, awaiting delivery -02/11/23 10:57 AM: Brillinta oral tablet, waiting for delivery -02/11/23 10:38 PM: Brillinta oral tablet, awaiting delivery -02/12/23 8:08 AM: Brillinta oral tablet, awaiting for pharmacy delivery -02/12/23 7:08 PM: Brillinta oral tablet, awaiting delivery</p> <p>Resident #1 had not received the Brillinta medication for nine medication administrations.</p> <p>A Situation, Background, Assessment, and Recommendation (SBAR) Communication Form dated 02/13/23 at 2:35 AM, documented the following for Resident #1:</p> <p>-Change in condition, symptoms, or signs observed and evaluated were cardiac arrest, respiratory arrest, and unresponsiveness. -Mental status evaluation: unresponsiveness -Functional status evaluation: without pulse and respirations -Respiratory evaluation: respirations ceased</p>	F 760		

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F 760	<p>Continued From page 25</p> <p>-Cardiovascular evaluation: without pulse</p> <p>-Observation and evaluation summary: 2:30 AM Resident #1 was diaphoretic, pursed lipped breathing and unresponsive upon entering room. Eyes fixated. The resident's respirations and pulse ceased when the blood pressure cuff was applied. 2:35 AM, cardiopulmonary resuscitation (CPR) initiated per full code status, call placed to 911. Six rounds of compressions with oxygen at 15 liters per minute given until paramedics/fire took over code, intubated resident, administered epinephrine twice along with intravenous fluids, and transported resident to the hospital at 3:00 AM with continued chest compressions.</p> <p>A Hospital Nursing Progress Note dated 02/13/23, documented Resident #1 arrived with pulseless electrical activity, had received CPR in the field for over 30 minutes, and did not have a pulse.</p> <p>An Emergency Department Physician Record dated 02/13/23, documented Resident #1 arrived in the Emergency Department at 3:15 AM. Resident #1 presented with cardiac arrest and CPR was in progress upon arrival. The resident was intubated to establish an airway. A total of 45 minutes of CPR was administered and Resident #1 never achieved a return of spontaneous circulation. The resident expired on 02/13/23 at 3:33 AM, with a high suspicion for an in-stent thrombosis leading to a fatal cardiac arrest.</p> <p>A Nursing Progress Note dated 02/13/23, at 4:14 AM, documented a call was placed to the hospital for a status update on Resident #1 and was informed by the hospital nurse the resident had expired.</p>	F 760		
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F 760	<p>Continued From page 26</p> <p>On 10/09/23 at 3:42 PM, a Licensed Practical Nurse (LPN) explained if a medication was missing, and not stocked in the automated medication dispensary (Passport), the nurse should call the pharmacy and find out why the medication was not sent. The LPN verbalized the facility pharmacy could send a prescription to a local pharmacy and have it delivered to the facility. The LPN explained missing medication, the follow up, and physician notification should be documented in the clinical record as a progress note. The LPN confirmed Brillinta was not stocked in Passport and would have to be ordered through the pharmacy.</p> <p>On 10/09/23 at 3:57 PM, the Director of Nursing (DON) explained the expectation of nursing staff to follow up on missing medications was to call the pharmacy, find out where the medication was, what caused the delay, and notify both the physician and the Nurse Supervisor or DON. The DON verbalized it was the nurse's responsibility to follow up on any medication issues and would expect a missing medication to be available by the next scheduled administration. The DON confirmed the facility pharmacy was available seven days per week and for 24 hours per day.</p> <p>On 10/09/23 at 4:00 PM, the DON confirmed Resident #1 did not receive the prescribed medication Brillinta from 02/08/23-02/12/23. The DON verbalized the DON did not know the resident had not received the medication until the resident was transferred out to the hospital on 02/13/23, and should have been notified of any issues with obtaining the medication. The DON explained a resident with a cardiac diagnosis could experience cardiac arrest or a blood clot without the prescribed medication.</p>	F 760		
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F 760	<p>Continued From page 27</p> <p>On 10/09/23 at 4:09 PM, the Administrator explained the expectation of nursing to follow up on a missing medication by calling the pharmacy, the physician, and the Nurse Manager or DON. The Administrator verbalized the missing medication was expected to be present by the next administration time. The Administrator confirmed it was not acceptable for a resident to miss a critical medication for five days and explained the medication order transcribed by the nurse had indicated the medication was on hand and part of house stock, therefore it was not filled through the pharmacy.</p> <p>On 10/10/23 at 10:09 AM, the Pharmacy Manager explained each new admission required an electronic notification to add the resident to the system. The nurse would enter all medication orders into the electronic system, the orders would go to the pharmacy, and the pharmacy would fill the orders. The nurse would have to indicate the status of each medication as on hand, house stock, or pharmacy fill. A medication indicated as on hand or house stock would not be filled by the pharmacy because it was not identified as a pharmacy fill. The Pharmacy Manager confirmed the Brillinta was not filled for Resident #1 until 02/13/23, as the fill request was not made until the evening of 02/12/23.</p> <p>An Order Audit Report, dated 10/10/23, documented Brillinta oral tablet 90 mg, give one tablet by mouth two times a day for NSTEMI and had an original status of "On Hand" with a source of "House Stock". On 02/13/23, the medication was auto-linked with a prescription number, had a source of "Pharmacy-Partners," and was dispensed on 02/13/23.</p>	F 760		
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F 760	<p>Continued From page 28</p> <p>The medication was not filled until 02/13/23, after the resident had transferred to the hospital and expired.</p> <p>A facility policy titled "Liberalized Medication Administration Policy and Procedure," dated February 2023, documented it was the policy of the facility to administer medication to residents in a safe manner. Medications prescribed by the physician would be given as such. The medical director and pharmacist would provide direction for any concerns that arose in order to optimize the care and safety for medication administration effects for each individual resident based on their needs. The general nursing standard of practice for medication administration would include the Five Rights of Medication Administration, maintaining infection control standards for medication administration, and maintaining resident dignity.</p> <p>A facility policy titled "Resident Rights," revised December 2019, documented the Resident had a right to receive treatment and support for daily living safely.</p> <p>Complaint #NV00069059</p>	F 760			