STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295110	A. Building B. Wing	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Valley Health and Wellness Suites	2965 Wigwam Parkway Henderson, NV 89074

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on record review, interview, and document review, the facility failed to implement a person-centered care plan for the utilization and maintenance protocol of a peripherally inserted central catheter (PICC) line for 1 of 3 sampled residents (Resident 2). This deficient practice posed a potential risk of improper care, including inadequate dressing changes and improper flushing, which could lead to complications such as infection, catheter occlusion, thrombus formation, or other adverse health outcomes. Findings include: Resident 2 (R2) R2 was admitted on [DATE], and readmitted on [DATE], with diagnoses including dysphagia (difficulty swallowing), dementia, protein-calorie malnutrition, and failure to thrive. The PICC Procedural Note dated 12/03/2024, documented the PICC line was inserted in R2's right upper arm for total parenteral nutrition (TPN) and antibiotics administration. A physician's order dated 12/03/2024, documented the Clinimix TPN was to be infused through the PICC line only, with a bag and line change every 24 hours. R2's medical records lacked documented evidence a person-centered care plan was formulated for the utilization and maintenance of the PICC line. On 02/04/2024 at 3:25 PM, the interim Director of Nursing (DON) verified R2's PICC line had been inserted on 12/03/2024, for TPN administration. The DON confirmed no care plan had been formulated when the PICC line was inserted. The DON indicated the Minimum Data Set (MDS) department was responsible for formulating the care plan if the PICC line was inserted after the resident's admission, while the licensed nurses were responsible if a resident was admitted with a PICC line. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/04/2025 at 4:03 PM, the Director of MDS confirmed no care plan had been put in place. The Director was unaware the PICC line had been inserted, and it had not been mentioned during the morning meeting. The Director indicated the expectation was for the licensed nurses to initiate the custom care plan, which would prompt the MDS department. The Director indicated there had been a lack of communication, as the MDS department did not perform routine visual assessments, and the PICC line insertion for R2 had not been identified. A facility policy titled Care Plan Process, Person-Centered Care, dated 05/05/2023, documented the facility would develop and implement a baseline and comprehensive care plan for each resident, including instructions needed to provide effective, person-centered care meeting professional standards of quality care. The facility would coordinate the development of the person-centered care plan within the required timeframes. Complaint #NV00073041

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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 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** 40131 Based on observation, interview, record review, and document review, the facility failed to ensure a peripherally inserted central catheter (PICC) line dressing care was changed for 1 of 3 sampled residents (Resident 1), and a physician order for flushing protocol was obtained, transcribed, and implemented for 1 of 3 sampled residents (Resident 2). The deficient practice had a potential for a resident to develop an infection from poor maintenance of an intravenous site and a potential for catheter occlusion. Findings include: Resident 1 (R1) R1 was admitted on [DATE], with diagnoses including diabetes mellitus and chronic hepatitis. The Admission Minimum Data Set for Brief Interview for the Mental Status dated 01/17/2025, documented a score of 15/15, which indicated R1's cognitive status was intact. On 02/04/2025 at 11:21 AM, R1 was seated in a wheelchair with a PICC line in the right upper arm. The dressing was undated, peeling, and soiled with dried, reddish-brown blood-like residues. R1's medical records lacked documented evidence a physician order for the maintenance of the dressing changes was obtained, transcribed, and implemented. On 02/04/2025 at 11:21 AM, a Registered Nurse (RN) confirmed the observation and explained a dressing change was attempted, but a PICC line dressing kit was unavailable. The RN explained the dressing should have been changed weekly, and failure to do so increased the risk of infection. The RN verified and confirmed there was no order for a dressing change or documentation of the actual insertion date existed. The RN indicated R1 was admitted on [DATE] with a PICC line, which was later dislodged on 01/16/2024, and replaced as ordered. On 02/04/2025 in the afternoon, R1 verbalized the previous PICC line was in the left upper arm, was dislodged, and a new PICC line on the RUA had been inserted for more than a week, flushed only twice, and the dressing had not been changed since it was inserted. R1 expressed a desire for a dressing change as it was soiled and peeling off. On 02/04/2024 at 3:25 PM, the interim Director of Nursing (DON) indicated the PICC line dressing change protocol required changes every 7 days from the date it was last changed. The DON explained the PICC line dressing should have been dated to determine the next scheduled change. The DON verified and confirmed there was no physician's order in place for the PICC line weekly dressing change for R1. The DON acknowledged without the order, the licensed nurses would not have been prompted to complete or implement the task. Resident 2 (R2) (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2 was admitted on [DATE], and readmitted on [DATE], with diagnoses including dysphagia (difficulty swallowing), dementia, protein-calorie malnutrition, and failure to thrive. The Admission Minimum Data Set, dated dated dated [DATE], documented the brief interview of the mental status score of 00/15, which indicated R2's cognitive status was severely impaired. The PICC Procedural Note dated 12/03/2024, documented the PICC line was inserted in R2's right upper arm for the total parenteral nutrition (TPN) and antibiotics. A physician Order dated 12/03/2024, documented the Clinimix TPN was to be infused through the PICC line only, with a bag and line change every 24 hours. R2's medical records lacked documented evidence a physician order for the PICC line saline flushing protocol was obtained, transcribed, and consistently implemented. A Nursing Progress Note dated 12/18/2024, documented a new order for PICC line replacement for Clinimix TPN administration due to the current PICC line of R2 was not patent or flushing. On 02/04/2025 at 11:35 AM, a Licensed Practical Nurse (LPN1) indicated the saline flushing protocol should have been in place to ensure patency. The LPN explained failure to flush the PICC line could result in clogging, and the dressing should have been changed at least weekly or as needed if wet or soiled. The LPN indicated Licensed Nurses assigned to the resident were responsible for intravenous protocol, including monitoring, flushing, and dressing changes. The LPN confirmed no order for saline flushing protocol was in place when R2's PICC line was inserted on 12/03/2024. The LPN acknowledged in the absence of the order, the licensed nurses would not have been prompted to complete the PICC line flushing. On 02/04/2025 at 11:54 AM, a Licensed Practical Nurse (LPN2) indicated the PICC line required an order for flushing protocol, weekly dressing changes, and monitoring for the signs and symptoms of infection at least every shift. The LPN indicated the PICC line should have been flushed promptly before and after administration to maintain patency and prevent clogging, and the dressing should have been changed weekly or as needed. On 02/04/2025 at 3:25 PM, the interim Director of Nursing (DON) verified R2's PICC line had been inserted on 12/03/2024 to administer TPN. The DON confirmed flushing orders were not obtained when the PICC line was initially inserted on 12/03/2024. The DON explained the previous PICC line was not flushing, leading to the insertion of a new line on 12/18/2024, along with maintenance orders. The DON indicated the Licensed nurses were expected to obtain and implement the flushing protocol to maintain patency. The DON acknowledged while PICC line care and maintenance were included in the order set, was unsure why the flushing protocol was not transcribed and implemented. A facility policy titled PICC Line revised 05/05/2023, documented Licensed Nurses may perform the following procedures with the PICC. 1. Assessing/Dressing Care of a PICC line. Procedure Reference: Lippincott Nursing Procedure 9th. Edition. Label the dressing with the date you performed the procedure or the date the dressing is next due to be changed as directed by your facility. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Physician Orders revised 05/05/2023, documented a qualified licensed nurse was responsible for obtaining and transcribing orders in accordance with facility practice guidelines. In facilities with electronic medical records, Medication Administration Records or Treatment Records were generated electronically. Complaint #NV00073041