

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295040	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Saint Joseph Transitional Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W. Charleston Blvd. Las Vegas, NV 89102	

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)
<p>F 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37718</p> <p>Based on interview, record review, and document review, the facility failed to consistently provide residents with a quarterly trust account statement for 1 of 19 sampled residents (Resident 72) and 2 unsampled residents (Residents 30 and 31). The deficient practice caused residents to lack peace of mind about their trust account balances.</p> <p>Findings include:</p> <p>Resident 30 (R30)</p> <p>R30 was admitted on [DATE] with diagnoses including stroke. The record indicated the resident was responsible for their finances.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated R30 had normal memory function.</p> <p>On 09/19/2024, at 12:16 PM, R30 verbalized keeping a trust account with the facility. R30 revealed being furnished with a trust account statement monthly in the past. R30 reported not having received a trust account statement for a long time. R30 reported submitting a grievance to the facility about four months ago regarding the lack of the monthly trust account statement. R30 verbalized despite filing the grievance, the resident was still not being furnished with a monthly trust account statement. R30 revealed not knowing how much money was in the trust account. The resident verbalized a plan to buy a new I-pad, because the one currently being used by the resident was not holding a battery charge. R30 reported feeling curious about the lack of a facility response to the grievance even after months had elapsed.</p> <p>Resident 31 (R31)</p> <p>R31 was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease. The record indicated the resident was responsible for their finances.</p> <p>The MDS assessment dated [DATE] indicated R31 had normal memory function.</p> <p>(continued on next page)</p>

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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<p>F 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/19/2024, in the afternoon, R31 stated they had a trust account with the facility. The resident verbalized had not received a trust account statement despite filing a grievance with the facility. The resident felt frustrated and disregarded by the lack of response from the facility. The resident reported being handed today a facility bill showing they owed about \$5000.00 to the facility, past due. The resident verbalized not knowing how this could have happened and felt shocked and concerned as to how to pay this large bill.</p> <p>Resident 72 (R72)</p> <p>R72 was admitted on [DATE] with diagnoses included congestive heart failure. The record indicated the resident was responsible for their finances.</p> <p>The Quarterly MDS dated [DATE] documented R72 had normal memory function.</p> <p>On 09/19/2024, in the afternoon, R72 stated they had a trust account with the facility. The resident verbalized they had received one trust account statement after filing a grievance with the facility and getting the Ombudsman involved. R72 felt frustrated and angry at having had to go to great lengths to get a statement. R72 verbalized statements still were not furnished monthly as they should be. The resident reported not knowing the state of finances and did not like that feeling. The resident verbalized feeling suspicious the facility might be defrauding the resident. R72 verbalized we may be old but we are not asinine.</p> <p>On 09/18/2024, in the morning, the Business Office Manager (BOM) verbalized being responsible for managing the resident Trust Accounts and billing. The BOM verbalized starting this position on 06/12/2024. The BOM verbalized R30, R31, and R72 had Medicaid funding, and all had trust accounts with the facility. The resident's social security checks came directly to the facility and were credited to the trust account. Any and all transactions must be documented in the trust account. The facility process was each resident with a trust account should receive a statement monthly, or the person who pays the bills for the resident. The statements were hand delivered to the resident rooms or mailed to persons who were responsible for the resident's finances.</p> <p>The BOM verbalized being new to the position, getting organized and learning the ropes, and had not distributed the monthly statements since beginning work. The BOM was not aware of the grievances which had been filed by R30, R31, and R72. The BOM verified R31 owed the facility over \$5,000 dollars. The BOM verbalized R31 had withdrawn too much money from the trust account by asking the front desk clerk for \$50 cash every day for many months. The BOM acknowledged the facility should not have given cash to R31 without checking the trust account balance first to see if the funds were available.</p> <p>On 09/18/2024, in the morning, the Regional BOM verbalized R31 actually had not paid the share of cost in three months, for unknown reasons, in addition to overdrawing petty cash. The Regional BOM verbalized these findings were not in accordance with how resident funds should be managed and was currently in the process of sorting things out in the business office.</p> <p>(continued on next page)</p>

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<p>F 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/18/2024, in the morning, the Administrator (ADM) reported starting in the position recently. The ADM stated there had been recent changes in management. The ADM verbalized the former BOM had quit, and then another BOM had been hired and then quit, and then the current BOM had been hired. The ADM verbalized a corporate consultant Regional BOM was currently helping the BOM get up to speed on the facility procedures for trust accounts and billing. The ADM reported this was a work in progress.</p> <p>The policy and procedure titled Management of Residents' Personal Funds, revised 04/2017, indicated the resident may have the facility manage their personal funds. The facility would account for the resident funds.</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37718</p> <p>Based on interview, record review, and document review, the facility failed to respond to each resident's grievance about their trust account statements for 1 of 19 sampled residents (Resident 72) and 2 unsampled residents (Residents 30 and 31). The deficient practice caused residents to feel slighted, angry, or suspicious of financial mismanagement by the facility.</p> <p>Findings included:</p> <p>Resident 30 (R30)</p> <p>R30 was admitted on [DATE] with diagnoses including stroke. The record indicated the resident was responsible for their finances.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated R30 had normal memory function.</p> <p>On 09/19/2024, at 12:16 PM, R30 verbalized keeping a trust account with the facility. R30 revealed being furnished with a trust account statement monthly in the past. R30 reported not having received a trust account statement for a long time. R30 reported submitting a grievance to the facility about four months ago regarding the lack of the monthly trust account statement. R30 verbalized despite filing the grievance, the resident was still not being furnished with a monthly trust account statement. R30 revealed not knowing how much money was in the trust account.</p> <p>The Grievance/Complaint Resolution Report, dated 05/08/2024, documented R30 request Trust Account Statement for 2024. The employee assigned to address the concern was Business Office. No date was provided. Department Findings documented Accts to be audited, statements first week in June. Pt reports wanting to be kept informed of .allowance. The Resolution and Action plan area of the form was left blank. The Grievance/Complaint Resolution Report lacked documentation the resident had received the statement.</p> <p>Resident 31 (R31)</p> <p>R31 was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease. The record indicated the resident was responsible for their finances.</p> <p>The MDS assessment dated [DATE] indicated R31 had normal memory function.</p> <p>On 09/19/2024, in the afternoon, R31 stated they had a trust account with the facility. The resident verbalized they had not received a trust account statement despite filing a grievance with the facility. The resident felt frustrated and disregarded by the lack of response from the facility.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Grievance/Complaint Resolution Report, dated 05/14/2024, documented R31 requests Trust Account Statement. The employee assigned to address the concern was not documented. No date was provided. Department Findings documented Pt has not been given a statement since admission. The Resolution and Action plan area of the form documented Accounts to be audited 1st then statement will be forwarded. The Grievance/Complaint Resolution Report lacked documentation the resident had received the statement.</p> <p>Resident 72 (R72)</p> <p>R72 was admitted on [DATE] with diagnoses included congestive heart failure. The record indicated the resident was responsible for their finances.</p> <p>The Quarterly MDS dated [DATE] documented R72 had normal memory function.</p> <p>On 09/19/2024, in the afternoon, R72 stated they had a trust account with the facility. The resident verbalized they had received one trust account statement after filing a grievance with the facility and getting the Ombudsman involved. R72 felt frustrated and angry at having had to go to great lengths to get a statement. R72 verbalized statement still were not furnished monthly as they should be.</p> <p>The Grievance/Complaint Resolution Report, dated 05/16/2024, documented R72 concern as Pt request Trust Account Statement. The employee assigned to address the concern was not documented. No date was provided. Department Findings documented Business Office reports acct will be audited and then statement forwarded. The Resolution and Action plan area of the form documented Pt .OK with acct to audited and then will provide a trust Acct Statement The Grievance/Complaint Resolution Report lacked documentation the resident had received the statement.</p> <p>On 09/18/2024 at 2:15 PM the retired Social Worker (SW) verbalized had worked at the facility from 05/01/2024 until around 08/01/2024. The SW reported in accordance with the facility process, a completed grievance must include documentation of resolution of the resident's concern, or a rationale as to why the grievance was not resolved. The SW verbalized a grievance should be resolved as quickly as feasible, usually within 30 days. The SW verbalized the resident must be notified of the outcome in writing. The SW remembered R30, R31, and R72. The SW verbalized having taken grievances down for all three of these residents, with the concern of not being furnished with their trust account statements each month. The SW recalled forwarding the grievances to the Business Office Manager (BOM) for resolution. The SW verbalized being unable to recall if each or any of the grievances had been acted upon or resolved.</p> <p>On 09/18/2024, in the morning, the Business Office Manager (BOM) verbalized being responsible for managing the resident Trust Accounts and billing. The BOM verbalized starting this position on 06/12/2024. The BOM verbalized R30, R31, and R72 had Medicaid funding, and all had trust accounts with the facility. The resident's social security checks came directly to the facility and were credited to the trust account. Any and all transactions must be documented in the trust account. The facility process was each resident with a trust account should receive a statement monthly, or the person who pays the bills for the resident. The statements were hand delivered to the resident rooms or mailed to persons who were responsible for the resident's finances. The BOM verbalized being new to the position, getting organized and learning the ropes, and had not distributed the monthly statements since beginning work. The BOM was not aware of the grievances which had been filed by R30, R31, and R72.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/18/2024, in the morning, the Administrator (ADM) reported starting in the position recently. The ADM stated there had been recent changes in management. The ADM reviewed the Grievance/Complaint Resolution Reports for R30, R31, and R72. The ADM verbalized the reports lacked evidence the grievances were resolved. The ADM verbalized the grievance process had lacked follow-through and evidence of resolution. The ADM had been aware of the grievance filed by R72 and the involvement of the Ombudsman. The ADM verbalized and had also talked with R31 frequently and the resident had not mentioned the concern. The ADM verbalized not having been made aware of R30s concern.</p> <p>The policy and procedure titled Grievance/Concern, dated 08/25/2021, indicated upon receipt of the grievance, the Administrator and appropriate department manager would be notified, and immediate action would be taken. The department manager would investigate the grievance and corrective actions would be taken as needed. The department manager would notify the person filing the grievance of resolution and/or status within 72 hours.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33980</p> <p>Based on interview, record review and document review, the facility failed to ensure restorative nursing services were provided as ordered and scheduled for 1 of 19 sampled residents (Resident 16). The deficient practice had the potential for the resident's further decline in mobility and physical functioning.</p> <p>Findings include:</p> <p>Resident 16 (R16)</p> <p>R16 was admitted on [DATE], with diagnoses including quadriplegia, age-related osteoporosis, muscle wasting and atrophy, and polyneuropathy.</p> <p>The Rehab Restorative Transition Program form for R16 documented the following:</p> <ul style="list-style-type: none"> - Restorative Program(s): Standing frame - Measurable Goal(s): Resident would maintain ability to tolerate static standing using a standing frame. - Restorative Program Instructions: Standing frame activity as tolerated. - The Physical Therapist (PT) designed R16's restorative nursing program. - The PT signed the form on 08/27/2024. <p>The physician's order dated 08/27/2024, documented restorative nursing program (RNP) one time weekly for standing frame activity as tolerated every day shift.</p> <p>On 09/15/2024 at 10:05 AM, R16 revealed having spinal cord injury. R16 indicated restorative nursing services for standing frame activity were scheduled every Thursday. R16 confirmed not receiving restorative nursing services on Thursday, 09/12/2024, because the staff had a meeting. R16 indicated the session (standing frame activity) was not rescheduled to cover for the missed restorative nursing services on 09/12/2024. R16 explained the facility should have more restorative nurse assistants (RNA) and the resident needed more RNA sessions.</p> <p>On 09/17/2024 at 1:52 PM, an RNA explained there were three RNAs employed at the facility. The RNA indicated R16's RNP included standing frame activity which was scheduled every Thursday. The RNA confirmed R16 missed the standing frame activity on 09/12/2024 because all nursing staff had a meeting at 10:30 AM. The RNA revealed the session was not rescheduled to compensate for the missed restorative nursing services on 09/12/2024.</p> <p>(continued on next page)</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The RNA explained they could not accommodate R16's standing frame activity on 09/12/2024 due to their workload and the two RNAs were scheduled to leave at 3:00 PM. The other RNA (3rd RNA) worked on 09/12/2024 from 10:00 AM to 5:00 PM. The RNA explained two RNAs were required to perform R16's standing frame activity.</p> <p>The RNA revealed a total of two hours was spent in providing R16's standing frame activity including a half hour for the preparation, like dressing up the resident and getting up from bed. The actual standing frame activity lasted for one hour and a half.</p> <p>The RNA provided a copy of R16's Restorative Nursing Record for September 2024. A handwritten note documented R16's standing frame activity was withheld today (09/12/2024) due to the staff having a meeting at 10:30 AM.</p> <p>On 09/18/2024 at 12:02 PM, the PT explained R16 wanted to work on lower extremity weight bearing activity, so the standing frame activity was recommended. The PT indicated once a week standing frame activity for R16 was the minimum recommended for the meantime because of staffing requirement, and to be able to perform the activity safely with the resident since it required two RNAs.</p> <p>On 09/18/2024 at 3:13 PM, the Director of Nursing (DON) acknowledged the RNAs should have reported to the DON or the Assistant DON (ADON) about R16 not receiving the standing frame activity on 09/12/2024, as scheduled, due to the staff meeting held on the same day. The DON explained the session could have been rescheduled to accommodate the resident's standing frame activity.</p> <p>The facility's policy titled Restorative Nursing Services dated July 2017, documented residents would receive restorative nursing care as needed to help promote optimal safety and independence.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37718</p> <p>Based on observation, interview and record review, the facility failed to ensure the physician ordered medications were available for 2 of 19 sampled residents (Resident 72 and 16) and one unsampled resident (Resident 29). The deficient practice had the potential for the residents to have adverse events.</p> <p>Findings include:</p> <p>Resident 29 (R29)</p> <p>R29 was admitted on [DATE] with diagnoses including epilepsy.</p> <p>On 09/17/24 at 09:05 AM, the Licensed Practical Nurse (LPN) gave R29 oral medications. The resident swallowed the medications with water.</p> <p>On 09/17/24 at 09:20 AM, the LPN verbalized R29 had Keppra, (an anti-seizure medication), and was supposed to be given during the morning medication pass, but Keppra had not been given to R29 because the supply had run out and the Keppra was not available. The LPN verbalized the medication needed to be ordered for delivery.</p> <p>R29's medical record indicated a physician order dated 05/09/2024, to give Keppra 750 milligrams (mg) by mouth two times a day for seizure, at 8:00 AM and at 8:00 PM.</p> <p>A progress note documented by the Nurse Practitioner (NP), dated 09/18/2024 at 10:30 AM, indicated the NP was aware the resident missed the morning dose of Keppra the previous day.</p> <p>The September 2024 Medication Administration Record (MAR) for the resident documented NN for the 8:00 AM dose of Keppra on 09/17/2024, indicating the medication had not been given.</p> <p>On 09/18/24 at 1:02 PM, the Corporate Consultant verified the AM dose of Keppra had not been given on 09/17/2024 due to not being available.</p> <p>33980</p> <p>Resident 72 (R72)</p> <p>R72 was admitted on [DATE], with diagnoses including gastro-esophageal reflux disease (GERD) without esophagitis and hypothyroidism.</p> <p>The physician's order dated 05/09/2024, documented Protonix Oral Tablet Delayed Release 40 milligram (mg) by mouth one time a day for GERD.</p> <p>R72's Medication Administration Record (MAR) for September 2024, documented Protonix was scheduled to be given at 9:00 AM.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/17/2024 at 8:13 AM, during the Medication Administration Pass observation, a Licensed Practical Nurse (LPN) prepared the following medications for R72:</p> <ul style="list-style-type: none"> - Aspirin 81 mg one tablet by mouth - Cyclobenzaprine Hydrochloride (HCl) 5 mg one tablet by mouth - Lisinopril 2.5 mg one tablet by mouth <p>On 09/17/2024 at 8:17 AM, the LPN indicated R72's Protonix 40 mg was not available and would be reordered electronically from pharmacy.</p> <p>Resident 16 (R16)</p> <p>R16 was admitted on [DATE], with diagnoses including quadriplegia, age-related osteoporosis, muscle wasting and atrophy, and polyneuropathy.</p> <p>The physician's order dated 08/05/2024, documented Alendronate Sodium Oral Tablet 70 mg by mouth one time a day every seven days for osteoporosis prevention.</p> <p>R16's MAR for September 2024, documented Alendronate Sodium was scheduled to be given every Tuesday at 9:00 AM. The MAR lacked documented evidence R16 received the medication on 09/10/2024.</p> <p>On 09/17/2024 at 8:24 AM, during the Medication Administration Pass observation, the LPN prepared the following medications for R16:</p> <ul style="list-style-type: none"> - Active Liquid Protein 30 milliliter (ml) by mouth - Vitamin C 500 mg by mouth - Cranberry Oral Tablet 450 mg by mouth - Magnesium Oxide 400 mg by mouth - Multivitamin Oral Tablet by mouth - Vitamin E 180 mg by mouth <p>The LPN revealed R16's Alendronate Sodium 70 mg was not available and would be reordered electronically from pharmacy.</p> <p>On 09/17/2024 at 8:44 AM, the LPN acknowledged the medications should have been reordered when there were four remaining doses left to ensure the medications were available for the residents.</p> <p>On 09/17/2024 at 9:40 AM, the LPN indicated there was no documentation why R16's Alendronate Sodium was held on 09/10/2024. The LPN confirmed R16 did not receive Alendronate Sodium on 09/10/2024 and 09/17/2024 and there was no documentation the resident refused the medication on 09/10/2024.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/18/2024 at 3:06 PM, the Director of Nursing (DON) explained the nurses were expected to reorder the medications at least within 72 hours prior to the supply of the medications being utilized or ran out.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33980</p> <p>Based on observation, interview, record review and document review, the facility failed to ensure it was free of a medication error rate of five percent (%) or greater for 1 of 19 sampled residents (Resident 16). Failure to administer medications as prescribed could have delayed the therapeutic treatment for the resident.</p> <p>Findings include:</p> <p>On 09/17/2024 in the morning, a Medication Administration Pass observation was performed with 27 opportunities observed and revealed two errors. The medication error rate was 7.41%.</p> <p>Resident 16 (R16)</p> <p>R16 was admitted on [DATE], with diagnoses including quadriplegia, age-related osteoporosis, muscle wasting and atrophy, and polyneuropathy.</p> <p>On 09/17/2024 at 8:24 AM, during the Medication Administration Pass observation, the LPN prepared the following medications for R16:</p> <ul style="list-style-type: none"> - Active Liquid Protein 30 milliliter (ml) by mouth - Vitamin C 500 milligram (mg) by mouth - Cranberry Oral Tablet 450 mg by mouth - Magnesium Oxide 400 mg by mouth - Multivitamin Oral Tablet by mouth - Vitamin E 180 mg by mouth <p>On 09/17/2024 at 8:42 AM, the LPN confirmed there was a total of five tablets to be given to the resident as listed above (Vitamin C, Cranberry Oral Tablet, Magnesium Oxide, Multivitamin, and Vitamin E). The LPN administered the five tablets and the Active Liquid Protein to R16.</p> <p>The physician's order dated 08/22/2024, documented Cranberry Tablet 300 mg by mouth two times a day, scheduled at 9:00 AM and 5:00 PM.</p> <p>The physician's order dated 08/29/2024, documented Fish Oil Oral Capsule (Omega-3 Fatty Acids) 3,000 mg by mouth three times a day, scheduled at 9:00 AM, 1:00 PM, and 5:00 PM.</p> <p>On 09/17/2024 at 9:40 AM, the LPN confirmed Cranberry Oral Tablet 450 mg was given to R16, but the physician's order was Cranberry Oral Tablet 300 mg. The LPN explained the order should have been clarified because Cranberry Oral Tablet 450 mg was the house stock and the one given to the resident. The LPN acknowledged the physician's order was not followed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295040	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Saint Joseph Transitional Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W. Charleston Blvd. Las Vegas, NV 89102	

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The LPN confirmed Fish Oil Capsule 3,000 mg was not given to R16. The LPN explained the Fish Oil Capsule and the Vitamin E 180 mg given to the resident were the same.</p> <p>On 09/17/2024 at 2:02 PM, the LPN confirmed Fish Oil Capsule 3,000 mg was available in the medication cart and should have been given to R16 during the Medication Administration Pass observation. The LPN acknowledged being confused with the Fish Oil Capsule and Vitamin E and thought both medications were the same.</p> <p>On 09/18/2024 at 3:06 PM, the Director of Nursing (DON) indicated the nurses were expected to verify the physician's order, right medication, right dose, and right resident prior to medication administration.</p> <p>The facility's policy titled Administering Medications dated April 2019, documented medications were administered in accordance with prescriber orders, including any required time frame. The individual administering the medications would check the label three times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295040	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>37718</p> <p>Based on observation and interview, the facility failed to ensure raw chicken stored inside the walk-in refrigerator was labeled with the date and time the chicken had been placed in the refrigerator. The deficient practice had the potential to allow bacteria to proliferate in raw poultry, a high-risk food.</p> <p>Findings include:</p> <p>On 09/16/24 at 08:14 AM, a tour of the kitchen was conducted with Dietary Regional Director. A metal pan full of cut-up chicken, weighing about 10 pounds, was stored in the walk-in refrigerator. The chicken was covered with plastic wrap. The chicken lacked a label as to the date and time the chicken had been placed in the refrigerator.</p> <p>The Dietary Regional Director verbalized the facility policy and procedure required staff to affix a label to all refrigerated products listing the name of the product, and the date and time the product was placed in the refrigerator. The Dietary Regional Director verbalized the chicken lacked a label. The Dietary Regional Director verbalized not knowing when the chicken had been placed in the refrigerator.</p>