STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295073	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Springs Healthcare and Rehab	8501 Del Webb Blvd Las Vegas, NV 89134

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50289 Based on interview, record review and document review, the facility failed to ensure Preadmission Screening and Resident Review (PASARR) level two referrals were completed for residents with newly identified psychiatric diagnoses for 5 of 35 sampled residents (Residents 24, 119, 110, 88 and 81). The deficient practice had the potential to deprive the residents of concern of necessary behavioral health services. Findings Include: Resident #24 (R24) R24 was readmitted on [DATE], with diagnoses including congestive heart failure, type 2 diabetes mellitus, chronic pain syndrome, and bipolar disorder. A PASARR level one document dated 10/19/2018, revealed R24 did not have dementia, mental illness (MI), intellectual disability (ID), mental retardation (MR), or any related condition (RC) and was deemed appropriate for nursing facility (NF) placement. A review of the resident's medical notes revealed R24's bipolar disorder was diagnosed on [DATE], during an admit at an acute care hospital. A review of the recent nursing behavioral documentation documented resistance of care on 04/21/2024, 04/24/2024, 04/30/2024, 05/05/2024, and 02/04/2025. The nursing behavioral documentation documented screaming/yelling at staff/other residents on 04/25/2024, 11/24/2024, 12/31/2024, 01/15/2025, and 01/17/2025. The nursing behavioral documentation documented disrupting the unit and other persons on 01/20/2025. Resident #119 (R119) R119 was readmitted on [DATE], with diagnoses including heart failure, type 2 diabetes mellitus, generalized anxiety disorder, depression, bipolar disorder, and post-traumatic stress disorder. A PASARR level one document dated 03/27/2006, revealed R119 did not have dementia, mental illness (MI), intellectual disability (ID), mental retardation (MR), or any related condition (RC), and was deemed appropriate for nursing facility (NF) placement. (continued on next page)

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's medical notes revealed R119's depression and post-traumatic stress disorder were diagnosed on [DATE], during an admit at an acute care hospital due to a change in the resident's mental condition at the facility on 03/14/2024. A review of the recent nursing behavioral documentation documented resistance of care on 04/01/2024, 04/04/2024, 04/15/2024, 04/28/2024, 04/29/2024, 05/30/2024, and 09/02/2024. The nursing behavioral documentation documented screaming/yelling at staff/other residents on 04/01/2024, 04/02/2024, 11/24/2024, and 12/14/2024. The nursing behavioral documentation documented disrobing on 04/02/2024 and other observed behaviors on 03/31/2024, 04/07/2024, 04/09/2024, and 06/22/2024. The medical record lacked documented evidence R24 and R119 were referred for a PASARR level two after newly identified psychiatric diagnoses. 40142 Resident 110 (R110) R110 was admitted on [DATE] and readmitted [DATE], with diagnoses including hemiplegia with hemiparesis following cerebral infarction. A pre-admission screening and resident review (PASARR) level one dated 09/26/2019, documented R110 did not have MI, MR, IC, RC and was appropriate for NF placement. The Annual minimum data set (MDS) dated [DATE], documented R110 had no psychiatric diagnoses and was not receiving any psychotropic medications. A psychiatric follow up note dated 06/14/2021, revealed R110 was diagnosed with bipolar disorder and was started on an anti-depressant. The Annual MDS dated [DATE], documented R110 had a new diagnosis of depression and was on an anti-depressant. The Annual MDS dated [DATE] documented R110 had a new diagnosis of bipolar disorder and was on an anti-depressant. The Annual MDS dated [DATE] documented R110 had bipolar disorder and depression and was on an anti-depressant. The medical record lacked documented evidence the resident was referred for a PASSAR level two after newly identified psychiatric diagnoses. Resident 88 (R88) Resident # 88 was admitted on [DATE] and readmitted on [DATE], with diagnoses including cerebral infarction due to embolism and schizoaffective disorder. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Annual MDS dated [DATE], documented R88 was admitted with a negative PASARR level one (no MI, MR, IC or RC), did not have an active psychiatric diagnosis and was not receiving any psychotropic medications. A psychiatric consult note dated 06/20/2021, revealed R88 was diagnosed with anxiety disorder and paranoid schizophrenia. The Annual MDS dated [DATE], documented R88 had anxiety and schizophrenia and was receiving psychotropic medications. The medical record lacked documented evidence the resident was referred for a PASSAR level two after newly identified psychiatric diagnoses Resident 81 (R81) R81 was admitted on [DATE] and readmitted on [DATE], with diagnoses including spondylosis without myelopathy, schizoaffective disorder and depression. A PASARR level one dated 05/18/2022, documented R81 did not have MI, MR, IC and dementia. Appropriate for NF placement but may need a level of care (LOC) assessment. The Admission MDS dated [DATE], documented R81 did not have psychiatric diagnoses and was not receiving psychotropic medications. A hospital discharge summary revealed R81 was diagnosed with schizophrenia diagnoses and was started on Risperidone (anti-psychotic). The Annual MDS dated [DATE], documented R81 had a diagnosis of schizophrenia and depression and was receiving an anti-psychotic medication and an anti-depressant. The medical record lacked documented evidence R81 was referred for a PASARR level two after newly identified psychiatric diagnosis. On 12/14/2025 at 12:54 PM, the Behavioral Coordinator (BC) indicated being responsible for PASARR for the last two years and had access to the PASARR Medicaid online portal. The BC explained the purpose of PASARR was to ensure residents were appropriately placed and the facility was capable of providing necessary behavioral services as indicated in the resident's level of care (LOC) assessment. The BC indicated not being well-versed with how residents met criteria for a referral for a new LOC or a PASARR level two. The BC indicated having referred only one resident for a PASARR level two and it was a resident who had intellectual disability (ID). The BC acknowledged residents who were admitted with a negative PASARR level one but were later diagnosed with a psychiatric condition during their stay at the facility were not referred for a new LOC or a PASARR level two due to a knowledge deficit on the part of the facility. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/14/25 at 1:34 PM, the Director of Nursing (DON) acknowledged the facility had a knowledge deficit with the PASARR referral process. The DON indicated the facility made sure services were being provided for existing PASARR level two residents, but the inter-disciplinary team (IDT) was not well-versed on identifying residents who may have met criteria for a new LOC or PASARR two referral. The DON reviewed the PASARR policy which identified the social worker as being responsible for PASARR referral process but according to the DON, the social worker was not trained nor played a part in the PASARR process. The DON indicated not being surprised the BC had not referred any residents with newly identified psychiatric diagnoses. The Pre-Admission Screening and Resident Review (PASARR) policy revised December 2006, documented residents with level one screening who meet criteria for a mental illness, intellectual disability, or related disorders were referred to the state PASARR representative for Level two (evaluation and determination) screening process. The social worker was responsible for making referral to the appropriate state-designated authority.

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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** 40142 Based on observation, interview, record review, and document review, the facility failed to ensure comprehensive care plans were revised to reflect new interventions, specifically, a nutrition care plan for 2 of 35 sampled residents (Residents 110 and 84) and a care plan for functional abilities and mobility for 2 of 35 sampled residents (Residents 156 and 67). The deficient practice had the potential to deprive residents of necessary interventions to maintain overall well-being. Findings include: Nutrition Care Plan Resident 110 (R110) R110 was admitted on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction. Review of R110's medical record revealed R110 had a recorded weight of 172 pounds (lbs.) on 09/29/2024 and 157 lbs. on 12/29/2024 or a significant weight loss of 8.72 percent (%) over a three-month period. A physician's order dated 01/13/2025, documented R110 would be provided 1:1 assistance with meals at slow pace. On 02/12/2025 at 7:37 AM, R110 laid awake in bed with television on. A breakfast tray was observed on the bedside table which included scrambled eggs with melted cheese, pureed bread, a carton of chocolate health shake, a carton of chocolate milk and strawberry yogurt. R110's meal ticket documented the resident required feeding assistance. There were no staff members inside the resident's room. The medical record lacked documented evidence R110's nutrition care plan initiated on 07/22/2024, was revised to include physician's order to provide R110 with 1:1 feeding assistance on 01/13/2025. Resident 84 (R84) Resident # 84 was admitted on [DATE], with diagnoses including mild neurocognitive disorder and protein calorie malnutrition. Review of R84's medical record revealed the resident had a recorded weight of 137 lbs. on 10/26/2024 and 117 lbs. on 01/31/2025 or a significant weight loss of 14.6 % over a three-month period. A weight change note dated 02/12/2025, documented R84 had significant weight loss and required assistance with meals. A physician's order dated 01/14/2025, documented 1: 1 feeding assistance. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/12/25 at 7:45 AM, R84 was seated upright in bed and eating breakfast independently with no staff present. The resident's tray contained scrambled egg with melted cheese, pureed bread, Boost protein shake, a bowl of oatmeal and two cartons of orange juice. The meal ticket reflected R84 was on a soft bite-sized regular diet with thin liquids and required feeding assistance. The medical record lacked documented evidence R84's nutrition care plan initiated on 01/24/2023, was revised to include physician's order to provide R110 with 1:1 feeding assistance on 01/14/2025. Restorative Nursing Services Resident 156 (R156) R156 was admitted on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left dominant side. On 02/11/2025 at 10:04 AM, R156 was awake and alert in bed. R156 expressed having issues with not receiving restorative nursing services because the facility only had one restorative nurse aide (RNA). R156 indicated receiving physical therapy (PT) and occupational therapy (OT) services on admission but when insurance stopped covering the PT/OT services, the resident was placed on RNA services which used to be provided three times a week. R156 indicated two RNAs quit in October 2024 leaving the facility with one RNA. R156 pointed to a walker leaning against the wall and indicated being unable to use the walker independently and relied on the RNA to assist with ambulating. R156 indicated not being provided RNA services for over a month and the resident feared declining in strength and stamina. On 02/12/2025 at 1:10 PM, the Director or Rehabilitation (DOR) indicated being familiar with R156 who received PT/OT services from 05/16/2023 until 01/04/2024. R156 was discharged from therapy services on 01/05/2024 due to having met goals and attained maximum potential with skilled services. The DOR indicated R156 was referred to RNA services on 05/16/2024. A PT discharge summary dated 01/05/2024, documented a discharge recommendation to refer R156 to the restorative nursing program. A communication form dated 05/16/2024, documented a therapy recommendation for RNA services, specifically, ambulation using a hemi-walker 75 feet or to maximum tolerance, training with transfers form varying surfaces. Focus on ambulation program up to five days a week. The medical record lacked documented evidence R156's care plan for physical functioning initiated 05/17/2023 and care plan for risk for impaired mobility initiated on 11/29/2023, were revised to include RNA services. Resident 67 (R67) R67 was admitted on [DATE], with diagnoses including traumatic brain injury, epilepsy and gastrostomy status. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/11/2025 in the morning, R67 laid flat in bed, head turned towards right side, bilateral foot contractures more pronounced on the left foot were evident. Tube feeding supplies were observed inside the resident's room. On 02/12/2025 at 1:30 PM, the DOR indicated R67 was receiving PT/OT services from 04/13/2024 until 07/12/2024 and was discharged from therapy for attaining maximum potential. The DOR indicated not being aware if another therapy staff member completed a communication form which would contain specific instructions for the RNA team and whether this was communicated to the 100-Hall Unit Manager (UM). A PT discharge summary dated 07/29/2024, documented a discharge recommendation to refer R67 to the RNA program to maintain current level of performance and prevent decline. The medical record lacked documented evidence R67's care plan for mobility was revised to include therapy recommendations for RNA services. On 02/13/2025 at 11:16 AM, the Director of Rehabilitation (DOR) deferred to nursing for care plan issues. On 02/13/2025 at 11:17 AM, the Unit Manager confirmed R156's and R67's care plans were not revised to reflect therapy recommendations for RNA services, but they should have been revised to reflect provision of RNA services. On 02/13/2025 at 1:25 PM, the Director of Nursing (DON) indicated R110's and R84's nutrition care plans should have been revised when new interventions were added specifically physician's orders for 1:1 feeding assistance. The DON indicated R156's and R67's care plan for mobility and functional abilities should have been revised to include new interventions for RNA services in accordance with therapy recommendations. The Comprehensive Care Plan policy revised December 2016, documented assessment of residents was ongoing, and care plans were revised as information about the resident's condition changes. The care plan was updated when the resident's desired outcome was not met.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interview, record review, and document review, the facility failed to ensure restorative nursing services were provided for 2 of 35 sampled residents (Residents 156 and 67) . This failure had the potential to result in increased pain, worsening contractures, reduced mobility, and a decline in the resident's overall quality of life. Findings include: 40142 Resident 156 (R156) R156 was admitted on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left dominant side. On 02/11/2025 at 10:04 AM, R156 was awake and alert in bed. R156 expressed having issues with not receiving restorative nursing services because the facility only had one restorative nurse aide (RNA). R156 indicated receiving physical therapy (PT) and occupational therapy (OT) services on admission but when insurance stopped covering the PT/OT services, the resident was placed on RNA services which used to be provided three times a week. R156 indicated two RNAs quit in October 2024 leaving the facility with one RNA. R156 pointed to a walker leaning against the wall and indicated being unable to use the walker independently and relied on the RNA to assist with ambulating. R156 indicated not being provided RNA services for over a month and the resident feared declining in strength and stamina. On 02/12/2025 at 1:10 PM, the Director or Rehabilitation (DOR) indicated being familiar with R156 who received PT/OT services from 05/16/2023 until 01/04/2024. R156 was discharged from therapy services on 01/05/2024 due to having met goals and attained maximum potential with skilled services. The DOR indicated R156 was referred to RNA services on 05/16/2024. A PT discharge summary dated 01/05/2024, documented a discharge recommendation to refer R156 to the restorative nursing program. A communication form dated 05/16/2024, documented a therapy recommendation for RNA services, specifically, ambulation using a hemi-walker 75 feet or to maximum tolerance, training with transfers form varying surfaces. Focus on ambulation program up to five days a week. On 02/12/2025 at 1:16 PM, the DOR explained not all residents were candidates for RNA services but for residents who were deemed appropriate for RNA services, a communication form would be completed by a therapy staff member where recommendations would be specified such as in the case of R156. According to the DOR, the form would then be handed to the 100-Hall Unit Manager who was expected to communicate the recommendations to the RNA team. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/12/2025 at 1:27 PM, the DOR stated the purpose of RNA services was to maintain functional level of mobility and strength and prevent a decline in functional abilities as it pertains to activities of daily living (ADL). The DOR indicated being aware RNA services were not being provided in accordance with therapy recommendations due to the facility having only one RNA since October 2024. The DOR verbalized consequences of not receiving RNA services included a decline in functional abilities, loss of strength and stamina and development of contractures. On 02/12/2025 at 1:37 PM, the 100-Hall Unit Manager (UM) confirmed receiving R156's therapy recommendations on 05/16/2024. The UM explained the form was utilized as a reference to complete section GG (functional abilities) of the resident's minimum data set (MDS) assessment, but the recommendations were not communicated to the residents' attending physician. The UM indicated therapy recommendations should have been communicated to the physician to give the physician the opportunity on whether the therapy recommendations would be transcribed into a physician's order to ensure the services would be carried out. The UM confirmed therapy recommendations for R156 and all other residents who were deemed appropriate to receive RNA services had not been communicated to their attending physicians. On 02/12/2025 at 1:47 PM, the RNA confirmed the UM communicated R156's therapy recommendations to the RNA team on 05/16/2024 and the resident was being seen by a member of the RNA team three times a week until October 2024 when two RNAs quit. The RNA indicated being the sole RNA and was responsible for obtaining daily, weekly and monthly weights for all residents in the facility, occasionally assisted with transporting residents to appointments and currently had 20 residents on the RNA case load. The RNA verbalized it was impossible to provide RNA services by themself. On 02/13/2025 at 3:57 PM, the RNA indicated having had time to review R156's medical record and confirmed the resident was seen a total of eight times from 11/03/2024 through 02/13/2025 which was below therapy recommendations. Resident 67 (R67) R67 was admitted on [DATE], with diagnoses including traumatic brain injury, epilepsy and gastrostomy status. On 02/11/2025 in the morning, R67 laid flat in bed, head turned towards right side, bilateral foot contractures more pronounced on the left foot were evident. Tube feeding supplies were observed inside the resident's room. On 02/12/2025 at 1:30 PM, the DOR indicated R67 was receiving PT/OT services from 04/13/2024 until 07/12/2024 and was discharged from therapy for attaining maximum potential. The DOR indicated not being aware if another therapy staff member completed a communication form which would contain specific instructions for the RNA team and whether this was communicated to the 100-Hall Unit Manager (UM). A PT discharge summary dated 07/29/2024, documented a discharge recommendation to refer R67 to the RNA program to maintain current level of performance and prevent decline. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The medical record lacked documented evidence a communication form was completed and R67's therapy recommendations were communicated to any member of the inter-disciplinary team (IDT) which included R67's attending physician. On 02/13/2025 at 10:27 AM, the DOR indicated having spoken with the PT assigned to R67 who acknowledged failing to complete R67's therapy recommendations for RNA services. On 02/13/2025 at 10:30 AM, the Unit Manager and RNA confirmed not receiving therapy recommendations for RNA services for R67 and confirmed R67 had never been on the RNA case load and the resident had not been provided any RNA services since being discharged from PT/OT services in July 2024. The DON, Unit Manager and RNA acknowledged there was a breakdown in communication which resulted in R67 not receiving RNA services in accordance with PT recommendations since July 2024. On 02/13/2025 at 1:07 PM the Director of Nursing (DON) indicated therapy recommendations for RNA services should be communicated to the resident's attending physician to give the physician the opportunity to decide on whether to transcribe the recommendations into a physician's order. The DON verbalized therapy recommendations which were conveyed to the 100-Hall UM should not be used merely to complete section GG of the MDS but communicated to the physician and IDT to ensure the services were carried out. The DON confirmed the facility used to have three RNAs but two RNAs quit in October 2024. The DON indicated it was unreasonable to expect one RNA to obtain weights for all residents in the facility and provide RNA services for 20 residents. The DON verbalized it was fair to confirm RNA services were not being provided to R156 and other residents on the RNA case load. The DON indicated depriving residents of RNA services could lead to decline in function. The Restorative Nursing Services policy revised July 2017, documented residents would receive nursing care needed to help promote optimal safety and independence. Residents may be started on the RNA program upon admission, during the course of stay, or upon discharge from rehabilitation services.

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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** 40142 Based on observation, interview, record review and document review, the facility failed to ensure feeding assistance was provided timely for residents with orders for one-on-one (1:1) feeding assistance with meals for 2 of 35 sampled residents (Residents 110 and 84). The deficient practice potentially contributed to the residents' significant weight loss. Findings include: Resident 110 (R110) R110 was admitted on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction. Review of R110's medical record revealed R110 had a recorded weight of 172 pounds (lbs.) on 09/29/2024 and 157 lbs. on 12/29/2024 or a significant weight loss of 8.72 percent (%) over a three-month period. A physician's order dated 01/13/2025, documented R110 would be provided 1:1 assistance with meals at slow pace. On 02/12/2025 at 7:37 AM, R110 laid awake in bed with television on. A breakfast tray was observed on the bedside table which included scrambled eggs with melted cheese, pureed bread, a carton of chocolate health shake, a carton of chocolate milk and strawberry yogurt. R110's meal ticket documented the resident required feeding assistance. There were no staff members inside the resident's room. On 02/12/2025 at 7:40 AM, R110 had difficulty mouthing words but was able to express self when given time to speak. R110 indicated being unable to feed self and relied on staff for help with eating. R110 indicated staff often left the resident's meal tray on the bedside table and returned later, sometimes up to one hour before returning to assist the resident. R110 indicated by the time staff returned to provide assistance with meals, the resident's food would get cold, and the shakes, milk and yogurt became warm which affected the resident's appetite. On 02/12/2025 at 7:56 AM, a Certified Nursing Assistant (CNA1) was observed assisting R110 with breakfast. CNA1 acknowledged serving R110's tray at around 7:30 AM and returned to the resident's room around 7:45 AM to assist the resident. CNA1 explained being assigned to provide care for 15 residents, three of whom required 1:1 assistance with meals. CNA1 explained assisting a resident with meals took anywhere from 15 minutes to 30 minutes depending on the resident. According to CNA1, R110 typically took 20 to 25 minutes to eat due to slow pace related to aspiration precautions. On 02/12/2025 at 8:00 AM, R110 told CNA1 being done with breakfast. CNA1 indicated R110 did not finish breakfast, and the meal consumption would be documented as 75% and the shake supplement would be documented at 60% while the yogurt was refused due to being warm. Resident 84 (R84) (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident # 84 was admitted on [DATE], with diagnoses including mild neurocognitive disorder and protein calorie malnutrition. Review of R84's medical record revealed the resident had a recorded weight of 137 lbs. on 10/26/2024 and 117 lbs. on 01/31/2025 or a significant weight loss of 14.6 % over a three-month period. A weight change note dated 02/12/2025, documented R84 had significant weight loss and required assistance with meals. A physician's order dated 01/14/2025, documented 1: 1 feeding assistance. On 02/12/25 at 7:45 AM, R84 was seated upright in bed and eating breakfast independently with no staff present. The resident's tray contained scrambled eggs with melted cheese, pureed bread, Boost protein shake, a bowl of oatmeal and two cartons of orange juice. The meal ticket reflected R84 was on a soft bite-sized regular diet with thin liquids and required feeding assistance. On 02/12/2025 at 7:48 AM, CNA2 entered R84's room and began to assist the resident with breakfast. CNA2 explained R84 did not have dysphagia (difficulty swallowing) and was not on aspiration precautions however, R84 had significant weight loss and fluctuating meal consumptions due to cognition issues and had orders for 1:1 feeding assistance. CNA2 acknowledged the resident's tray was served ahead of staff assistance. CNA2 explained being assigned 15 residents, three of whom required assistance with meals and CNA2 had assisted another resident prior to R84. On 02/12/2025 at 8:59 AM, the Unit Manager confirmed Residents 110 and 84 had recently identified significant weight loss and had physician's orders for 1:1 feeding assistance. The Unit Manager confirmed CNA1 and CNA2 were assigned to provide care for 15 residents each and both CNAs were assigned three residents each who needed feeding assistance. The Unit Manager indicated CNAs must distribute meal trays to independent residents first and leave meal trays in meal carts until the CNAs were ready to serve and assist residents who required feeding assistance. The Unit Manager indicated R110's tray should not be placed in the room prior to staff assistance because the improper food temperatures may affect the resident's appetite and consumption. The Unit Manager indicated R84 was not on aspiration precautions but had fluctuating meal intakes which an intervention of 1:1 feeding assistance was deemed necessary by the inter-disciplinary team (IDT) for more consistent meal consumption. The Unit Manager defined 1:1 feeding assistance to mean staff would provide assistance to the resident from tray service to tray collection, beginning to end. On 02/12/2025 at 9:07 AM, the Unit Manager indicated being employed for six years and recounted the facility used to have a restorative dining program where all residents who required assistance or supervision were transported to the restorative dining room where staff were able to provide assistance to multiple residents at the same time. The Unit Manager indicated the restorative dining program was discontinued during COVID and had not been resumed or revisited by the facility since. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/13/2025 at 9:00 AM, the Registered Dietitian (RD) confirmed Resident 110 had significant weight loss and physician's orders for 1:1 feeding assistance. The RD explained R110 had expressed a dislike for chocolate shakes and milk and a preference for vanilla shakes and milk. The RD verbalized being disappointed R110 was served chocolate shake/milk instead of vanilla and was provided feeding assistance more than 15 minutes after tray service where food may have been served in improper temperature. On 02/13/2025 at 9:05 AM, the RD confirmed R84 had significant weight loss and had orders for 1:1 feeding assistance due to weakness and increased confusion resulting in inconsistent meal consumption. The RD expressed disappointment to learn staff was not present when R84's breakfast tray was served. The RD corroborated the Unit Managers recollection the facility used to have a restorative dining program where residents who required supervision or assistance were transported to the restorative dining room where staff were able to assist multiple residents at the same time. The RD indicated the restorative dining program had not resumed even after COVID restrictions were lifted but the RD did not know why. On 02/13/2025 at 12:52 PM, the Director of Nursing (DON) indicated expecting meal trays to remain in meal carts until staff were ready to serve the resident's tray and provide assistance because food served in improper temperatures could impact a resident's meal consumption. The DON indicated 1:1 feeding assistance meant staff were expected to be present and providing assistance to the resident from the beginning of the meal until completion. The DON indicated physician's orders for 1:1 feeding assistance must be followed. The DON indicated beginning employment in September 2021 and there was no restorative dining program in place due to COVID restrictions. The DON indicated restoring the RNA dining program had not been discussed in IDT and Quality Assurance Performance Improvement meetings. The Supporting Activities of Daily Living (ADL) policy, revised March 2018, documented appropriate care, and services would be provided to residents unable to carry out ADLs such as dining.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interview, record review, and document review, the facility failed to ensure the enteral feeding was completely delivered as ordered or the duration of the order was clarified for 1 of 35 sampled residents (Resident 105), and the head of the bed was elevated during enteral infusion for 1 of 35 sampled residents (Resident 136). This failure could result in inadequate nutrition and hydration and an increased risk of aspiration pneumonia or other complications for residents. Findings include: Resident 105 (R105) R105 was admitted on [DATE], with diagnoses including bed confinement and gastrostomy. A Physician Order dated 09/16/2024 documented to infuse Jevity 1.2 tube feeding formula, volume: 1400 milliliters (ml), calories: 1680, rate: 70 ml per hour. A Care Plan dated 06/06/2022, documented R105 required tube feeding (TF) related to Pelizaeus-Merzbacher disease (a rare genetic condition that causes movement and coordination problems due to faulty nerve protection). The goal was to maintain adequate nutritional and hydration status, weight stability, and no signs or symptoms of malnutrition or dehydration. On 02/11/2025 at 10:37 AM, R105 was lying in bed, and the TF Jevity 1.2 was paused. The TF bag was unlabeled except for R105's name. The head of the bed was not elevated. On 02/12/2025 at 8:00 AM, R105 was lying in bed, and the TF was not infusing. On 02/13/2025 at 8:41 AM, R105 was lying in bed, and Jevity 1.2 was infusing at 70 ml per hour, along with water flushes. On 02/14/2025 in the afternoon, a Registered Nurse (RN) indicated the tube feeding (TF) was supposed to run for 20 hours, starting at 2:00 PM until 10:00 AM. The RN indicated the pump prompted feed complete and beeped when the feeding was finished. The RN indicated frequent interruptions occurred during the day due to the provision of care, such as wound and continence care. The RN indicated the new feeding tubing clogged easily because the tubing was thin, and the formula was thick. The RN conveyed sometimes the feeding had not been completed and was unaware of how to check the feeding pump to determine if the resident had received the complete volume of the TF formula. The Medication Administration Record from 02/11/2025-02/14/2025, documented R105's TF Jevity volume dose was completely delivered at 1400 ml per day or 4200 ml for three days. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/14/2025 at 1:56 PM, the Unit Manager (UM) verified at the bedside and confirmed R105's Jevity TF formula dose was not completely delivered as ordered. The UM indicated the prescribed rate was 70 ml per hour, totaling 1,400 ml daily and 4,200 for three days. The UM confirmed over three days, only 2,979 ml had been delivered, leaving a deficit of 1,221 ml. The UM indicated the TF order should have been clarified regarding the number of hours it should run, or to be continued until the full dose was delivered to compensate for interruptions due to the provision of care. The UM indicated this deficit could lead to potential malnutrition or weight loss, if the TF was not properly administered. On 02/14/2025 at 3:33 PM, during a telephone interview, the Registered Dietitian (RD) confirmed R105's TF order was to infuse 70 ml per hour for 20 hours continuously, starting at 2:00 PM and ending at 10:00 AM, totaling 1,400 ml per day. The RD indicated a deficit of 1,221 ml was significant and expected the full TF volume to be delivered to meet the resident's daily caloric requirements. The RD acknowledged in case of interruptions, TF should have been infused until the volume dose was completely delivered. The RD indicated the ongoing deficit, with an estimated loss of approximately 488 calories daily, had the potential to contribute to resident's further weight loss or malnutrition. The RD confirmed significant weight loss had occurred, but R105's body mass index remained stable at 23.8. A facility policy titled Enteral Tube Feeding via Continuous Pump revised in 2018, documented the need to verify a physician's order for the procedure. The policy required reviewing the resident's care plan and addressing any special needs. It also stated the formula label should include initials, date, and time the formula was hung/administered, and the label should be initialed to confirm it was checked against the order. Facility procedures for administration times were to be followed. 41903 Resident 136 Resident 136 (R136) was admitted [DATE] and readmitted [DATE], with diagnosis including cerebral palsy unspecified, dependence on respirator (ventilator status) and functional quadriplegia. A Care Plan dated 12/17/2024, documented R136 required tube feeding related to dysphagia. R136 would be free of aspiration and of side effects or complications related to tube feeding. Interventions included to elevate the head of the bed (HOB) during and thirty minutes after the tube feeding. A Physician order revised 07/06/2024, documented enteral feed formula Jevity 1.2, volume 1300 cubic centimeters (cc), calories 1560, and rate 65 cc per hour. A Physician order revised 03/19/2024, documented to elevate HOB 30-45 degrees during and one hour after feeding. On 02/11/2025 at 9:20 AM, R136 was observed in bed lying on their back, face turned slightly to the right and covered by a blanket up to the neck. R136's arms appeared contorted under the blanket. R136 was resting with eyes closed. R136's head of the bed (HOB) was observed flat, not elevated while the tube feeding pump was on and running at 65 milliliters an hour. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/11/2025 at 09:22 AM, a Registered Nurse (RN) Unit Manager, confirmed R136's HOB was not elevated, and the resident was lying flat. The RN Unit Manager acknowledged the HOB should have been elevated 35-45 degrees to prevent aspiration of the feeding formula and complications. The RN Unit Manager reported staff may have recently cleaned the resident and missed to elevate the HOB when the task was completed. On 02/14/2025 at 12:50 PM, the Director of Nursing (DON) explained residents receiving tube feeding must have the HOB elevated 30-45 degrees to prevent aspiration and resulting complications. The DON reported staff were trained to raise the HOB for tube feeding and if resident care was provided where the HOB was momentarily lowered, it needed to be raised again. A facility policy titled Enteral Tube Feeding via Continuous Pump revised November 2018, documented steps in the procedure included to position the head of the bed at 30-45 degrees (semi-Fowler's position) for feeding unless medically contraindicated.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interview, record review, and document review, the facility failed to ensure a physician's order for Oxygen (O2) use and care orders were obtained and implemented, and Oxygen saturation was monitored for 1 of 35 sampled residents (Resident 68). This deficient practice had the potential to result in improper Oxygen administration, delays in necessary treatment, and potential harm to the resident's health and well-being. Findings include: Resident 68 (R68) R68 was admitted on [DATE], with diagnoses including shortness of breath and pulmonary disease. On 02/11/2025 at 8:51 AM, R68 was lying in bed with eyes closed. O2 was flowing at 2 liters per minute (LPM) via nasal cannula connected to the wall O2, and the humidifier bottle was undated and empty. No signs or symptoms of respiratory distress were noted. On 02/12/2025 at 10:25 AM, R68 was lying in bed, awake, and verbally responsive. O2 was flowing at 2 LPM via nasal cannula, and the humidifier bottle remained undated and empty. R68 indicated being O2 dependent and received continuous O2 administration by staff. R68's medical records lacked documented evidence a physician's order for O2 use and care orders were obtained, transcribed, and implemented. On 02/14/2025 at 10:42 AM, a Registered Nurse (RN) indicated familiarity with R68 and confirmed continuous O2 use. The RN verified the absence of an O2 order and explained care orders were not transcribed until 02/13/2025. The RN explained if a resident was on O2, an order was required to be obtained, transcribed into the medication administration record, included in the care plan, and implemented accordingly. On 02/14/2025 at 10:48 AM, the Unit Manager (UM) indicated O2 use required assessment, a care plan, and transcription of batch orders, including tubing changes, humidifier care, and O2 saturation monitoring. The UM verified and confirmed no O2 orders were in place until 02/13/2025. The UM also expressed being unable to determine when O2 use began due to the lack of documentation. On 02/14/2025 at 1:32 PM, the Director of Medical Records confirmed the absence of documentation or assessment regarding the resident's O2 use until 02/13/2025. A facility policy titled Oxygen Therapy, revised in January 2019, documented the facility's responsibility to provide Oxygen to residents in a safe and therapeutic manner. The administration of Oxygen therapy was required to be based on physician's orders. Humidifiers and tubing were to be labeled and dated. An appropriate plan of care was to be developed to reflect the resident's current condition and include the use of Oxygen per physician's orders.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interview, record review, and document review, the facility failed to ensure a physician's order for dialysis was transcribed, the dialysis access was monitored, and vital signs were obtained and documented pre- and post- dialysis for 1 of 35 sampled residents (Resident 166). This deficient practice could have the potential to increase the risk of bleeding, infection, hypotension, and inadequate dialysis, compromising the resident's health and safety. Findings include: Resident 166 (R166) R166 was admitted on [DATE] and readmitted on [DATE], with diagnoses including end stage renal disease and dependence on renal dialysis. The Quarterly Minimum Data Set, dated dated [DATE], documented the brief interview of mental status for R166 with a score of 15/15, indicating cognitive status was intact and dialysis had been provided. On 02/11/2025 at 9:17 AM, R166 was verbally alert and oriented, seated in the wheelchair, with a dialysis port in place on the right chest. R166 indicated receiving dialysis treatment three times a week with chair time from 11:00 AM to 3:00 PM. R166's medical records lacked documented evidence a physician's order for dialysis was transcribed, the dialysis access was monitored, and vital signs were obtained and documented before and after dialysis. On 02/12/2025 at 8:30 AM, R166 was seated in the wheelchair expecting dialysis treatment scheduled for that day. R166 indicated the dialysis port was assessed in the dialysis center, but not assessed in the facility. R166 verbalized the vital signs were taken at 4:00 AM but not taken in the facility upon return post-dialysis. On 02/12/2025 in the morning, a Licensed Practical Nurse (LPN) indicated the resident's vital signs should have been taken a few minutes prior to leaving for the dialysis center and not using the same vital signs taken earlier in the morning, as the vital signs could have changed after the medications were administered and to prevent hypotension. The LPN indicated the assessment should have been documented in the dialysis communication form to be filled out by the facility and the dialysis center. On 02/12/2025 at 9:59 AM, Registered Nurse (RN) indicated the dialysis access should have been monitored for patency or, in the case of an arteriovenous access, for bruit and thrill to ensure it was functioning properly. The RN indicated the neurological assessment, and vital signs should have been completed in a timely manner. The RN explained the importance of obtaining new vital signs before dialysis treatment and immediately upon the resident's return to the facility post-dialysis to monitor for potential hypotension. The RN indicated using a communication dialysis form wherein the pre and post assessment were documented in the form. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/12/2025 at 9:19 AM, the Unit Manager (UM) explained if a resident had been admitted with dialysis treatment, batch orders should have been transcribed into the Medication Administration Record (MAR), including the name of the dialysis center, its address, phone number, and chair time. The UM indicated the IV access should have been assessed for bleeding and signs of infection. The UM explained vital signs should have been taken before the resident left the facility for dialysis and obtained immediately upon return to the facility post-dialysis. The UM explained the facility utilized a dialysis communication form to be filled out with information at the facility, brought to the dialysis center, completed by the dialysis center during dialysis, and returned to the facility for completion of the assessment and filing in the individualized dialysis binder. The UM confirmed the dialysis orders were not completely transcribed in the MAR and the dialysis communication forms had not been completed, including the assessment of the dialysis access sites and vital signs. On 02/12/25 at 9:45 AM, the Director of Nursing (DON) indicated pre- and post-dialysis access should have been assessed for bruit and thrill and signs and symptoms of infection. The DON indicated the dialysis access assessment was important to ensure patency for blood flow during dialysis treatment. The DON indicated vital signs should have been obtained prior to leaving for the dialysis center and upon returning to the facility post-dialysis, with documentation in the dialysis communication form. A facility policy titled Dialysis Care dated October 2019, outlined standards for residents receiving dialysis. It required shunt sites to be checked every shift and evaluated after each dialysis treatment for complications. Licensed nurses were to monitor and document pre- and post-dialysis observations, including vital signs, weight, bruits, and the shunt site for color, warmth, redness, or edema. The policy also required documentation in the resident's medical record, including dialysis orders, treatment schedule, transportation details, and dialysis center contact information.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 50289 Based on observation, interview, and document review, the facility failed to ensure a sufficient number of nursing staff were scheduled to meet the needs of the residents during the weekends of December 2024 and January through February of 2025. The deficient practice placed the residents at risk for receiving inappropriate and delayed care. Findings include: The Centers for Medicare and Medicaid Services, Payroll-Based Journal (PBJ) Staffing Data Report, dated 07/01/24 through 09/30/2024, documented the facility had excessively low weekend staffing. This was the latest report available. The Daily Staffing Plan which was provided to the surveyors documented the facility staffing needs per unit. The Licensed Nursing and CNA schedule was maintained over two separate shifts; the 6:00 AM-6:30 PM (first shift) revealed five CNAs per unit and four licensed nurses for 100 unit and three licensed nurse each for the 200 and 300 units were needed. The 6:00 PM-6:30 AM (second shift) also revealed five CNAs per unit and four licensed nurses for 100 unit and three licensed nurse each for the 200 and 300 units were needed. The Nursing Hours Per Patient Day (NHPPD) staffing document, dated 2/13/2025, documented the facility would require four licensed nurses for the 100 unit and three for each of the 200 and 300 units for the day shift and five CNAs for each 100 and 300 units and six CNAs for the 200 unit for coverage during the day. It also documented the facility would require three licensed nurses for each unit for the night shift and five CNAs for each unit for coverage during the night. NHPPD is a metric used to calculate staffing needs and to assess the quality of care and resident safety provided by nursing staff. On 02/14/2025 at 12:12 PM, the Director of Nursing (DON) and the Scheduler explained this daily staffing plan was what was used to allocate the appropriate number of staff to each unit. The only difference between the Daily Staffing Plan and the posted NHPPD was the facility was no longer using six CNAs on the day shift 200 unit, the facility was using five CNAs. The DON and Scheduler also explained the facility was using 4 licensed nurses for both day and night shift for the 100 unit, instead of the three listed on the NHPPD document. The Scheduler explained the NHPPD form and daily staffing plan had not been updated. Facility nursing schedules and timesheets documented the facility lacked adequate staffing coverage on the following weekend dates during stated shifts: - December 1, 2024, the facility was missing one licensed nurse and three CNAs on dayshift as well as one licensed nurse and two CNAs on the nightshift. - December 7, 2024, the facility was missing one licensed nurse and one CNA on dayshift as well as one licensed nurse and three CNAs on the nightshift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- December 8, 2024, the facility was missing one licensed nurse and two CNAs on dayshift as well as one licensed nurse and three CNAs on the nightshift. - December 14, 2024, the facility was missing one licensed nurse and one CNA on dayshift as well as one licensed nurse and two CNAs on the nightshift. - December 15, 2024, the facility was missing one licensed nurse and two CNAs on dayshift as well as one licensed nurse and two CNAs on the nightshift. - December 21, 2024, the facility was missing one licensed nurse and three CNAs on dayshift as well as one licensed nurse and three CNAs on the nightshift. - December 22, 2024, the facility was missing one licensed nurse on dayshift as well as one licensed nurse and three CNAs on the nightshift. - December 28, 2024, the facility was missing one licensed nurse and two CNAs on dayshift as well as one licensed nurse and three CNAs on the nightshift. - December 29, 2024, the facility was missing one licensed nurse on dayshift as well as one licensed nurse on the nightshift. - January 4, 2025, the facility was missing one licensed nurse and one CNA on dayshift as well as two CNAs on the nightshift. - January 5, 2025, the facility was missing one licensed nurse on dayshift as well as three CNAs on the nightshift. - January 11, 2025, the facility was missing one licensed nurse on dayshift as well as one licensed nurse and two CNAs on the nightshift. - January 12, 2025, the facility was missing one licensed nurse on dayshift as well as two CNAs on the nightshift. - January 18, 2025, the facility was missing one licensed nurse on dayshift as well as one licensed nurse and two CNAs on the nightshift. - January 19, 2025, the facility was missing one licensed nurse on dayshift as well as two CNAs on the nightshift. - January 25, 2025, the facility was missing three CNAs on the nightshift. - January 26, 2025, the facility was missing one licensed nurse on dayshift as well as three CNAs on the nightshift. - February 1, 2025, the facility was missing two CNAs on dayshift as well as one licensed nurse and four CNAs on the nightshift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- February 2, 2025, the facility was missing one licensed nurse and one CNA on dayshift as well as three CNAs on the nightshift. - February 8, 2025, the facility was missing three CNAs on the nightshift. - February 9, 2025, the facility was missing three CNAs on the nightshift. On 02/12/2025 at 08:23 AM a CNA was interviewed whom stated was assigned 15 residents, which was standard, and when someone calls off or they are working short, the CNA was assigned 20 residents. The CNA indicated 15 or more residents was too many. The resident care could be done, but not with the quality the CNA wants, or the residents need. on 02/12/2025 at 2:01 PM, during the resident council meeting Resident #174 stated had to wait for more than 6 hours for someone to answer the call light on the 6:00 AM to 6:00 PM shift because they are constantly short on the weekends. Unsampled Resident #207 stated weekend staffing is consistently low, especially on night shift. There were only two nurses at night in the 100 hall, but 5 were scheduled. The CNAs are overworked and end up quitting. On 02/14/2025 at 12:12 PM, the Director of Nursing (DON) and the Scheduler verified the schedules were correct and the facility did not have the above positions filled for the dates referenced above. The DON stated they have seen increased staff complaints due to the low weekend staffing as well staff burnout where staff transfer from these positions to weekday day positions as soon as one becomes available. The DON also expressed management saw resident complaints increased as well as call light answer times increased due to the low weekend staffing. The Centers for Medicare and Medicaid Services, Payroll-Based Journal (PBJ) Staffing Hours per Resident Day (HRD), dated 04/01/24 through 06/30/2024, documented the facility was utilizing 2.1 total nursing hours (RN, LPN, and CNA) of nursing care per patient per day on weekends. The national average was 3.355 of total nursing hours (RN, LPN, and CNA) of nursing care per patient per day on weekends. The facility was utilizing 1.255 hours less than the average facility. This was the latest CMS staffing hours available. HRD is the overall time expended by nurses and nursing assistants providing care to the residents on their unit per resident day excluding vacation time, sick time, orientation time, educational leave, or meeting times. The PBJ data affects the facility's star rating, which currently is a one-star rating effective January 2025, prior to that the facility was a two-star rating. According to CMS Nursing Services, the facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility failed to ensure there was a sufficient number of skilled licensed nurses, nurse aides, and other nursing personnel to provide care and respond to each resident's basic needs and individual needs as required by the resident's diagnoses, medical condition, or plan of care. 40131 (continued on next page)

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	295073	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Springs Healthcare and Rehab	8501 Del Webb Blvd Las Vegas, NV 89134

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/12/2025 at 8:22 AM, two Certified Nursing Assistants (CNAs) reported challenges in meeting resident needs such as showering, turning and repositioning, transfers, and feeding due to the higher acuity in 100 halls, where most residents were totally dependent on staff. Three meal trays were to be passed daily, residents were to be cleaned, and more than 12 residents were assigned to each CNA for care. Both CNAs indicated difficulty in taking breaks, with only a 30-minute lunch break allowed for the entire day. Some Licensed Nurses did not assist CNAs, either due to being busy with their own tasks or too tired. On 02/12/2025, a Registered Nurse (RN) reported the facility was previously on 12-hour shifts before transitioning to 8-hour shifts, which disrupted continuity of care, and then returned to 12-hour shifts. The 100 halls should have had four nurses assigned during the day shift due to the workload's acuity, but staffing shortages left only three nurses. The census was divided among three nurses in 100 halls, where most residents were on ventilators or dependent on tube feeding, and required two staff members for bed mobility and transfers.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 40131 Based on observation, interview, record review, and document review, the facility failed to remove discontinued and expired medications and supplies from the active supply in 2 of 3 medication rooms. This deficient practice had the potential to result in medication errors, including the unintentional administration of discontinued medications, posing a risk to resident safety and well-being. Findings include: On 02/13/25 at 9:11 AM, the medication room in 200 Hall was inspected, accompanied by a Licensed Practical Nurse (LPN1). The LPN indicated the Licensed Nurse on duty was responsible for monitoring expiration dates and discontinued medications, with the Unit Manager overseeing the process. The LPN explained expired and discontinued medications should have been separated or removed from the active supply for destruction or return to the facility. The LPN confirmed the following medications had been discontinued for discharged residents, and some had expired. The LPN explained these medications had already been removed from the active supply but was unaware of the reason for being kept and mixed back in. On 02/13/25 at 9:20 AM, the Unit Manager (UM) in 200 Hall verified and confirmed the medications had been discontinued and some had expired. The UM explained medications should have been removed from the active supply for destruction. The medications were as follows: Discontinued Medications: -2 vials Cefepime 2 grams - Discontinued on 08/27/2024 -4 vials Teflaro 600 mg - Discontinued on 11/29/2024 -9 vials Meropenem 1 gram - Discontinued on 08/29/2024 -1 bag Sodium Chloride 0.9% solution 100 mL - Discontinued on 02/02/2025 -1 bag Sodium Chloride 0.9% 1000 mL - Discontinued on 02/02/2025 Expired Medications and Supplies: -15 containers of BD SurePath collection - Expired on 12/01/2024 -8 boxes of BinaxNOW - Expired on 01/23/2024 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/13/25 at 10:02 AM, the medication room in 300 Hall was inspected, accompanied by another Licensed Practical Nurse (LPN). The LPN indicated discontinued medications should have been removed from the active supply and placed in the designated bin under the counter in the medication room for destruction. The LPN explained this process was intended to prevent medication administration errors. The LPN confirmed the following medication, discontinued on 02/09/2025, had not been removed from the active supply: -4 Lovenox 40 mg injection syringes - Discontinued on 02/08/2025 On 02/13/2025 at 10:15 AM, the UM confirmed the Lovenox injections for the resident had been discontinued upon discharge and should have been removed from the active supply. The UM acknowledged responsibility for checking the medication room but missed separating the medication. A facility policy titled Storage of Medications revised in September 2019, outlined all drugs and biologicals were to be stored in a safe, secure, and orderly manner. The policy indicated discontinued or expired drugs and biologicals were not to be used and had to be either returned to the dispensing pharmacy or destroyed.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 50289 Based on interview and document review, the facility failed to ensure the Facility Assessment (FA) was updated to reflect accurate and current staffing needs of the facility and residents, and all required FA components were accurately documented. This deficient practice has the potential to deprive the residents of needed care. Findings include: The FA, updated 01/02/2025, lacked the following documentation: - The care required by the resident population, using evidence-based, data-driven methods which consider the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, or overall acuity - Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies - A facility-based and community-based risk assessment, utilizing an all-hazards approach - Active involvement of Nursing home leadership and management in the Facility Assessment process -Information on the staffing levels needed for specific shifts, such as day, evening, and night and adjusted as necessary based on changes to resident population On 02/12/2025 at 09:25 AM, the Scheduler, who also identified themselves as the Administrator-in-Training (AIT) explained the purpose of the FA was a total assessment of all facility operations. The AIT confirmed the Executive Director was responsible to complete the FA annually and as needed with any changes. The AIT clarified the FA would be updated annually and when there was a change in operations, new information was added, or when a new risk was identified. The AIT was unable to find in the FA who in facility leadership/management had active involvement in the FA development process. The AIT verified and acknowledged the FA was missing the names and signatures of the people who helped to develop and/or reviewed and approved the updated FA. The AIT was unable to find in the FA the types of services the facility provided. The AIT verified and acknowledged the FA was missing the types of services the facility provided, such as respiratory therapy, pharmacy, behavioral health, and wound care. The AIT was unable to find in the FA a facility-based and community-based risk assessment, utilizing an all-hazards approach. The AIT explained the facility's all-hazards Risk Assessment Policy was in the FA, but the qualitative tool, the Hazard Vulnerability Assessment document was not included in the FA. The AIT was also unable to find in the FA both an evaluation of the resident population and its acuity, and information on the staffing levels needed for specific shifts and adjusted as necessary based on changes to resident population such as a staffing plan. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/14/2025 at 02:22 PM, the Director of Nurses (DON) and AIT confirmed the facility failed to define or incorporate acuity in the FA. On 02/14/2025 at 3:00 PM, the DON indicated on 01/24/2025 the QAPI committee convened to finalize the FA, and this would have been the best time to review the staffing plan. The DON and AIT confirmed the staffing plan should have been, but was not, included in the FA. The facility policy titled Facility Assessment, revised October 2018, documented the purpose of the facility assessment was to determine and update the facility's capacity to meet the needs of and competently care for their residents during day-to-day operations. The policy names a specific team responsible for conducting, reviewing, and updating the facility assessment. The policy documented the facility assessment includes a detailed review of the resident population which includes resident acuity. The policy also revealed the facility assessment also includes a detailed review of the resources available to meet the needs of the resident population to include a staffing plan and services currently being provided at the facility.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 40142 Based on interview and document review, the facility failed to ensure the Quality Assurance Performance Improvement Plan (QAPI) program 1) followed through on the facility's performance improvement project (PIP) for staffing shortage, 2) conducted a root cause analysis on the facility's high staff turnover rate, and 3) maintained oversight over low weekend staffing patterns. The deficient practice had the potential to negatively impact the quality of care provided to residents. Findings include: Staffing Shortage PIP The facility's QAPI plan reviewed January 2024, documented performance improvement projects were a concentrated effort towards a particular problem which may be on one area of the facility or facility wide. The PIP involved gathering information systematically to clarify issues, or problems and intervening to make improvements. The facility conducted PIPs to examine and improve care and services in areas which the facility has identified as needing attention. A PIP titled Staffing Shortage initiated on 12/31/2021, documented a root cause of pay rate and benefits. The PIP enumerated action plans which included: -facility offering competitive pay and benefits -facility offering sign-on bonus -facility offering retention bonus -department heads who were licensed nurses would assist on the floor -facility maintained an ongoing contract with a staffing agency On 02/14/2025 at 2:05 PM, the Director of Nursing (DON) indicated the staffing shortage PIP was started on 12/31/2021 during the pandemic. The DON verbalized the staffing shortage PIP was ongoing and was reviewed by the QAPI committee on 11/28/2023 and 01/01/2024 but there was no documentation of minutes to reflect whether the PIP's root cause was still accurate, whether the action plan was still effective or whether new interventions needed to be added. On 02/14/2025 at 2:20 PM, the DON explained the PIP for staffing shortage was expected to be reviewed by the QAPI committee at least once a year and as needed to determine the effectiveness of the action plan. The DON indicated the PIP was no longer current for example the facility had stopped using agency nurses since 2022 due to high expense and care issues. On 02/14/2025 at 2:46 PM, the DON acknowledged the QAPI committee failed to follow through on the facility's PIP for staffing shortage and the DON acknowledged staffing had not been discussed in the last three QAPI meetings held on 11/27/2024, 12/20/2024 and 01/31/2025. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff Turnover The facility's QAPI plan reviewed January 2024, documented the QAPI program was expected to use a systemic approach to determine when an in-depth analysis was needed to fully understand the problem. The QAPI committee was expected to demonstrate proficiency in the use of root cause analysis (RCA) which was focused on continuous learning and promote sustained improvement. The Center for Medicare and Medicaid Services (CMS) Provider Rating Report for September 2024, revealed the facility had a 42.9 percent (%) turnover rate for Registered Nurses (RNs) and a 35.2 % turnover rate of all nursing staff. Specifically, the report reflected the facility lost 51 licensed nurses which included 15 RNs from 01/01/2023 to 03/24/2024. On 02/14/2025 at 2:42 PM, the DON and staff scheduler confirmed there were 51 licensed nurses who left over a one-year period. The DON and staff scheduler indicated the facility did not have a formal process of identifying reasons why employees leave such as conducting exit interviews. The DON acknowledged conducting exit interviews would have been an effective feedback tool to determine the root cause of why a high number of nurses were leaving the facility. The DON indicated not being able to provide a root cause as to why nurses were leaving because exit interviews were not being conducted on a routine basis and certainly not in writing. The DON indicated the facility would be able to better address the root cause if they were properly identified. On 02/14/2025 at 2:52 PM, the Human Resources (HR) Director confirmed exit interviews were not done for all employees who left the facility. The HR Director indicated asking employees why they left when the HR Director had time, and the information would be passed on to leadership in an informal manner. The HR Director stated the facility currently had no systematic formal method for identifying the reasons why staff left. Low Weekend Staffing The facility's QAPI plan reviewed January 2024, documented the governing body (GB) or administration would develop a culture which involved the leadership seeking input from staff, residents and families. The GB must create an atmosphere where staff felt comfortable identifying and reporting problems as well as opportunities for improvement. The CMS Payroll-Based Journal (PBJ) Staffing Data Report for Quarter four (07/01/2024 to 09/30/2024) revealed the facility triggered for excessively low weekend staffing. On 02/14/2025 at 12:12 PM, the DON and staff scheduler were present when staffing schedules were reviewed for December 2024, January 2025 and February 2025. The DON and staff scheduler confirmed weekend staffing levels were consistently low and open positions were not successfully covered during the weekends. The DON reported an increase in staff complaints regarding weekend staffing as well as burnout which had led to an increase in weekend nurses trying to move to weekday positions. The DON reported leadership had received complaints from residents regarding call lights response times on weekends. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/14/2025 at 2:56 PM, the DON indicated weekends were not staffed significantly lower compared to weekdays, so the DON expressed being surprised why the facility triggered for excessively low weekend staffing in the PBJ report. The DON could not speak to whether call-offs were part of the issue. On 02/14/2025 at 3:00 PM, the DON acknowledged the QAPI process was not fully utilized to address the facility's staffing shortage. The DON specified 1) the QAPI committee did not follow through on the PIP for staffing shortage, 2) a root cause analysis was not conducted to identify reasons behind the high turnover of nursing staff and 3) failed to maintain oversight over weekend staffing issues. The QAPI plan reviewed January 2024, documented quality assurance performance improvement principles would drive decision-making within the organization. The Administrator would assure the QAPI plan was reviewed at minimum on an annual basis by the QAPI committee and revisions would be made to the plan ongoing as the need arises.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41903 Based on observation, document review, and interview, the facility failed to prevent the following in a nourishment room: a staff member from consuming a drink, a trash can overflowed onto the floor, cubed ice placed inside a handwashing sink, and loose cubed iced on the bottom and around the food in a freezer. The failed practice had the potential to cause the spread of bacteria in the nourishment room. Findings include: On 02/11/2025 at 8:30 AM, in the 300 hall nourishment room, a staff member was observed sitting on a chair next to the handwashing sink and drank from a small cup filled with liquid, a clear bag with a knot tied on top filled with cubed ice was inside the handwashing sink, the trash can overflowed onto the floor, and loose cubed ice was covering the bottom of the freezer and around food products. On 02/11/2025 at 8:30 AM, the Food Service Director asked the staff member to exit the room, removed the chair, and advised the staff member they were not to drink in the nourishment room. The Food Service Director explained did not know why bagged ice was placed in the handwashing sink and acknowledged a handwashing sink should not be used to melt or discard ice. The Food Service Director acknowledged the trash was overflowing onto the floor and should have been emptied when partially full. The Food Service Director denied knowing why there was loose cubed ice at the bottom and around the food in the freezer. On 02/11/2025 at 8:40 AM, a Registered Nurse (RN), disclosed did not know why there was ice in the handwashing sink and explained it may have been placed in the sink to melt. The RN acknowledged ice should not be left to melt in a handwashing sink. On 02/13/2025 at 10:51 AM, the Infection Preventionist (IP) explained staff cannot eat or drink in the nourishment rooms. Nothing was supposed to be placed in handwashing sinks including bagged ice. The IP acknowledged trash should have been removed at 1/2 or 3/4 full and a new bag placed on the trash bin. The IP reported cubed ice should not have been placed at the bottom of the freezer and around the food. The IP acknowledged all of these findings were infection control concerns that should not have happened to avoid cross contamination which could lead to illness. A facility policy titled Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices Revised October 2017, documented personnel may not eat or drink in the food preparation area. A facility policy titled Refrigerators and Freezers revised December 2014, documented refrigerators and freezers would be kept clean, free of debris, and mopped with sanitizing solution on a scheduled basis and more often as necessary. A facility policy titled Housekeeping undated, documented general duties of the housekeeping staff included to empty and clean all waste containers.