STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295083	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heights of Summerlin, LLC	10550 Park Run Drive Las Vegas, NV 89144

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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, record review, and document review, the facility failed to ensure the accuracy of assessment reflected the resident's status regarding the harness and straps being used for safety rather than as a restraint for 1 of 31 sampled residents. This deficient practice had the potential to result in the improper use of restraints, restricted mobility, and diminished quality of care. Findings include: Resident 60 (R60) R60 was admitted on [DATE], and readmitted on [DATE], with the diagnoses including spastic quadriplegic cerebral palsy and epileptic seizures (episodes of abnormal electrical activity in the brain that cause sudden changes in behavior, movement, or consciousness). On 03/18/2025 at 7:50 AM, R60 was in the activity room seated in the tilted wheelchair. R60 was incoherent, non-verbal and appeared comfortable. The harness and straps were in place securing R60. A physician order dated 01/09/2025, documented to ensure harness and strap were secured and on properly while in wheelchair for safety. The Quarterly Minimum Data Set (MDS) assessment dated [DATE], documented an incomplete brief interview of mental status due to R60's cognitive function being severely impaired. The assessment was coded; a restraint was used daily. A Care Plan (undated), documented R60 was at risk for complications from seatbelt use, wheelchair harness, and foot straps. The intervention included applying a four-point seat belt with a chest guard for safety and mobility with foot straps adjusted to ensure proper positioning. Additionally, regular assessments were scheduled to monitor comfort and prevent any potential skin irritation or pressure sores. straps while up in the wheelchair and as needed. To complete restraint assessment/reduction review per protocol. On 03/18/025 at 12:35 PM, the DON indicated the harness, and straps were not considered restraint or restrictions on R60's freedom, for it was needed for R60's safety. The DON explained there was no restraint assessment or reduction required because it was not considered a restraint due to R60's involuntary movements. The DON indicated the MDS assessment was inaccurately coded. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/18/2025 at 3:31 PM, the MDS Nurse confirmed the assessment was coded inaccurately because the harness and straps were being used for R60's safety and not for restrictions. A facility policy titled Comprehensive Care Plan revised 08/25/2021, documented the Interdisciplinary Team (IDT), in coordination with the resident and/or family, to develop and implement a person-centered care plan addressing identified needs. The plan included measurable objectives and timeframes, with concerns evaluated using specific tools, such as Care Area Assessments, before adding interventions. Assessments of residents were ongoing, and care plans were reviewed and revised as information about the resident changed. The IDT was responsible for evaluation and updating of care plans.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to develop comprehensive care plans to reflect new interventions, specifically a smoking care plan for 1 of 13 sampled residents (Resident 65). The deficient practice had the potential to deprive residents of necessary interventions to maintain overall well-being. Findings included: Resident 65 (R65) R65 was admitted on [DATE] with diagnoses including anxiety disorder, muscle weakness, and nicotine dependence. Review of an admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/02/2024 indicated under J1300 Current Tobacco Use, R65 was a tobacco user. The assessment under Section I: Active Diagnoses indicated the resident had seizure disorder or epilepsy, anxiety disorder, and depression. Review of R65's Comprehensive Care Plan initiated on 03/26/2024, included a smoking care plan initiated on 09/27/2024. On 03/18/2025 at 2:59 PM, the Minimum Data Set (MDS) Nurse verbalized upon admission of a new resident, an MDS assessment was conducted for the resident. The MDS Coordinator advised if questions were marked Yes, a care plan should be triggered. The MDS Nurse verbalized the assessment under J1300 Current Tobacco Use was marked Yes for R65. The MDS Nurse indicated the resident should have had a smoking assessment and smoking care plan conducted upon admission on [DATE], but one was not conducted until 09/27/2024. On 03/18/2025 at 3:50 PM, the Director of Nursing (DON) verbalized the facility had 21 days to conduct a comprehensive care plan for a resident. The DON indicated if the resident had been marked as Yes under J1300 Current Tobacco Use for the admission MDS, the resident should have had a comprehensive care plan. The facility policy titled Comprehensive Care Plan, with an effective date of 08/25/2021, documented the facility's Interdisciplinary Team, in coordination with the resident and/or his/her family or representative, would develop and implement a comprehensive person-centered care plan for each resident, which included measurable objectives and timeframes to meet a resident's medical, physical, and mental and psychosocial needs identified in the comprehensive assessment. Each resident's comprehensive care plan would be designed to build on the resident's individualized needs, strengths, and preferences. Areas of concern triggered during the resident assessment would be evaluated using specific assessment tools (including Care Area Assessments) before interventions were added to the care plan.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure showers or a bath, were provided as scheduled for 1 of 4 unsampled residents (Resident 471). The deficient practice had the potential to increase skin breakdown, infections, odor and bacteria buildup. Findings include: Resident 471 (R471) R471 was admitted on [DATE] with diagnoses of chronic obstructive pulmonary disease, anemia, left foot cellulitis, gastritis, and stroke. The Minimum Data Set (MDS) in section GG dated 12/24/2024, indicated partial/moderate assistance with showering and bathing self. Review of R471's Care Plan initiated on 12/19/2024, indicated resident was dependent for Activities of Daily Living (ADL) care. R471's medical record for December 2024 and January 2025 lacked documented evidence the resident received either a shower or bath on the following dates: - 12/21/2024 (Saturday) - 01/01/2025 (Wednesday) R471's medical record lacked documented evidence the resident refused a shower or bath during the above-mentioned dates, and shower or bath were provided on other days to compensate for the missed shower or bath as scheduled. On 03/14/2025 at 8:24 AM, a Certified Nursing Assistant (CNA) indicated showers were provided to residents twice a week dependent on the shower schedule for each floor. Weekly Bath and Skin Report sheets were utilized to document if a shower or bath was provided to the resident. If the shower or bath was denied by the resident, the CNAs would document the refusal on the weekly bath and skin report sheet and place the report in the binder. Another means of documenting the shower or bath was in the electronic medical record. 03/18/2025 at 8:28 AM, another CNA verbalized showers were offered to residents twice a week. CNAs would either document the shower on the weekly bath and skin report or the electronic medical record. Ultimately, the electronic medical record was the main source of documentation. If a resident refuses the shower or bath, this was reported to the nurse. On 03/18/2025 at 8:30 AM, an observation of the updated 2025 shower schedule on the unit where the resident was housed, indicated showers were designated twice a week for room [ROOM NUMBER], which were Wednesday and Saturday evenings. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/18/2024 at 10:50 AM, the Director of Nursing (DON) indicated the provided shower schedule located at the front desk in the [NAME] Hallway marked as 2025 updated did not change from 2024. According to the shower schedule, room [ROOM NUMBER] was to shower on the evening shift on Wednesday and Saturdays. R471's documented showers throughout the resident's admission were reviewed with the Director of Nursing (DON). There was no documented evidence the resident was offered a shower or bath on 12/21/2024 and 01/01/2025. The DON confirmed the findings and indicated there was no documentation R471 had refused or was unavailable during the shift. The policy titled, Activities of Daily Living (ADLs), Supporting, revised on 03/2018, documented appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, record review, and document review, the facility failed to appropriately assess residents who smoked upon admission/readmission, secure smoking materials, including lighters, and establish a policy outlining guidelines on how to address smoking among residents in a non-smoking facility, and ensure safety measures were implemented for 3 of 13 sampled residents (Residents 66, 104, and 65). This deficient practice had the potential to place residents at risk of self-inflicted burns, fire hazards, or other safety concerns. Findings include: Resident 66 (R66) R66 was admitted on [DATE], and readmitted on [DATE], with diagnoses including shortness of breath and heart failure. The Minimum Data Set, dated [DATE], documented R66's brief interview of mental status a score of 15/15, and R66 was a current tobacco user. The Nursing Progress Notes dated 03/06/2025, documented R66 expressed unwillingness to use the Nicotine patch and intention was to continue smoking. The Assistant Director of Nursing (DON), Director of Nursing (DON), and Administrator were notified. On 03/14/2025 at 3:40 PM, Residents 66 and 65 were in the lobby and appeared upset. Both residents expressed a desire to smoke but had been informed staff assistance was required to smoke outside. Both residents verbalized cigarettes and lighters were kept in pouches in their possession and indicated since admission, the facility had been aware both residents were smokers. On 03/14/2025 at 4:00 PM, a Licensed Practical Nurse (LPN) indicated the facility was non-smoking and confirmed R66 was a smoker. The LPN expressed it had been noticed a smell of smoke was present, especially after returning from outside the facility. The LPN explained the facility is a non-smoking facility, but if a resident was a smoker, an assessment should have been conducted upon admission, smoking items should not have been in the resident's possession, and an alternative, such as a nicotine patch, should have been offered. On 03/14/2025 at 4:25 PM, R66 was in a motorized chair and expressed satisfaction after having smoked outside with R65 and a staff member. R66 verbalized cigarettes and a lighter were kept in a pouch in possession. The assigned LPN checked R66's pouch and found 18 cigarettes and three lighters. On 03/14/2025 at 4:45 PM, a Registered Nurse (RN) confirmed R66 and R65 were accompanied outside the facility to smoke and stated both residents kept cigarettes and lighters in their possession. The RN was uncertain about the process for managing residents who smoked, as only was asked to accompany the residents. The RN confirmed there were residents at the facility who were actively smoking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/18/2025 in the morning, the Director of Nursing (DON) indicated there were 13 residents who were smokers at the facility; their cigarettes, including the lighters, were confiscated after it was reported by the survey team, and an alternative had been offered. The DON indicated the facility remained a non-smoking facility. R66's medical records lacked documented evidence a smoking assessment was completed in a timely manner upon admission or readmission, smoking items including the lighters, were secured for safety, and safety measures and smoking protocols were outlined and implemented to address smoking among residents in a non-smoking facility. On 03/18/2025 at 11:30 AM, the Nurse Practitioner (NP) indicated residents who smoked should have been assessed in a timely manner upon admission and should not have been allowed to keep smoking items and lighters in their possession to prevent self-inflicted burns and fire hazards. The NP verbalized an alternative should have been offered, but if smoking persisted, transitioning the resident to another facility for safety should have been considered. Resident 104 (R104) R104 was admitted [DATE] and readmitted [DATE], with diagnosis including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, type 2 diabetes with unspecified complications, and acute kidney failure. On 03/12/2025 at 11:33 AM, R104 was sitting in a wheelchair in the room. R104 reported was a smoker. R104 explained a few days ago was told the facility was a non-smoking facility. R104 reported used to go unaccompanied by staff, to the entrance of the park outside the facility to smoke but was no longer allowed to do so. R104 reported kept cigarettes and a cigarette lighter in their possession in the room. A Smoke-Free Center Acknowledgement Form was signed by R104 on 03/15/2022. The form stated the facility was a smoke-free environment and agreement was not to smoke while residing at the facility. A facility document titled, The Heights of [NAME] is a non-smoking facility, but the residents listed below have expressed a desire to smoke, undated, listed R104. A Care Plan dated 11/21/2024 documented R104 was not to smoke at non-smoking facility. R104 was non-compliant with facility smoking policy. A Smoking Evaluation dated 03/03/2025, documented R104 was not allowed to smoke per facility policy. A monthly Inservice dated February 2025, documented under No Smoking, this was a non-smoking facility, included the entire campus. Smoking was not allowed anywhere on campus, including any vehicles, if the vehicle was parked on campus. On 03/14/2025 at 11:04 AM, a Registered Nurse (RN) reported the facility was a non-smoking facility. The RN explained at admission residents were told the facility was non-smoking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/14/2025 at 11:51 AM, the Admissions Director reported at admission, residents were provided the admission agreement, a document titled Smoke-Free Center Acknowledgement Form. The form notified residents the facility was smoke-free. Residents acknowledged and agreed not to smoke by signing the form. On 03/14/2025 at 4:19 PM, the Administrator and the Director of Nursing (DON) were informed R104 had cigarettes and a cigarette lighter in their possession in the room. The Administrator and the DON reported would speak to R104 and collect the smoking materials. On 03/14/2025 at 4:58 PM, R104 confirmed the cigarettes, and the cigarette lighter were confiscated by the facility's Social Worker the same day. Resident 65 (R65) R65 was admitted on [DATE] with diagnoses including anxiety disorder, depression, muscle weakness, and nicotine dependence. Review of R65's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/02/2024 indicated under J1300 Current Tobacco Use indicated Yes, R65 was a tobacco user. Review of R65's Comprehensive Care Plan initiated on 03/26/2024, included a smoking care plan initiated on 09/27/2024. On 03/12/2025 at 12:46 PM, R65 was lying in bed, alert and oriented. R65 verbalized being unhappy because the facility was no longer allowing R65 to go outside the front door to smoke as of 03/10/2025. On 03/13/2025 at 1:45 PM, the Social Services Director verbalized the facility had always been a non-smoking facility, and if a resident was in possession of smoking materials, the social services department would lock it up for the resident. On 03/13/2025 at 1:45 PM, the Administrator verbalized the facility was a non-smoking facility, but the facility had not been actively enforcing the non-smoking policy until that week. The Administrator advised all identified smokers would have a smoking care plan and a smoking assessment conducted. If a resident did not want to comply with the facility's non-smoking policy, the resident would be offered a nicotine patch, tobacco cessation, or the facility could find the resident a smoking facility. On 03/14/2025 at 3:56 PM, R65 and R66 were outside the facility doors by the 100-hall entrance/exit, going across the parking lot to a covered patio area. Two surveyors followed R65 and R66 to the covered patio. The LPN from the facility was with the two residents outside smoking cigarettes. On 03/14/2025 at 4:02 PM, R65 verbalized the unit clerk in the 100-hall had permitted R65 and R66 to sign out of the facility to go smoke off the property, under the supervision of the LPN. R65 stated the Assistant Administrator had specifically verbalized R65 and R66 could go out to smoke if they had a CNA, LPN, RN, or anyone over 18 who can dial 911 accompany them. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/14/2025 at 4:13 PM, the Administrator and Director of Nursing (DON) were informed R65 and R66 were outside under the covered patio smoking under the supervision of the LPN. The Administrator verbalized the covered patio was the property of the public park and was not a part of the facility grounds. On 03/18/2025 at 11:03 AM, upon entering Resident 65's room, the resident was observed lying in bed, alert and oriented. The resident expressed frustration because the resident's cigarettes and lighter were confiscated by management on 03/14/2025 after R65 and R66 returned from smoking outside under the covered patio with the LPN. R65 stated the facility had let R65 keep the cigarettes and lighter in the resident's possession since being admitted on [DATE]. The facility policy titled Smoking with an effective date of 08/09/2022, documented for Centers who wish to be smoke-free: A. Obtain approval from the VPO. B. Determine the date the facility would become smoke-free. C. Residents who smoke and have been in the Center before the effective date would be permitted to continue to smoke in the designated areas only. D. Starting on the effective date, new admissions and staff, volunteers, contractors, and visitors would not be permitted to smoke. The Admissions designee would explain the smoke-free policy to new residents and their families. Potential employees would be informed of the smoke-free policy during the interview process. Volunteers, contractors, and visitors would be informed of the smoke-free policy. E. The Resident/Responsible party would sign the Smoke-Free Center Acknowledgement Form and the form would be placed with the admissions paperwork. F. Failure to comply with this policy would result in disciplinary action up to and including termination for employees, initiation of a discharge plan for residents, and a request to leave the premises for volunteers, contractors, and visitors. On 03/18/2025 at 3:52 PM, the Administrator verbalized upon admission, residents were told the facility was non-smoking. Personal effects were inventoried, but a physical search of the resident's belongings was not conducted. Smoking paraphernalia was not routinely searched for during the personal effects inventory. If smoking paraphernalia, such as lighters or cigarettes, was discovered later, the items were collected. The facility had not developed a formal policy regarding the securement of smoking paraphernalia. The Administrator mentioned if a resident had been smoking and their smoking materials were not identified, there had been a risk of setting the building on fire, which had posed a serious safety concern for the facility.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to ensure the resident's prescribed Foley size order was followed or clarified and monitored for signs and symptoms of infection, and the physician was notified promptly for the presence of sediments and odorous urine for 1 of 31 sampled residents (Resident 16). This deficient practice had the potential to result in complications such as urinary tract infections (UTIs), discomfort, catheter-associated infections, and other related health risks. Findings include: Resident 16 (R16) R16 was admitted on [DATE] and readmitted on [DATE], with diagnoses including hydronephrosis and urinary retention. A Physician order dated 10/24/2024, documented 16 French by 10 milliliters (ml) water balloon for neuromuscular dysfunction of the bladder. The Minimum Data Set, dated [DATE], documented a score of the brief interview of mental status as 14/14, which indicated R16's cognitive status was intact. R16 had an indwelling catheter. A Care Plan (undated), documented to monitor for signs and symptoms of infection and report to the physician. Report to the physician promptly if the urine contains any sediment or blood or was cloudy or odorous. On 03/12/2025 at 10:28 AM, R16 alert, oriented but was hard of hearing. A Foley catheter, 18 French by 10 ml water balloon was in place, draining 150 ml of dark, brownish-colored urine with sediments. A Certified Nursing Assistant (CNA) indicated R16 had the brownish-colored urine with sediments. The CNA checked R16 and when the diaper was opened, a foul strong odor was noted from R16's Foley catheter insertion site and dark red, dried residue was adhered to the catheter. R16's coccyx or peri area had no open skin but redness. On 03/13/25 at 1:54 PM, a Licensed Practical Nurse (LPN) verbalized an indwelling catheter required a physician's order, including care and management instructions such as cleaning the resident's private parts, emptying the bag twice per shift, assessing and monitoring at least once per shift for color, odor, or any signs of infection, and notifying the physician if necessary to obtain an order for a urine sample. The LPN indicated orders also included changing the Foley catheter once a month and replacing the bag as needed due to leakage or dislodgement. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The LPN explained these tasks should have been documented in the administration record. The LPN confirmed R16's prescribed Foley catheter size was 16 Fr by 10 mL water balloon, but the actual catheter in place was an 18 Fr by 10 mL water balloon. R16 verbalized the Foley was inserted at the facility. The LPN acknowledged the Foley catheter order had not been followed and there was no documentation indicating the physician had been notified about the presence of odor, sediments, and brownish-colored urine. The LPN recalled R16's Foley catheter had been initiated in the facility after the resident's nephrostomy tube became dislodged but confirmed there was no documentation of when it was inserted. On 03/13/2025 at 2:36 PM, a Registered Nurse (RN) indicated the process if a resident had a Foley catheter required an order, including the size and the indication. The RN indicated the Foley care should have been populated in the medical record for monitoring and documentation purposes, such as cleaning, changing the bag and the Foley catheter if leaking or dislodged, and monitoring for signs and symptoms of infection. The RN explained it was important to populate the Foley orders in the administration record to have a reminder for the tasks that should have been done. R16's medical record lacked documented evidence of care orders for the maintenance and management of the Foley, which was implemented, and the urinary output was documented in the MAR. On 03/13/2025 at 2:52 PM, the Director of Nursing (DON) indicated the Foley catheter use required an order with the Foley size. The DON indicated the Licensed Nurses were expected to follow the prescribed Foley size to clarify the order. The DON explained the care order should have been transcribed in the Treatment Administration Record (TAR), which included the monitoring for signs or symptoms of infection, changes in schedule for blockage or leakage as needed, and Foley care every shift and documented under task. On 03/18/2025 at 11:30 PM, a Nurse Practitioner (NP) indicated the Foley catheter should have been assessed each shift for signs and symptoms of infection, presence of sediments, blood, and foul odor. The NP indicated sediments and foul odor were indicative of infection and it should have been reported to the physician. The NP indicated the licensed nurses were expected to follow the prescribed Foley catheter size to prevent complications. A facility policy titled Physician Orders dated 03/22/2022, documented Licensed Nurses were responsible for documenting and implementing physician orders. Documentation related to physician orders were to be maintained in the resident's medical record.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heights of Summerlin, LLC	10550 Park Run Drive Las Vegas, NV 89144

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to ensure: 1) The PT-INR (prothrombin time-international normalized ratio, a blood test measuring how long it took for blood to clot) was completed as ordered, and the level was monitored, documented in the Medication Administration Record and reported to the physician for 1 of 31 sampled residents (Resident 12). This deficient practice had the potential to result in adverse health outcomes, including an increased risk of bleeding or clotting complications and potential harm due to inadequate monitoring of anticoagulation therapy, and 2) A pain medication was administered despite a documented reported pain level of zero for one of 13 sampled residents (Resident 13). This deficient practice had the potential to over-medicate the resident with pain medication when not in pain, unnecessarily administer medication, and further worsen the resident's opioid dependency. Findings include: 1) PT-INR Resident 12 (R12) R12 was admitted on [DATE] and readmitted on [DATE], with diagnoses including pulmonary embolism (lung blood clot blocking flow, risking death), venous thrombosis (a vein blood clot, often in the legs, causing swelling and pain), and embolism (a traveling clot or substance blocking a blood vessel). On 03/12/2025 at 10:05 AM, R12 lay in bed, awake, alert, and verbally responsive. R12 was admitted to the facility after hospitalization for a stroke. A large, blackish-colored discoloration was observed on R12's right hip, and R12 acknowledged use of anticoagulant medication. A Physician order dated 03/07/2025, documented Warfarin Sodium tablet 5 milligrams (mg) to administer daily at 5:00 PM to treat/prevent blood clots. Repeat PT-INR on Mondays and Thursdays; call the physician with results. The Medication Administration Record from 03/07/2025-03/17/2025, documented the Warfarin was administered to R12. On 03/18/2025 at 12:10 PM, the Director of Medical Records confirmed no PT-INR laboratory results were available for 03/10/2025, 03/13/2025, and 03/17/2025, with the last recorded PT-INR result dated 03/04/2025. The laboratory results dated [DATE], documented R12's PT was 46.5 seconds (reference range: 11.0-13.6 seconds), which was high, and the INR was 3.80 (reference range: 2.00-3.00), which was also high. The report comment indicated the INR therapeutic range was 2.00-3.00. R12's medical records lacked documented evidence the PT-INR was performed as ordered, monitored, documented, and reported to the physician when the PT-INR level was high. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/18/2025 in the afternoon, a Registered Nurse (RN) indicated residents on Warfarin needed PT-INR levels checked every Monday and Thursday. The RN explained after receiving the laboratory results, the physician needed to be contacted to report the PT-INR level and make necessary adjustments, discontinue Warfarin, or adjust the dose. On 03/18/2025 at 12:51 PM, the Director of Staff Development and the Assistant Director of Nursing explained residents on Warfarin needed to be monitored for signs and symptoms of bleeding, and PT-INR levels should have been completed as ordered and reported the result to the physician. On 03/18/2025 at 1:30 PM, the Director of Nursing (DON) confirmed the PT-INR had not been completed, and the last PT-INR for R12 was obtained on 03/04/2025. The DON acknowledged the PT-INR was missed and the previous results were not properly documented in the MAR. The DON emphasized the importance of monitoring/reporting the PT-INR to prevent bleeding. On 03/18/2025 at 3:47 PM, a Licensed Practical Nurse (LPN) assigned to R12 explained residents on Warfarin required monitoring for bruising, signs and symptoms of bleeding, and laboratory tests for PT-INR levels. The LPN explained Licensed Nurses were responsible for preparing the requisition for the laboratory test to be performed by a third-party contractor. The LPN confirmed the test was not carried out as ordered because it was assumed to have been completed by the night shift Licensed Nurses. On 03/18/2025 at 4:20 PM, the Director of Nursing (DON) indicated the requisition should have been prepared by the Licensed Nurse and placed in the laboratory binder for the third-party contractor. The DON acknowledged it was the Licensed Nurse's oversight, not the third-party contractors. A policy titled Anticoagulant Clinical Protocol, revised in 2018, documented the nurse should have assessed and documented/reported the following: recent labs, including therapeutic dose monitoring if Warfarin was used. Staff should have used a Warfarin flow sheet or a comparable method to track trends in anticoagulant dosage and response in individuals on Warfarin. The PT-INR should have been monitored closely while the resident was receiving Warfarin to ensure stabilization within the therapeutic range. A facility policy titled Physician Orders dated 03/22/2022, documented Licensed Nurses were responsible for documenting and implementing physician orders. Documentation related to physician orders was to be maintained in the resident's medical record. 2) Pain medication Resident 13 (R13) R13 was admitted [DATE] and readmitted [DATE], with diagnosis including generalized anxiety disorder, chronic pain syndrome, and opioid dependence uncomplicated. On 03/12/2025 at 11:45 AM, R13 was sitting on the bed in the room. R13 reported pain medication had been managed by the same Nurse Practitioner for years. R13 explained continued to feel pain throughout the body, especially on the neck and knees. R13 reported was told pain medication would not be increased. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Care Plan dated 01/24/2025, documented R13 exhibited or was at risk for alterations in comfort related to chronic pain syndrome. R13 received as needed pain medication almost daily for pain management. Pain Evaluation dated 01/04/2025 at 11:26 AM, documented pain onset was chronic, aching pain, and no change to current plan. A Physician order dated 12/13/2022, documented Acetaminophen tablet, 325 milligrams (mg), give 2 tablets by mouth every 4 hours as needed for mild pain. A Physician order dated 04/20/2023, documented Gabapentin capsule, 300 mg, give 1 capsule by mouth three times per day for neuropathy (a condition of damage to nerves which could have caused symptoms including pain). A Physician order dated 04/05/2024 documented Oxycodone Hydrochloride (HCL) oral tablet 20 mg, give 20 mg by mouth every 4 hours as needed for moderate to severe pain related to chronic pain syndrome. A Medication Administration Record (MAR) dated March 2025 documented, Pain monitoring-document pain level rating scale: 1-4 = Mild pain 5-7 = Moderate pain 8-10 = Severe pain Every day and shift, start date 12/14/2022 A MAR dated March 2025 documented the following: Oxycodone HCL oral tablet 20 mg was administered as follows: 03/04/2025 at 10:09 PM, pain level 0 03/06/2025 at 2:20 AM, pain level 0 03/10/2025 at 8:30 PM, pain level 0 On 03/14/2025 at 12:44 PM, a Registered Nurse (RN), explained R13 reported pain and requested pain medication often. The RN reported R13 had been told by doctor was on highest possible dose of pain medication and no increase of dose was recommended. The RN explained R13 consistently asked for pain medication and the moment the medication was provided, even before the medication was taken, R13's demeanor and visual signs of pain went away. The RN reported R13 may have been seeking pain medication. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/14/2025 at 1:00 PM, a Pain Management Nurse Practitioner (NP), explained R13 was a well-known, long-term patient of the NP for the past few years. The NP reported R13 was currently on a large dose of Oxycodone HCL 20 mg every 4 hours as needed, as well as other pain medications on board for a multi model approach to pain. The NP reported pain management had been discussed many times with R13 as well as the need for R13 to be safe and remain functional as well. The NP explained wanted to ensure the pain R13 was reporting was legitimate pain and reported R13 has tolerance built to pain medications. The NP reported R13's pain was well managed at this time while protecting the resident from excessive medications. On 03/18/2025 at 11:00 AM, The Director of Nursing (DON) confirmed the MAR dated March 2025 documented on 03/04/2025, 03/06/2025, and 03/10/2025 Oxycodone HCL 20 mg was administered with a pain level documented as 0 prior to administration. The DON reported had spoken with the nurses that administered the medication, and the documentation of pain level 0 could have been a documentation error. The DON explained a level of 0 pain could have been the result of the effectiveness of the pain medication and not the level of pain before the administration. The DON acknowledged the pain level was not documented prior to administration and the pain level should have been documented prior to administration of pain medication, to ensure the resident was receiving the correct medication. On 03/18/2025 at 3:02 PM, a Registered Nurse (RN) explained a pain scale up to 7 was considered moderate and above 7 was considered severe pain. The RN explained had to ask residents what their pain level was prior to medication administration. The RN reported it would help determine which pain medication on order would be appropriate for their pain level. The RN acknowledged pain level had to be assessed prior to administration of medication and pain medication should not have been provided with a level of 0 pain. The RN explained the resident's organs may be affected including the kidneys and liver, and the resident could become more tolerant to pain medication and pain medication seeking. Administering pain medication when not necessary could have been harmful the resident.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation, interview, and document review, the facility failed to ensure snacks were available to residents outside of scheduled mealtimes. The failed practice had the potential to cause residents to remain hungry in between meals and the resident's nutritional needs not met. Findings include: On 03/12/2025 in the morning, the snack tray at the 1st floor east nursing station was observed empty. On the 2nd floor nursing station, the snacks refrigerator had a bottle of dark colored soda and no snacks available for residents. On 03/12/2025 in the morning, the Dietary Director reported resident snack refrigerators were replenished daily after breakfast and again in the afternoon. On 03/12/2025 in the morning, Resident 109 (R109) reported did not know how to request food alternatives or snacks. On 03/12/2025 at 12:17 PM, R74 reported had been at the facility for six years. R74 explained sometimes there were crackers available, however, there were no sandwiches or other snacks for residents between meals. R74 explained residents able to visit the kitchen could have requested a sandwich but unfortunately for those residents unable to go to the kitchen, there were no snacks. On 03/12/2025 at 11:08 AM, R22 reported snacks were an issue, there were never any sandwiches available during the day or night. R22 explained would order food from outside the facility to be delivered or would go to the kitchen in person to request a sandwich. On 03/12/2025 in the morning, R46 reported there was no food or snacks available for residents in between meals. R46 explained there was only juice available after dinner and until 9:00 AM. On 03/12/2025 in the afternoon, a Registered Nurse (RN) reported the lack of snacks was a concern at the facility. If residents requested a snack such as a sandwich, staff could call the kitchen and sometimes would get the sandwich and sometimes would not. On 03/13/2025 at 2:01 PM, the District Kitchen Manager, reported the expectation was snacks at the units needed to be replenished 7:00 AM and 2:00 PM daily. On 03/18/2025 at 8:42 AM, the 300-hall nursing station snack refrigerator was observed empty. The snack tray on top of refrigerator was also empty. There were no snacks available for the 3rd floor residents. On 03/18/2025 at 8:52 AM, at the 200-hall nursing station, the resident snacks refrigerator was empty, and the snack tray on top of refrigerator was also empty. There were no snacks available for the 2nd floor residents. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/18/2025 in the morning, a Unit Clerk reported during the previous two weeks snacks were not consistently being brought to the unit. If residents asked for a snack, staff would have had to go to the kitchen. The Unit Clerk reported it was a struggle to get snacks at the facility. On 03/18/2025 in the morning, a Registered Nurse (RN), reported had one resident that asked for snacks. The RN explained would go to the kitchen to find a snack for the resident. Sometimes there were snacks available and sometimes none. On 03/18/2025 in the morning, a Licensed Practical Nurse (LPN) reported there were no snacks for the residents. The LPN explained if residents would request snacks, the LPN would send a request to the kitchen sometimes without success. On 03/18/2025 at 9:03 AM, there were no snacks available for residents at the 100 East nursing station. A Certified Nursing Assistant (CNA) confirmed if there were snacks available, they would have been placed on a tray on the counter at the nurse's station. The CNA confirmed there were no snacks available. On 03/18/2025 at 4:15 PM, the Administrator reported concerns regarding snacks availability had not been brought to the Administrator's attention. The Administrator reported the expectation was snacks at all units be replenished twice daily, morning and afternoon, and snacks were to be available as requested by residents. A facility policy titled Snacks (Between Meal and Bedtime) Serving undated, documented the purpose of the procedure was to provide the resident with adequate nutrition. The policy included a description of preparation, equipment and supplies, steps in the procedure, documentation, and reporting.