STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295098	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sage Creek Post-Acute	2350 Ione Road Las Vegas, NV 89123

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **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 completed Physician Orders for Life-Sustaining Treatment (POLST) form reflecting the resident's do not resuscitate (DNR) status was obtained and maintained in the medical record for 1 of 18 sampled residents (Resident 147). The failed practice had the potential to result in the resident not receiving care consistent with the resident's resuscitation preferences. Findings include: Resident 147 (R147) R147 was admitted [DATE], with diagnosis including osteomyelitis of vertebra lumbar region, lack of coordination, and abnormalities of gait and mobility. On 05/13/2025 at 8:48 AM, R147 was observed walking in the room. R147 was alert and oriented and participated in conversation. R147 reported was admitted to the facility the previous night. The electronic medical record documented R147's code status as DNR. A Care Plan dated 05/13/2025, lacked documented evidence the DNR code status determination was included in the care plan. The medical record lacked documented evidence a POLST form was completed for R147 at admission. On 05/15/2025 at 10:21 AM, the Medical Records Director confirmed R147's medical record lacked documented evidence a POLST form was completed. On 05/15/2025 at 12:50 PM, the DON explained the facility's procedure to complete a POLST form included the document must have been signed by both the resident and the medical provider. Completion of the POLST should have been done prior to a DNR status entered in the electronic medical record, to confirm the resident's decision of DNR. The DON explained residents were to remain a full code in the electronic medical record until the POLST form with a DNR determination was signed by both the medical provider and the resident. The DON confirmed the medical record lacked documented evidence the DNR code status was care planned for R147. The DON acknowledged R147 should have had a POLST form completed at admission. The DON acknowledged an incorrect code status determination had the potential to place the resident at risk of not having clear directives in place based on their preferences. (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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Advanced Directives revised September 2022, documented the resident had the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advanced directives were honored in accordance with state law and facility policy.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to obtain and review health and vaccination status at the time of admission for a companion pet residing with a resident for 1 of 18 sampled residents (Resident 3). The failed practice created a potential risk for the spread of animal transmitted disease and compromised safety and well-being of other residents and staff. Findings include: Resident 3 (R3) R3 was admitted [DATE], with diagnosis including encounter for orthopedic aftercare following surgical amputation and acute osteomyelitis left ankle and foot, severe sepsis without septic shock, and chronic systolic congestive heart failure. On 05/13/2025 at 9:00 AM, R3 was observed in bed, pleasant and welcoming. R3 lifted the blankets and revealed a small dog. R3 explained the dog was an alert dog, a companion, and had been with R3 since admission to the facility. A Health Certificate dated 05/13/2025 (15 days post admission), documented lab test results and vaccination records for R3's companion dog. R3's medical record lacked documented evidence the health and vaccination status of R3's dog was received and reviewed by the facility at R3's admission on [DATE] and prior to 05/13/2025. On 05/14/2025 at 12:21 PM, the Assistant Director of Nursing (ADON)/Infection Preventionist (IP), explained service animals were allowed on a case-by-case basis at the discretion of the Administrator. The process of allowing a pet to reside at the facility included assessment of the resident's ability to care for the dog independently and review of health and vaccination records for the dog to ensure safety for all. The ADON/IP explained R3 had a companion dog residing with R3 due to anxiety. The ADON/IP reported during the process of admission, the dog's vaccine records were to be reviewed and a copy kept with the receptionist. On 05/16/2025 at 8:30 AM, the Director of Nursing (DON), acknowledged the health and vaccination record for R3's dog was not received by the facility until 05/13/2025. The DON confirmed review of the health and vaccination record was to be completed upon admission. The DON explained the consequences of having a dog at the facility could be catastrophic, up to and including death, if anyone was bit by a dog with rabies or other diseases. The DON reported the facility could have done better to review and document the results of the health and vaccination records of the animal. On 05/16/2025 at 4:15 PM, the Receptionist explained kept all animal health records at the reception desk. The Receptionist confirmed had received R3's dog companion's health and vaccine record on 05/13/2025. The Receptionist acknowledged the health and vaccination record should have been received upon R3's admission and was not received by the facility until 05/13/2025. On 05/16/2025 at 4:30 PM, the ADON/IP acknowledged the health and vaccination record for R3's dog had not been received at the facility until 05/13/2025. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Pets, Animals, and Plants, dated 2001, included animals had to be in good health, received a health evaluation by a licensed veterinarian within the past year and have proof of vaccination for animal-borne diseases and negative tests for enteric parasites.

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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 a urinary bag and tubing were positioned to allow for proper drainage of urine and a physician's order for routine perineal care (the cleaning of the area between the anus and genitals to prevent infections) and a securement device was followed for a resident with an indwelling catheter for 1 of 18 residents (Resident 16). The deficient practice placed the resident at risk for a urinary tract infection (UTI). Findings include: Resident 16 (R16) R16 was admitted on [DATE] and readmitted on [DATE], with diagnoses including neuromuscular dysfunction of the bladder, urine retention and encounter for attention to other artificial openings of the urinary tract. A nursing admission assessment dated [DATE], revealed R16 was admitted with an indwelling catheter. A physician's order dated 03/29/2025, documented indwelling urinary (Foley) catheter care: cleanse with soap and water every shift. A physician's order dated 03/29/2025, documented to secure indwelling catheter tubing using anchoring device to prevent movement and urethral traction. On 05/14/2025 at 8:04 AM, R16 laid in bed with head of bed elevated approximately 30 degrees. A covered urinary bag was observed hanging on the right side of R16's bed and dark yellow urine was observed throughout the Foley catheter tubing. R16's urine was not draining into the urinary bag; the bag was positioned higher than the distal portion of the urinary tubing which was dangling on the floor. R16 explained staff cleaned catheter insertion site during shower days on Wednesdays and Saturdays and when incontinence care was provided after bowel movements. R16 stated staff did not wash perineal area with soap and water every shift and certainly not last night or the day before. On 05/14/2025 at 8:18 AM, the certified nursing assistant (CNA) assigned to R16 gathered supplies to perform perineal care. The CNA prepared two basins, one with warm soapy water and the other contained rinse water. The CNA cleaned the resident's perineal area from inside out changing wash cloths as needed and later cleaned the urinary tubing. The CNA verbalized peri care was expected to be done once every shift, to which R16 responded the night shift CNA and the CNA yesterday did not perform perineal care to the resident. The CNA indicated being assigned to R16 the day before and acknowledged failing to perform perineal care to R16 on 05/13/2025 but could not speak on behalf of the night shift CNA. On 05/14/2025 at 8:30 AM, the CNA emptied the urinary bag and described the contents as 100 cubic centimeters (cc) of dark yellow urine. The CNA confirmed the urinary tubing was filled with stagnant urine from the catheter insertion site throughout the length of the tubing and was dangling on the floor. The CNA indicated urine was not properly draining into the urinary bag because the bag was positioned higher than the portion of the tubing which was on the floor. The CNA explained the urinary tubing had dangled to the ground because there was no securement device which was typically placed (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on the resident's thigh to ensure stabilization of the tubing and proper positioning. The CNA confirmed orders for a securement device and perineal wash were not followed for R16. On 05/14/2025 at 8:35 AM, the Assistant Director of Nursing (ADON) indicated an anchoring device was used for all residents who had a Foley catheter for the purpose of stabilizing the urinary tubing to prevent tugging, discomfort, and to facilitate proper drainage of urine due to gravity. The ADON indicated staff were expected to monitor every resident's indwelling catheter to be positioned properly to allow for proper drainage because backed up urine in the tubing placed residents at risk for developing a UTI. The ADON indicated washing the perineal area with soap and water was standard care for all residents with an indwelling catheter and should be done each shift to ensure the insertion site remained clean thereby avoiding a UTI. R16's medication administration record (MAR) revealed perineal care was provided to R16 on 05/13/2025 on day shift. On 05/14/2024 at 11:25 AM, the Licensed Practical Nurse (LPN) acknowledged signing for R16's perineal care on 05/13/2025 based on the CNA's report the task was performed. On 05/14/2024 at 11:46 AM, the CNA confirmed telling the LPN perineal care was completed when it was missed on 05/13/2025 on day shift. The CNA acknowledged this was a mistake on the CNA's part. On 05/16/2025 at 7:10 AM, the LPN was inside R16's room when R16 told the surveyor the night shift CNA did not perform perineal wash on the resident. The LPN indicated the night CNA had left the facility at 6:00 AM and was not available for interview. The Urinary Catheter Care policy revised August 2022, documented catheter care served the purpose of preventing urinary catheter-associated complications such as UTI. The procedure required using a clean washcloth with warm water and soap to cleanse and rinse the catheter insertion site for routine daily hygiene, ensure the catheter remained stabilized with a securement device, and position the drainage bag to allow for proper drainage and prevent urine from flowing back.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to ensure accurate documentation a protein supplement had been administered without direct observation of the resident's consumption of the protein supplement for 1 of 18 sampled residents (Resident 11). The deficient practice had the potential to compromise the resident's nutritional status and weight. Findings include: Resident 11 (R11) was admitted to the facility on [DATE] with a weight of 231.2 pounds (lbs.) and diagnoses of Parkinsonism, infection and inflammatory reaction due to internal right hip prosthesis, and cirrhosis of the liver. A nutritional assessment for R11, completed on 04/13/2025, referenced the resident was wearing well fitted dentures, required cues at meals to feed self, did not have any swallowing issues, had surgical wounds, and was at risk for malnutrition. A weight change note on 04/10/2025 indicated R11's weight was 222.3 lbs. while food intake was 50 to 100%. Recommendation was for R11 to continue with the current diet regimen and if R11's weight continues to trend down, adjustments to the diet regimen included increased calories for weight maintenance. A weight change note on 04/17/2025 noted R11's weight was 215.2 lbs. while food intake had declined to 25 to 100%. Recommendation was for R11 to add Ensure 500 kilocalories (Kcals) with 18 grams (g) of protein two times a day for wound healing and risk for malnutrition. An order was written by the physician for Ensure two times a day for at risk for malnutrition one carton 240 milliliters (ml). A weight change note on 04/24/2025 indicated R11's weight was 210.6 lbs. while food intake remained at 25 to 100%. Recommendation was for R11 to continue Ensure 500 kcals with 18 g protein two times a day and add a multivitamin with minerals daily for wound healing and risk for malnutrition. A physician Progress note on 05/10/2024 noted R11 has lost 18 lbs. since admitted to the facility on [DATE]. On 05/13/2025 at 01:54 PM, R11 had six unopened Ensure drinks on the over bed table. On 05/14/2025 at 12:15 PM, the Registered Dietitian (RD) indicated R11 was on Ensure twice per day at 9am and 2pm for weight loss and to assist with weight stabilization. R11's weight had hovered around 213 since the multivitamin addition. The RD was not sure the last time was in R11's room and was surprised to hear there were six Ensures on R11's bedside table. The RD stated the expectation was for the staff to document the supplement intake correctly and to notify the RD if the resident was not drinking the supplements. To the RD's knowledge, the family of R11 was not bringing in any supplements/ensure. According to the Medication Administration Record (MAR), as of 05/13/2025, it was documented R11 had been drinking 240ml, which is a whole carton of ensure, everyday twice a day with only three exceptions. On 05/03/2025 AM 200 ml was consumed; on 05/05/2025 PM 100 ml was consumed; and on 05/03/2025 AM zero ml was consumed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/14/2025 at 02:52 PM, R11's Licensed Practical Nurse (LPN) stated when 240 ml is written in the MAR for an Ensure, it is what the resident consumed, not just what was given to the resident. For the May MAR as of 05/13/2025, R11 had not consumed one carton, and consumed less than half of another carton. The rest of the Ensure cartons were completely consumed based off the MAR. The LPN was not sure why there were six Ensure cartons on R11's overbed table. The LPN explained had worked three 12-hour shifts and both of R11's ensure passes are during this LPN's shift. The LPN revealed the shift has a split hall which can be difficult to run back and forth to meet the residents' needs on both sides of the building. The LPN stated relied on the Certified Nursing Assistant (CNA) to let the LPN know how much R11 consumed of the Ensure because it takes R11 a while to finish a carton of Ensure. The LPN explained it could be possible the CNA did not give the LPN the correct information on the amount of Ensure R11 consumed. On 05/14/2025 at 03:31 PM, R11 stated the LPN had come in and removed all the Ensures from the over bed table earlier in the day. R11 also stated only gets the Ensures from the facility, as they would bring them to the room twice a day. R11 revealed no family/friends from outside the facility bring Ensures. On 05/14/2025 in the afternoon, the Director of Nursing (DON) indicated the expectation would be for the nurse to give the drink carton to the resident and make certain the resident had access to it and the resident was able to open and drink it. Then the nurse would need to go back to verify the drink carton was consumed and then document the amount of the drink consumed. R11 had a care plan for malnutrition with an intervention to provide diet, supplements, and vitamins/minerals per physician order. The facility policy titled Documentation of Medication Administration, revised November 2022, documented the administration of medication would be documented immediately after it is consumed.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to obtain physician orders for the insertion of intravenous (IV) lines for 2 of 18 sampled residents (Resident 149 and 150). The failed practice had the potential to result in inappropriate medical treatment and compromised resident safety. Findings include: Resident 149 (R149) R149 was admitted [DATE] and readmitted [DATE], with diagnosis including dysphagia following unspecified cerebrovascular disease, chronic obstructive pulmonary disease with acute exacerbation, and pneumonia. On 05/13/2025 at 9:55 AM, R149 was observed in bed. R149 had an IV line on top of the right hand, covered with an undated bandage. A small amount of blood was visible in the line. R149 reported the IV line was previously used for medication but was no longer used. R149 explained the IV leaked fluids at times, was slightly painful, and R149 felt a bump at the insertion site that changed and varied in size from small to large. R149's medical record lacked documented evidence a physician order was obtained for insertion of the IV line. R149's medical record lacked documented evidence the IV line was inserted. On 05/14/2025 at 2:56 PM, A Registered Nurse (RN), confirmed the medical record lacked physician orders and documentation for insertion of R149's IV line. The RN acknowledged a physician's order was to be obtained for the insertion of IV lines. On 05/14/2025 at 3:09 PM, the Assistant Director of Nursing (ADON)/Infection Preventionist (IP), confirmed R149's medical record lacked documented evidence a physician order was obtained for insertion of the IV line. The ADON/IP acknowledged a physician order should have been obtained for the insertion of the IV line. Resident 150 (R150) R150 was admitted [DATE], with diagnosis including displaced mid-cervical fracture of left femur, subsequent encounter for closed fracture with routine healing, iron deficiency anemia, and dysphagia. On 05/13/2025 at 10:13 AM, R150 had an IV line on the left arm. R150 reported was unsure whether the IV line was still being used or not. R150's medical record lacked documented evidence a physician order was obtained for insertion of the IV line. On 05/14/2025 at 2:03 PM, a Registered Nurse (RN), acknowledged a physician order should have been (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	obtained for the insertion of an IV line. On 05/15/2025 at 4:25 PM, the ADON/IP, confirmed the medical record lacked physician orders for insertion of R150's IV line. The ADON/IP acknowledged a physician order should have been obtained for insertion of R150's IV line. A facility policy titled Peripheral IV Catheter Insertion dated 2001, documented a provider's order was necessary for the procedure to start an IV. Documentation included the date and time of the procedure, the type, length and gauge of the catheter, type of antiseptic agent used, and the signature and title of the person recording the data.

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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, document review and record review, the facility failed to ensure resident was free from unnecessary medications. Specifically, a pain medication prescribed for severe pain was administered to 1 of 18 sampled residents (Resident 16) when resident was not experiencing a specific level of pain as ordered by the physician. The deficient practice exposed the resident to potential adverse effects of opioid use, including constipation and narcotic dependence. Findings include: Resident 16 (R16) R16 was admitted to the facility on [DATE], and readmitted on 03/28/ 2025, with diagnoses including osteoarthritis of the knee, (a chronic condition marked by joint pain, stiffness, and decreased mobility). R16's medical record documented Brief Interview for Mental Status (BIMS) of 10 (moderate cognitive impairment). The hospital discharge summary (undated) documented R16 experienced right hip pain without evidence of fracture following a mechanical fall. A Physician's order dated 03/28/2025, documented to give Hydrocodone-Acetaminophen 5-325 (Opioid pain medication) Milligrams (mg) one tablet by mouth every six hours as needed for severe pain, defined as a pain level of 7-10 on the pain scale (a scale used to determine a resident's level of pain with 0 being no pain and 10 being most pain). R16's Medication Administration Record (MAR) for March 2025, to May 2025 revealed Hydrocodone-Acetaminophen was administered to R16 outside of the prescribed pain scale parameters of 7-10 level on the following dates: -03/30/2025 Pain level 2 at 10:21 AM -04/04/2025 Pain level 5 at 2:32 PM -04/11/2025 Pain level 6 at 2:31 AM -04/11/2025 Pain level 5 at 9:37 AM -04/12/2025 Pain level 4 at 4:17 AM -04/13/2025 Pain level 6 at 4:52 PM -04/14/2025 Pain level 6 at 2: 16 AM -04/17/2025 Pain level 4 at 4:19 AM -04/17/2025 Pain level 6 at 2:38 PM (continued on next page)

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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	-04/18/2025 Pain level 6 at 9:08 PM -04/19/2025 Pain level 6 at 4:44 AM -04/19/2025 Pain level 6 at 4:18 PM -04/20/2025 Pain level 0 at 9:02 AM -04/242025 Pain level 6 at 4:54 AM -04/24/2025 Pain level 6 at 9:23 PM -04/25/2025 Pain level 6 at 5:47 AM -04/25/2025 Pain level 6 at 9:23 PM -04/26/2025 Pain level 0 at 4: 13 PM -05/01/2025 Pain level 5 at 10:15 PM -05/02/2025 Pain level 5 at 5:01 AM -05/02/2025 Pain level 6 at 6:09 PM -05/03/2025 Pain level 5 at 12:28 AM -05/03/2025 Pain level 5 at 7:25 PM -05/07/2025 Pain level 6 at 10:25 PM -05/08/2025 Pain level 5 at 5:58 AM -05/08/2025 Pain level 6 at 9:07 PM -05/09/2025 Pain level 5 at 3:33 AM -05/09/2025 Pain level 5 at 11:15 PM -05/10/2025 Pain level 5 at 6:11 AM On 05/13/2025 at 9:28 AM, R16 verbalized pain was from right leg and forthcoming appointment with physician for knee shot. On 05/14/2025 at 3:23 PM, the Assistant Director of Nursing (ADON) explained the expectation was for nurses to administer Hydrocodone-Acetaminophen to R16 at the pain scale level of 7-10 per physician orders. The ADON reviewed R16's MAR, and confirmed the Hydrocodone-Acetaminophen had been administered 30 times between 03/28/2025 through 05/14/2025 outside of the ordered parameters. The ADON indicated nursing staff had not followed physician's orders. The ADON verbalized administering Hydrocodone-Acetaminophen when the resident reported pain below the 7-10 constituted an excessive dosage and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295098	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sage Creek Post-Acute	2350 Ione Road Las Vegas, NV 89123

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was considered unnecessary medication. On 05/14/2025 at 03:36 PM, the Licensed Practical Nurse (LPN) assigned to indicated R16's pain comes from the lower extremities. The LPN indicated nurses who administered Hydrocodone-Acetaminophen to R16 with a pain scale below 7-10 were not following the physician's order. The LPN explained the process when the resident's pain level is below 7, the resident should be given Acetaminophen and non-pharmacological interventions such as repositioning, massaging, distracting with activities like TV, and interaction with staff. The LPN indicated Hydrocodone-Acetaminophen was considered a narcotic and controlled medication, typically ordered for severe pain. The LPN stated when Hydrocodone-Acetaminophen was administered for mild to moderate pain or below pain level 7-10, this was considered overmedication or unnecessary medication. On 05/15/2025, at 1:04 PM, the Consultant Pharmacist confirmed nursing staff did not adhere to the physician's orders regarding the administration of Hydrocodone-Acetaminophen for R16. The physician's order specified Hydrocodone-Acetaminophen was to be administered only for pain rated between 7-10 on the pain scale. The Consultant Pharmacist indicated Hydrocodone-Acetaminophen had been administered outside of these specified pain parameters on 30 occasions between 03/ 28/2025, and 05/2025. The Consultant Pharmacist stated these instances are where the administration of unnecessary medication occurs. The Facility policy titled Administering Medications, revised April 2019, documented medications must be administered in strict accordance with the prescribing physician's orders. The Facility policy titled Pain Assessment and Management, revised October 2022, documented residents receiving opioid medications for the long-term management of chronic pain are at increased risk for opioid-related complications, including overdose.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295098	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interviews, and document review, the facility failed to ensure an expired medication for a current resident and medication for a discharged resident was removed from active stock of medications and destroyed or sent back to the pharmacy. The deficient practice put residents at risk of receiving ineffective medications. On 05/16/2025 at 8:20 AM, the South medication room revealed a medication (antibiotic) for a discharged resident in the stock of active medications. There was a medication labeled for a current resident of Daptomycin 400 mg/Normal Saline 100 milliliters (antibiotic) which had a do not use after date of 05/13/2025, mixed in with the active medications. On 05/16/25 at 8:30 AM, the Charge nurse indicated when a resident was discharged , the nurse would be informed by case management of what medications would be going with the resident. Generally, for intravenous medications, the process would be to send back to pharmacy. The charge nurse confirmed medications were present and should have been removed from the active stock. On 05/16/25 at 9:20 AM, the Director of Nursing indicated expired medications and medications for discharged residents would be destroyed or picked up by the pharmacy. The medications for discharged residents should be removed from active stock and to immediately remove expired medication as the efficacy could be impacted. The facility policy titled Storage of Medications (revised November 2020) documented drug containers having missing, incomplete, improper, or incorrect labels were to be returned to the pharmacy for proper labeling. Discontinued, outdated, or deteriorated drugs or biologicals were to be returned to the dispensing pharmacy or destroyed.