STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295105	A. Building B. Wing	02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Nevada State Veterans Home	36 Battleborn Way Sparks, NV 89431

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310 Based on clinical record review, interview, and document review the facility failed to protect 1 of 6 Facility Reported Incident (FRI) sampled residents (Resident #3) from physical and verbal abuse, and ensure 1 of 6 FRI sampled residents (Resident #4) was provided the services necessary to prevent neglect resulting in harm. Findings include: Resident #3 Resident #3 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Parkinson's disease, Hemiplegia, unspecified affecting left nondominant side, other muscle spasm, pain unspecified, and contracture of left hand. A Facility Reported Incident (FRI) report, dated 11/14/22, documented on 11/12/22, Resident #3 and facility staff reported a Licensed Practical Nurse 1 (LPN) accused Resident #3 of pulling Resident #3's gastric tube (g-tube) out, used profanity towards the resident and slapped the resident's hand away when the resident attempted to lift the resident's shirt to show LPN1 what happened. Resident #3's quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE], section C0500 (cognitive patterns) documented the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact. A nurse progress note dated 11/12/22, documented Resident #3 removed Resident #3's gastric tube (g-tube) and a foley catheter was inserted to hold patency. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/21/22 at 9:58 AM, Resident #3 recalled the resident was lying in bed and felt something warm and wet on the resident's left side and noticed the resident's g-tube had come out. The resident informed a Certified Nursing Assistant (CNA) the g-tube was out and the CNA informed LPN1. Resident #3 communicated LPN1 entered the resident's room in a rushed manner and yelled at the resident using profanity and asked the resident, what have you done? Resident #3 explained the resident attempted to lift the resident's shirt to show LPN1 the g-tube site and LPN1 hit Resident #3's hand away from the resident's shirt and using profanity, yelled at the resident you don't need to show me anything, I see what you have done and tubes don't just come out. Resident #3 verbalized the resident felt belittled and scared and was angry the LPN called the resident a liar. Resident #3 shared the resident remained upset throughout the night and the next day. On 12/21/22 at 10:23 AM, LPN2 verbalized LPN2 relieved LPN1 on the morning of 11/12/22, and explained LPN1 communicated to LPN2 it had been a crazy night and LPN1 verbalized to LPN2, using profanity, that guy down there pulled out his g-tube. LPN2 explained the conversation took place at a medication cart in the resident hallway and LPN1 flailed LPN1's arms around and yelled loudly using profanity. LPN1 claimed Resident #3 argued with LPN1 about how the g-tube came out. LPN2 confirmed Resident #3 reported the incident to LPN2 and explained LPN1 yelled at the resident using profanity and hit the resident's hand. On 12/21/22 at 11:49 AM, the Administrator confirmed LPN1 accused Resident #3 of removing the resident's g-tube, yelled at the resident using profanity, and hit the resident's hand away when the resident attempted to show LPN1 the g-tube site. The facility policy titled Freedom From Abuse, Neglect and Exploitation, dated 11/2017, documented the facility provided a safe resident environment and protected residents from abuse, including verbal, mental, and physical abuse. Staff were expected to be in control of behavior and behave professionally. The facility's protection from abuse included contracted staff. Resident #4 Resident #4 was admitted to the facility on [DATE], with diagnoses including neuromuscular dysfunction of the bladder, unspecified, presence of urogenital implants, and vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Resident #4's Comprehensive Care Plan included a care plan for a Foley (urinary) catheter, initiated on 12/28/21, the care plan included the following interventions: -Observe for potential complications involving catheter occlusion, (decreased or no output), catheter migration (catheter movement), and skin breakdown at the insertion site. Notify a Licensed Nurse (LN) if any complications were observed. -monitor, record, and report to the physician signs and symptoms (s/s) of a urinary tract infection (UTI) The s/s of a UTI included blood-tinged urine, no urinary output, and deepening of urine color. Resident #4's bladder elimination record documented Resident #4's urinary output as follows: -On 05/05/22 at 5:18 AM, 250 cubic centimeter (cc) of urine, and (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 05/05/22 at 1:51 PM, 0 cc of urine, a notation documented the resident had not voided. The bladder elimination record lacked documented evidence Resident #4's urinary drainage bag was checked for urinary output from 05/05/22 at 5:19 AM, until 5/05/22 at 1:51 PM. A nurse progress note dated 05/05/22 at 3:09 PM, documented Resident #4's urinary drainage bag contained a small amount of dark colored urine with sediment. A nurse progress note dated 05/05/22 at 3:52 PM, documented a bladder scan was completed and Resident #4 was retaining 275 milliliters (ml) of urine. Urine was not draining into the drainage bag and the drainage bag contained less than 10 cc of urine. The catheter balloon was deflated, and a 16 French (Fr)/30 cc catheter was removed. Upon removal of fluid from the balloon, a large amount of bright blood was noted coming from the urethra, and light pressure was applied. The resident was sent via ambulance to the emergency room for evaluation and treatment. On 12/20/22 at 4:51 PM, the Administrator communicated Resident #4's urinary catheter was changed around 1:00 AM on 05/05/22, and no urine was present in the drainage bag when assessed by the day shift nurse around 3:00 PM on 05/05/22. The Administrator confirmed the incident occurred and could have been prevented by more closely monitoring the resident's urinary output. On 12/21/22 at 12:37 PM, the DON confirmed on 05/05/22, between 5:19 AM and 1:51 PM, Resident #4 did not have any urinary output resulting in urinary retention and urethral trauma. The DON confirmed the lack of urinary output should have been identified during hourly rounds and reported to the physician immediately. The facility policy titled Quality of Care, Urinary Catheterization, dated 04/2021, documented if a resident had an indwelling catheter, the medical record would reflect the resident's response to treatment and on-going monitoring for a potential change in condition. The facility policy titled Freedom for Abuse, Neglect, and Exploitation-Abuse, dated November 2017, documented abuse included the deprivation by an individual, including a caretaker, of the goods or services necessary to attain or maintain physical, mental, and psychological well-being. Staff were not to withhold care and services which resulted in care deficits to a resident. Neglect could be the result of a pattern of failures or could be the result of one or more failures involving one resident and one staff member. FRI #NV00066278 FRI #NV00067398

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310 Based on clinical record review, interview, and document review, the facility failed to ensure a nurse did not take a resident's personal property for 1 of 6 Facility Reported Incident (FRI) investigated residents (Resident #2). Findings include: Resident #2 was admitted to the facility on [DATE], with a diagnosis of type II diabetes mellitus with diabetic neuropathy, unspecified. A purchase order dated 09/19/22, documented Resident #2 purchased a Wi-Fi 6 Range Extender device from an online company for $119.99. A facility Check Requisition form documented reimbursement was to be made to Resident #2 in the amount of $199.00, to purchase a new Wi-Fi booster (booster). On 12/20/22 at 3:50 PM, Resident #2 explained the resident bought a booster, but it did not work in the facility. The resident offered to sell the booster to a Licensed Practical Nurse (LPN). The LPN took the booster home and the resident never saw the LPN again. Resident #2 confirmed the LPN did not return or pay for the booster. On 12/20/22 at 5:00 PM, the Administrator communicated the resident submitted a receipt for the booster and the facility was reimbursing the resident for the cost of the device. The Administrator confirmed the LPN, a travel nurse, took the device from Resident #2, and did not return or pay for the device. The Administrator confirmed Resident #2's purchase amount for the booster was $119.99, and the facility was reimbursing the resident $199.00. The Administrator explained the difference in the purchase amount and the reimbursement amount was a clerical error. The facility policy titled Freedom From Abuse, Neglect and Exploitation, dated 11/2017, documented the facility kept resident free from abuse, including misappropriation of resident property and exploitation. The protection extended to abuse by staff including contracted staff. Staff would not borrow or take a resident's personal items. FRI #NV00067604

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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** 43310 Based on interview, clinical record review, and document review, the facility failed to ensure a care plan was updated and included interventions to monitor the occurrence of and prevent recurrence of urinary retention and urethral trauma for 1 of 6 Facility Reported Incident (FRI) investigated residents (Resident #4) Findings include: Resident #4 Resident #4 was admitted to the facility on [DATE], with diagnoses including neuromuscular disfunction of the bladder, unspecified, presence of urogenital implants, and vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A nurse progress note dated 05/05/22 at 1:12 AM, documented Resident #4's urinary catheter was changed and a 16 French (Fr)/30 cubic centimeters (cc) balloon (urinary) urinary catheter was inserted. A nurse progress note dated 05/05/22 at 3:09 PM, documented Resident #4's urinary drainage bag contained a small amount of dark colored urine with sediment. A nurse progress note dated 05/05/22, at 3:52 PM, documented a bladder scan was completed and Resident #4 was retaining 275 milliliters (ml) of urine. Urine was not draining into the drainage bag and the drainage bag contained less than 10 cc of urine. The catheter balloon was deflated, and a 16 Fr/30 cc catheter was removed. Upon removal of fluid from the balloon, a large amount of bright blood was noted. The resident was sent via ambulance to the emergency room for evaluation and treatment. A care plan initiated on 12/28/21, documented the resident had a urinary catheter due to urinary retention. Interventions included the following: - monitoring intake and output, -monitor for signs and symptoms of urinary tract infections, -monitor for potential complications involving occlusion, migration, and skin breakdown, and -catheter care each shift. The care plan was last revised on 04/10/22, and did not include new goals or interventions. The care plan lacked documented evidence the care plan was revised on or after 05/05/22, following Resident #4's urinary catheter becoming dislodged resulting in urinary retention and urethral trauma. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/21/22 at 12:37 PM, the DON confirmed on 05/05/22, between 5:18 AM and 1:51 PM, Resident #4 did not have any urinary output resulting in urinary retention and urethral trauma. The DON confirmed the lack of urinary output should have been identified during hourly rounds and reported to physician immediately. On 12/21/22 at 12:49 PM, the DON confirmed Resident #4's care plan should have been reviewed and revised/updated after the resident's urinary catheter became dislodged resulting in urinary retention and urethral trauma. The DON explained the care plan should have been updated to include monitoring related to urethral bleeding and trauma sustained, psychosocial well-being, and pain. The care plan should have included interventions to ensure the trauma was resolving, and no long-term signs or symptoms of adverse outcomes were present. The facility policy titled Comprehensive Care Plans, dated 11/2017, documented the care planning process was an ongoing process. The care plan was comprehensive, person centered, and addressed the residents medical, nursing, physical, mental, and psychosocial needs. FRI #NV00066278

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F 0690 Level of Harm - 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** 43310 Based on clinical record review, interview, and document review the facility failed to ensure 1 of 6 FRI sampled residents (Resident # 4) received the care required to prevent urinary retention and urethral trauma (bleeding from the urethra). Findings include: Resident #4 was admitted to the facility on [DATE], with diagnoses including neuromuscular dysfunction of the bladder, unspecified, presence of urogenital implants, and vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A physician's order dated 02/28/22, documented an order to change an indwelling Foley 16 French (Fr)/10 cubic centimeters (cc) balloon (urinary) catheter every 30 days on night shift. A physician's order dated 05/04/22, documented an order to change an indwelling 16 fr/30 cc catheter every 30 days and check for functionality every shift. A nurse progress note dated 05/05/22 at 1:12 AM, documented Resident #4's urinary catheter was changed and a 16 Fr/30 cc urinary catheter was inserted. Resident #4's bladder elimination record documented Resident #4's urinary output as follows: -On 05/05/22 at 5:18 AM, 250 cc of urine, and -On 05/05/22 at 1:51 PM, 0 cc of urine, a notation documented the resident had not voided. The bladder elimination record lacked documented evidence Resident #4's urinary drainage bag was checked for urinary output from 05/05/22 at 5:19 AM, until 5/05/22 at 1:51 PM. A nurse progress note dated 05/05/22 at 3:09 PM, documented Resident #4's urinary drainage bag contained a small amount of dark colored urine with sediment. A nurse progress note dated 05/05/22 at 3:52 PM, documented a bladder scan was completed and Resident #4 was retaining 275 milliliters (ml) of urine. Urine was not draining into the drainage bag and the drainage bag contained less than 10 cc of urine. The catheter balloon was deflated, and a 16 Fr/30 cc catheter was removed. Upon removal of fluid from the balloon, a large amount of bright blood was noted coming from the urethra, and light pressure was applied. The resident was sent via ambulance to the emergency room for evaluation and treatment. A facility Physician Discharge Summary note, dated 05/05/23, documented Resident #4's summary of care/reason for transfer was bleeding with foley (urinary catheter) removal. An emergency room Progress note dated 05/05/22, documented Resident #4 had an abnormal genitourinary exam related to blood draining from the urethra status post traumatic foley placement (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	A physician's order dated 05/06/22, documented an order to change an indwelling 16 fr/10 cc catheter every 30 days on night shift. A physician's order dated 05/06/22, documented to flush Resident #4's urinary catheter with 30 milliliters of normal saline three times per day for three days due to bleeding from urethra. A nurse progress note dated 05/06/22, documented Resident #4 continued to have a fair amount of red blood inside of the resident's brief, coming from the resident's urethra. On 12/20/22 at 4:48 PM, the Director of Nursing (DON) explained when Resident #4's urinary catheter was replaced on 05/05/22 at 1:12 AM, the catheter was inserted into the urethra and was not advance far enough. The DON explained when the night shift nurse inserted the catheter, the nurse reported urinary return was noted. On 05/05/22, at 1:51 PM, the day shift nurse assessed the urniary drainage bag and noted there was no evidence of urinary out put. On 12/20/22 at 4:51 PM, the Administrator communicated Resident #4's urinary catheter was changed around 1:00 AM on 05/05/22, and no urine was present in the drainage bag when assessed by the day shift nurse around 3:00 PM on 05/05/22. The Administrator confirmed the incident occurred and could have been prevented by more closely monitoring the resident's urinary output. On 12/21/22 at 12:22 PM, the DON explained the order for a urinary catheter with a 30-cc balloon was a transcription error and a 10-cc balloon should have been ordered. The DON confirmed the order to place a urinary catheter with a 30-cc balloon was an inaccurately written order and confirmed when the order was written, the order was not read back to the physician. On 12/21/22 at 12:37 PM, the DON confirmed on 05/05/22 between 5:19 AM and 1:51 PM, Resident #4 did not have any urinary output resulting in urinary retention and urethral trauma. The DON confirmed the lack of urinary output should have been identified during hourly rounds and reported to physician immediately. The facility policy titled Quality of Care, Urinary Catheterization, dated 04/2021, documented if a resident had an indwelling catheter, the medical record would reflect the resident's response to treatment and on-going monitoring for a potential change in condition. FRI #NV00066278