STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295090	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health Care of Las Vegas	5840 W Sunset Rd Las Vegas, NV 89118

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure physician's orders to obtain daily weights for residents with congestive heart failure (a chronic condition where the heart could not pump blood efficiently causing fluid to collect in lungs and legs) were followed for 3 of 12 sampled residents (Residents 2, 6 and 140). The deficient practice placed the residents at risk for a delay in identification of fluid overload and provision of timely interventions. Findings include: Resident 2 (R2) R2 was admitted on [DATE], with diagnoses including hypertensive heart disease with heart failure, acute respiratory failure with hypoxia and pneumonia (fluid in lungs). On 01/07/2025 in the morning, R2 laid awake in bed receiving two liters of humidified Oxygen by nasal cannula. R2 wore bilateral compression stockings and appeared weak as R2 spoke slowly and softly. R2 indicated having difficulty breathing and indicated being treated for pneumonia in the hospital. A physician's order dated 11/30/2024, documented to obtain daily weights, notify physician of three-pound weight gain or continuous weight gain. R2's edema/fluid status care plan initiated on 11/30/2024, documented an intervention to obtain weights per physician's order. A nutritional assessment dated [DATE], revealed R2 had a diagnosis of congestive heart failure (CHF), was on a fluid restriction of 1,500 milliliter (ml) per day and was to be weighed daily. R2's medical record lacked documented evidence weights were taken on 12/07/2024, 12/14/2024, 12/17/2024, 12/21/2024, 12/28/2024, 12/29/2024, and 01/04/2025 with no documented reason for the missed weights such as patient refusal. Resident 6 (R6) R6 was admitted on [DATE], with diagnoses including hypertensive heart disease with heart failure and chronic diastolic congestive heart failure (CHF). (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/07/2025 in the morning, R6 laid awake in bed receiving two liters of humidified Oxygen by nasal cannula. R6 indicated not being able to be without Oxygen and would be hooked to an Oxygen source during physical therapy. A physician's order dated 11/18/2024, documented to obtain daily weights, notify physician of three-pound weight gain or continuous weight gain. R6's edema/fluid status care plan initiated 11/18/2024, documented interventions to restrict fluids and obtain weights per physician's order. A nutritional assessment dated [DATE], revealed R6 had a diagnosis of CHF with an intervention of obtaining daily weights. R6's medical record lacked documented evidence weights were taken on 11/30/2024, 12/07/2024, 12/14/2024, 12/17/2024, 12/21/2024, 12/28/2024, 12/29/2024, 12/31/2024, and 01/04/2025 with no documented reason for the missed weights such as patient refusal. Resident 140 (R140) R140 was admitted on [DATE], with diagnoses including hypertensive heart disease with heart failure and chronic kidney disease stage four. On 01/07/2025 in the morning, R140 was seated on a chair receiving two liters of humidified Oxygen by nasal cannula. A signage on the head of the bed read Fluid restriction 1,200 ml per day. The LPN pulled R140's pants up, pressed on bilateral lower legs and indicated R140 had bilateral pitting edema plus 4 (severe fluid retention). The LPN indicated the resident liked to sit because R140 had difficulty breathing when lying down in bed. A physician's order dated 12/23/2024, documented to obtain daily weights, notify physician of three-pound weight gain or continuous weight gain. R140's fluid status care plan initiated 12/24/2024, documented interventions to restrict fluid and obtain weights per physician's order. A nutritional assessment dated [DATE], revealed R140 had a diagnosis of CHF with interventions of fluid restrictions and obtaining daily weights. The medical record lacked documented evidence weights were obtained on 12/28/2024, 12/29/2024, and 01/04/2025. On 01/08/2025 at 2:25 PM, the Licensed Practical Nurse (LPN) explained obtaining weights were the responsibility of the restorative nurse aide (RNA) who worked five days a week and not on weekends. The LPN indicated expecting assigned certified nursing assistants (CNAs) to obtain weights on days when the RNA was off duty. The LPN confirmed the missing weights for R2, R6 and R140 and confirmed there was no documented reason for the missed weights such as patient refusal or being out of the facility to an appointment. The LPN indicated daily weights were important for residents with CHF because it enabled nurses to identify weight variances for timely notification to the physician who may want to change the resident's diuretic therapy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/08/2025 at 2:45 PM, the Registered Dietitian (RD) confirmed Residents 2, 6 and 140 had CHF and were on fluid restrictions and daily weight orders. The RD indicated tracking weight fluctuations for these residents were important because they were at risk for fluid imbalances particularly fluid overload. According to the RD, missed weights may mean missed opportunities to identify fluid imbalances and delay necessary interventions. On 01/08/2025 at 3:00 PM, the interim Director of Nursing (DON) indicated it was the facility's standard of practice to restrict fluids and obtain daily weights for residents with CHF. According to the DON, missed weights were also missed opportunities to identify a weight variance and a potential delay in appropriate interventions to address fluid overload issues. The DON explained physicians were known to modify a resident's diuretic therapy when significant weight changes were identified related to fluid gains. The DON explained the facility employed one RNA who was responsible for taking weights. The DON indicated expecting assigned CNAs to obtain weights when the RNA was off duty. The DON confirmed missed weights for Residents 2, 6 and 140 did have a documented reason. The Patient Care policy (undated), documented delivery of medications and treatments were provided as ordered by the attending physician. The Weight policy (undated), documented weights would be obtained on admission, weekly and/or per physician's order.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure physician's orders for pain medications were followed for 1 of 12 sampled residents (Resident 6). The deficient practice placed the resident at risk for inadequate pain control. Findings include: Resident 6 (R6) R6 was admitted on [DATE], with diagnoses including osteoarthritis and pain in left hip. On 01/07/2025 in the morning, R6 laid in bed covered in blanket, a left boot device was observed in the room. R6 indicated being in the facility for two months after falling at home and although R6 did not sustain a fracture from the fall, the resident verbalized being diagnosed with osteoarthritis more severe in left leg causing the resident chronic pain. A History and Physical dated 11/18/2024, documented R6 had a mechanical fall at home landing on left hip. R6 has had difficulty walking on left leg since the fall and complained of hip pain. A care plan for pain management initiated 11/18/2024, documented interventions to include monitor and record the resident's pain and administer medications as ordered. A physician's order dated 12/05/2024, documented to give Hydrocodone-Acetaminophen 5 milligrams (mg)/325 mg one tablet by mouth PRN (as needed) every four hours for moderate pain level 4-6 (out of 10) on the pain scale. A physician's order dated 12/05/2024, documented to give Hydrocodone-Acetaminophen 7 mg/325 mg one tablet by mouth PRN every four hours for severe pain level 7-10 on pain scale. The medication administration record (MAR) revealed Hydrocodone-Acetaminophen 5 mg/325 mg was administered when R6's pain level was greater than 4-6 on the pain scale on: -12/05/2024 at 2:32 AM pain level 7/10 -12/05/2024 at 8:31 PM pain level 7/10 -12/06/2024 at 7:07 AM pain level 7/10 -12/16/2024 at 1:23 PM pain level 8/10 -12/22/2024 at 3:57 PM pain level 8/10 -12/28/2024 at 8:41 PM pain level 7/10 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/09/2025 at 9:31 AM, the Consultant Pharmacist explained it was not unusual to have two narcotic pain medication orders provided the medication given correlated with the resident's expressed pain intensity on the pain scale. On 01/09/2025 at 10:04 AM, the Clinical Nurse Manager (CNM) and interim Director of Nursing (DON) reviewed R6's medical record and confirmed there were two active orders for Hydrocodone, one for moderate pain (4-6) and the other for severe pain (7-10). The CNM and DON confirmed pain parameters were not followed on 12/05/2024, 12/06/2024, 12/16/2024, 12/22/2024 and 2/28/2024 when the resident expressed being in severe pain of 7 or greater and should have been given the stronger dose of Hydrocodone. The CNM and DON indicated expecting pain parameters to be followed and confirmed the above-mentioned administrations were not in accordance with physician's orders. The Pain Management policy (undated) documented all residents would be assessed for pain utilizing the standard pain scale 0 (zero) to 10. Prescribed medications would follow parameters based upon pain intensity. For example, a pain intensity 1-5 should receive the lowest dose while a pain intensity 6-10 may should receive the highest dose.

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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 a resident was free from unnecessary medications, specifically, a PRN (as needed) pain medication order was not given earlier than scheduled for 1 of 12 sampled residents (Resident 6). The deficient practice placed the resident at risk for side effects of opioids to include constipation and dependence. Findings include: The Unnecessary Medications policy (undated) documented each resident's drug regimen would remain free from unnecessary drugs which shall not be given in excessive doses and ordered by the attending physician. R6 was admitted on [DATE], with diagnoses including osteoarthritis and pain in left hip. On 01/07/2025 in the morning, R6 laid in bed covered in blanket, a left boot device was observed in the room. R6 indicated being in the facility for two months after falling at home and although R6 did not sustain a fracture from the fall, the resident verbalized being diagnosed with osteoarthritis more severe in left leg causing the resident constant pain. R6 expressed discomfort from chronic constipation due to pain medications. A History and Physical dated 11/18/2024, documented R6 had a mechanical fall at home landing on left hip. R6 has had difficulty walking on left leg since the fall and complained of hip pain. A care plan for pain management initiated 11/18/2024, documented interventions to include monitor and record the resident's pain and administer medications as ordered. A physician's order dated 12/05/2024, documented to give Hydrocodone-Acetaminophen 7 mg/325 mg one tablet by mouth PRN (as needed) every four hours for severe pain level 7-10 on pain scale. The medication administration record (MAR) revealed Hydrocodone-Acetaminophen 7 mg/325 mg was administered before the allowable time (sooner than every four hours) on: -12/07/24 administered at 3:16 AM -12/07/24 administered at 5:56 AM -12/07/24 administered at 9:36 AM -12/07/24 administered at 6:05 PM -12/07/24 administered at 9:44 PM -12/12/24 administered at 4:44 AM -12/12/24 administered at 8:25 AM (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-12/18/24 administered at 1:45 PM -12/18/24 administered at 5:30 PM On 01/09/2025 at 9:56 AM, the Clinical Nurse Manager (CNM) and the interim Director of Nursing (DON) explained routine medications were able to be administered one hour before or one hour after the scheduled time however, PRN controlled medications must follow the set frequency per physician's order. The CNM and DON confirmed R6's Hydrocodone-Acetaminophen 7 mg/325 mg must not be given sooner than four hours between each administration. The CNM and DON reviewed R6's medical record and confirmed R6 received the narcotic pain medication too early on 12/07/2024 (three times), 12/12/2024 (one time) and on 12/18/2024 (one time). The CNM and DON verbalized the nurse who administered R6's medications on the above-mentioned dates did not follow physician's orders. The Pain Management policy (undated) revealed routine medications allowed for a one-hour variance before or after the scheduled time while the nurse would be prompted by the electronic health record (EHR) for PRN medications. The Medication Administration policy (undated) documented the licensed nurse would appropriately administer prescribed medications at the right time.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review, the facility failed to ensure 1) infection event forms were being initiated and/or completed and discussions between nursing staff and prescribers were documented regarding adherence to the McGeer criteria for antibiotic orders (a set of guidelines used to determine if a patient has an infection which may need antibiotics) for 4 of 12 sampled residents (Residents and 87, 146, 149 and 5) and; 2) prescribers were being provided education regarding the facility's antibiotic stewardship program (ASP) on an annual basis and as needed in accordance with the facility's ASP policy. The deficient practice placed residents at risk for antimicrobial resistance and adverse effects of antibiotics. Findings include: The Antibiotic Stewardship Program policy and procedure (undated), documented the ASP was designed to improve the use of antibiotics to improve outcomes for patients with infectious disease, prevent antimicrobial resistance, and prevent adverse events associated with antibiotics such as Clostridium difficile diarrhea. The Infection Preventionist (IP) would evaluate the appropriateness of antibiotic therapy and would communicate recommendations with the prescribers. The prescriber would provide explicit written justification in the medical record for non-recommended antibiotic prescribing. Infection Event forms On 01/09/2025 at 10:08 AM, the Infection Preventionist (IP) and Clinical Nurse Manager (CNM) verbalized the facility utilized the McGeer Criteria as the facility's guideline for antibiotic use. The IP explained nurses initiated and completed infection event tracking forms for each infection event and/or antibiotic use. On 01/09/2025 at 11:01 AM, the Regional Director of Clinical Services (RDCS) confirmed the facility adopted the McGeer criteria as the facility's guideline for antibiotic therapies and indicated expecting prescribers to follow the McGeer criteria. The RDCS clarified the facility utilized two different forms for tracking infections, one was titled Admit Infection Tracker which was used for residents who were admitted to the facility with antibiotic orders from the hospital and the other was titled Infection Tracker with McGeer criteria for in-house antibiotic starts. According to the RDCS, the infection tracking forms were expected to be initiated and completed for each antibiotic use. On 01/09/2025 in the morning, the IP indicated there were currently four residents who were receiving antibiotics in the facility, namely, Residents 87, 146, 149 and 5. Resident 87 (R87) R87 was admitted on [DATE], with diagnoses including fracture of upper end of right humerus and subsequent encounter with routine healing. A physician's order dated 01/08/2025, documented to give Amoxicillin-pot clavulanate 875 milligrams (mg) - 125 mg one tablet by mouth twice a day for seven days for ear pain. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The medical record lacked documented evidence the Infection Tracker with McGeer criteria document was initiated or completed, discussions with the prescriber regarding non-adherence to the McGeer criteria was documented and an explicit written justification for the antibiotic was provided by the prescribing physician. On 01/09/2025 in the afternoon, the IP reviewed the McGeer criteria and confirmed R87's antibiotic order did not meet the criteria to be classified as a cellulitis, soft tissue, or wound infection because the only symptom present was ear pain. The IP confirmed there was no documented evidence the IP or any nurse questioned the prescriber's order nor did the prescriber record a written justification for the antibiotic order in the R87's medical record. Resident 146 (R146) R146 was admitted on [DATE], with diagnoses including sepsis due to Methicillin susceptible Staphylococcus aureus and infection and inflammatory reaction due to internal left knee prosthesis. A physician's order dated 12/24/2024, documented to give Cefazolin reconstituted solution 2 grams/2,000 mg intravenously every eight hours for left knee septic joint times 116 doses. A physician's order dated 12/24/2024, documented to give Metronidazole 500 mg one tablet by mouth three times a day for left knee septic joint for 42 days. The medical record lacked documented evidence the Admit Infection Tracker was initiated appropriately and completed which would include a re-evaluation of R146's treatment plan such as status, progress or effectiveness of R146's current regimen. On 01/09/2025 at 10:41 AM, the IP indicated R146's infection tracker was initiated but not completed. On 01/09/2025 at 10:48 AM, the RDCS indicated R146's infection tracker was started but lacked basic information made available by hospital records such as infection type, site, signs and symptoms, and any diagnostic tests done at the acute setting. Resident 149 (R149) R149 was admitted on [DATE], with diagnoses including laceration without foreign body of abdominal wall and protein-calorie malnutrition. A physician's order dated 01/06/2025, documented to give Amoxicillin-pot clavulanate 875 mg-125 mg one tablet by mouth twice a day for urinary tract infection (UTI). The medical record lacked documented evidence the Infection Tracker with McGeer criteria document was initiated or completed, discussions with the prescriber regarding non-adherence to the McGeer criteria was documented and an explicit written justification for the antibiotic was provided by the prescribing physician. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The McGeer Criteria for Infection Surveillance Checklist revised 11/05/2024, revealed residents without indwelling catheters must fulfill one sign and symptom such as acute dysuria (pain when urinating), fever or leukocytosis, suprapubic pain or gross hematuria if afebrile AND a positive diagnostic urine test showing equal to or greater than 10 colony-forming units per milliliter. On 01/09/2025 at 11:14 AM, the IP confirmed no infection tracker was initiated when R149 was started on antibiotics for a suspected UTI on 01/07/2025. The DON recalled the prescriber ordered antibiotics based on a staff report of foul-smelling, cloudy urine, a urine sample was collected with pending results. On 01/09/25 at 11:19 AM, the RDCS confirmed the R149's infection tracker should have been initiated on 01/07/2024 with information such as infection type, site, signs and symptoms, antibiotic order and indication for use, diagnostic tests, whether the treatment was ordered for prophylactic use or otherwise. 01/09/25 11:33 AM, the RDCS verbalized there should have been documented evidence of a discussion between the nurse and the prescriber regarding R149's signs and symptoms, history of UTI, and recommendations when antibiotic orders for the resident was received. On 01/09/2025 in the afternoon, the IP reviewed the McGeer criteria and stated the physician did not follow the McGeer criteria for R149's antibiotic order since R149 met none of the symptoms for a UTI. The IP confirmed there was no documented discussion between the IP and the prescriber regarding non-adherence to the McGeer criteria and there was no documented justification by the ordering physician regarding the antibiotic prescription. Resident 5 (R5) R5 was admitted on [DATE], with diagnoses including fracture of left tibia with subsequent encounter for closed fracture with routine healing. A physician's order for Doxycycline hyclate 100 mg one capsule by mouth twice a day for seven days for possible wound infection on left lower lateral and medial leg open wound. The medical record lacked documented evidence the Infection Tracker with McGeer criteria document was initiated or completed, discussions with the prescriber regarding non-adherence to the McGeer criteria was documented and a written justification for the antibiotic was provided by the prescribing physician. The McGeer Criteria for Infection Surveillance Checklist revised 11/05/2024, revealed cellulitis, soft tissue or wound infection must present with pus at wound, skin or soft tissue site, or four of the following symptoms to include heat, redness, swelling, tenderness, serous drainage and fever or a positive superficial wound culture. On 01/09/2025 at 3:29 PM, the CNM confirmed an infection tracker was not started and completed, a diagnostic test such as a wound swab was not recommended or ordered. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/09/2025 at 3:30 PM, the IP indicated the prescriber ordered R5's antibiotics based on reports of serosanguinous drainage of left leg wound with no other accompanying symptoms or a positive wound culture. The IP confirmed R5's infection status did not meet McGeer criteria for cellulitis, soft tissue or wound infection. The IP stated there was no documented evidence of a nurse-physician discussion regarding adherence to the McGeer criteria and no documented justification by the prescriber for R5's antibiotic order. On 01/09/2025 at 11:47 AM, the IP acknowledged there were gaps with the facility's implementation of the ASP program particularly with 1) completion of infection event tracking forms, 2) documentation of nurse-physician discussions regarding adherence to the McGeer criteria and 3) prescribers providing written justifications for antibiotic orders which went against the McGeer criteria for example prophylactic use. On 01/09/2025 at 3:43 PM, the RDCS indicated the infection tracking forms served the purpose of confirming the presence of an infection and ensuring appropriate antibiotic use. The completion of the form allowed the facility to identify prevalence or trend of an organism, classification of drug being used or a certain physician's trend with antibiotic ordering. Based on all the information, the facility could identify practices of care by staff or providers for timely interventions and education needs, if any. The RDCS indicated the following information was expected to be completed before initiation or upon receipt of new antibiotic order: Phase 1: infection type, site, origin, signs and symptoms, history of infection, device involved, type of diagnostic (results may be pending), and whether treatment was prophylactic or not, and order origin (ex: hospital, clinic, other nursing facility). Phase 2: laboratory results made available. New antibiotic orders. Communication with doctors for clarification on whether orders met criteria. Phase 3: resolution or outcome of treatment. On 01/09/2025 at 3:53 PM, the RDCS indicated expecting the infection tracker was expected to be completed or at least phases one and two, for resident who were admitted with existing antibiotic orders. The RDCS indicated the infection event form should be initiated with basic information present prior to the start of a new antibiotic order. Phase three would be completed if the resident was still in the facility when the infection resolved. 01/09/25 03:54 PM, the RDCS reiterated the infection tracker served as a guide to ensure clinicians were following the McGeer criteria which was the criteria the facility elected to employ for antibiotic therapy. The purpose of following the McGeer criteria was to ensure antibiotics were not being misused or abused thereby preventing antibiotic resistance. The RDCS acknowledged gaps with the facility's implementation of the ASP program and identified a knowledge deficit with nursing staff and prescribers. ASP Education for Prescribers The ASP policy and procedure (Undated) revealed education of practitioners regarding appropriate use of antibiotics would be done by the members of the ASP team as needed but not less than annually. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/09/2025 at 11:44 AM, the IP reported there were currently four physician groups who had rounding privileges in the facility. The IP confirmed there was no documentation education was provided to any of the physicians regarding the facility's ASP program and use of the McGeer criteria on an as needed basis or at minimum once a year in accordance with the facility's policy.