STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295040	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Joseph Transitional Rehabilitation Center	2035 W. Charleston Blvd. Las Vegas, NV 89102

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to ensure the care planning process included feedback and information from a resident for 1 of 32 sampled residents (Resident 5). The deficient practice had the potential to result in care which did not reflect the resident's preferences, goals, and choices, diminishing the resident autonomy and person-centered care. Findings include: Resident 5 (R5) was admitted on [DATE] with diagnoses including acute and chronic respiratory failure, neuromuscular dysfunction of bladder, and urinary tract infection. A Brief Interview for Mental Status (BIMS) assessment revealed a score of 13/15 indicating R5 was cognitively intact.On 09/09/2025 at 10:31 AM, R5 revealed the facility was not allowing R5 to participate in care planning for use of ventilator and care regarding tracheostomy. The medical record revealed a care conference was conducted on 09/09/2025 regarding skin alterations included the Director of Nursing, Social Worker, Rehab, and treatment nurse. A care conference was conducted on the following dates:08/05/2025, R5 was not identified as participating in the care conference.08/12/2025, R5 was not identified as participating in the care conference.08/21/2025, R5 was not identified as participating in the care conference.08/29/2025, R5 was not identified as participating in the care conference.The medical record revealed only facility staff members were present at the care conferences held for R5. On 09/11/2025 at 9:56 AM, a Respiratory Therapist (RT) explained respiratory therapists did not participate in the resident care conferences however the director would sometimes attend. On 09/11/2025 at 10:29 AM, a Licensed Practical Nurse (LPN) indicated, when possible, that the resident or representative would be included in the care planning process. The LPN indicated R5 was cognitively intact and would be able to participate in care planning as well as family who were involved in R5's care.On 09/11/2025 in the afternoon, the Respiratory Therapy Director indicated it would be appropriate for a resident with a BIMS of 13 to be involved in the care planning process.On 09/12/2025 at 11:05 AM, the Director of Nursing (DON) indicated it would be appropriate to invite a resident or resident representative to care plan conference and verbalized there was no documented evidence R5 was included in the care plan conferences.The facility policy titled Care Plan Comprehensive dated August 2021, documented the facility Interdisciplinary Team in coordination with the resident and/or representative must develop and implement a comprehensive person-centered care plan. The comprehensive care plan includes the resident's expressed wishes regarding care and treatment goals.

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review, the facility failed to ensure a significant change in status Minimum Data Set (MDS) assessment was completed within the required time frame for 1 of 32 sampled residents (Resident 50). The deficient practice had the potential to delay the development and implementation of a person-centered care plan for residents.Findings include:Resident 50 (R50) was admitted on [DATE], with diagnoses including fracture of unspecified part of neck of left femur, displaced fracture of base of neck of right femur, and major depressive disorder.R50's medical record contained the list of MDS assessments including a significant change in status MDS with an assessment reference date (ARD/the end date of an observation or look-back period for an MDS assessment) of 05/09/2025.The Centers for Medicare and Medicaid Services (CMS) Final Validation Report (a system-generated document which detailed the processing status of submitted data such as MDS) for the significant change in status MDS dated [DATE], documented the MDS was submitted to CMS on 05/27/2025 and a message the assessment was completed late (more than 14 days after the ARD).On 09/12/2025 at 9:57 AM, the MDS Director revealed the MDS assessments such as admission, quarterly, annual, and significant change in status were transmitted (submitted) to CMS upon completion of the assessments. On 09/12/2025 at 10:30 AM, the MDS Director indicated that R50's significant change in status MDS was completed and transmitted to CMS on 05/27/2025. The MDS Director confirmed R50's significant change in status MDS should have been completed on 05/23/2025, or 14 days after the ARD of 05/09/2025, when the significant change in the resident's status was identified. The MDS Director acknowledged R50's significant change in status MDS was not completed on time.The MDS Director was the only person in the department (MDS). The MDS Director indicated being a licensed practical nurse and had to wait for a registered nurse to sign the MDS assessments for its completion.The CMS Resident Assessment Instrument (RAI) Omnibus Budget Reconciliation Act (OBRA)- required Assessment Summary (assessment conducted using the RAI and the MDS to develop standardized care plans, ensuring residents would receive appropriate and quality care in long-term care facilities) dated October 2017, documented the significant change in status MDS should have been completed no later than determination date plus 14 calendar days (14th calendar day after determination that significant change in resident's status had occurred).The facility's policy titled Resident Assessments, revised in October 2023, documented that the resident assessment coordinator was responsible for ensuring that the interdisciplinary team would conduct timely and appropriate resident assessments.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review, the facility failed to ensure quarterly Minimum Data Set (MDS) assessments were completed within the required time frame for 3 of 32 sampled residents (Resident 21, 50, and 58). The deficient practice had the potential to delay the development and implementation of a person-centered care plan for the residents.Findings include:1) Resident 21 (R21) was admitted on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, tracheostomy status, gastrostomy status, and dependence on respirator (ventilator) status.R21's medical record contained the list of quarterly MDS with assessment reference date (ARD/the end date of an observation or look-back period for an MDS assessment) of 05/09/2025 and 08/07/2025.The Centers for Medicare and Medicaid Services (CMS) Final Validation Report (a system-generated document which detailed the processing status of submitted data such as MDS) documented the following:- R21's quarterly MDS with an ARD of 05/09/2025 was submitted to CMS on 05/27/2025 and a message (report feedback) the assessment was completed late (more than 14 days after the ARD).- R21's quarterly MDS with an ARD of 08/07/2025 was submitted to CMS on 09/09/2025 and a message the assessment was completed late (more than 14 days after the ARD).On 09/12/2025 at 9:57 AM, the MDS Director confirmed R21's quarterly MDS assessments were not completed on time or were completed more than 14 days after the ARD.The MDS Director revealed that the MDS assessments such as admission, quarterly, annual, and significant change in status were transmitted (submitted) to CMS upon completion of the assessments.2) Resident 50 (R50) was admitted on [DATE], with diagnoses including fracture of unspecified part of neck of left femur, displaced fracture of base of neck of right femur, and major depressive disorder.R50's medical record contained the list of MDS assessments including a quarterly MDS with an ARD of 08/06/2025.The CMS Final Validation Report for the quarterly MDS dated [DATE], documented the MDS was submitted to CMS on 09/09/2025 and a message the assessment was completed late (more than 14 days after the ARD).On 09/12/2025 at 10:30 AM, the MDS Director indicated R50's quarterly MDS was completed on 09/08/2025 and transmitted to CMS on 09/09/2025. The MDS Director confirmed R50's quarterly MDS should have been completed on 08/20/2025, or 14 days after the ARD of 08/06/2025. The MDS Director acknowledged R50's quarterly MDS was not completed on time.3) Resident 58 (R58) was initially admitted on [DATE], readmitted on [DATE], and discharged on 08/28/2025, with diagnoses including lower leg osteomyelitis, dehiscence of amputation stump, and depression.R58's medical record contained the list of MDS assessments including a quarterly MDS with an ARD of 08/06/2025.The CMS Final Validation Report for the quarterly MDS dated [DATE], documented the MDS was submitted to CMS on 09/09/2025 and a message the assessment was completed late (more than 14 days after the ARD). On 09/12/2025 at 10:36 AM, the MDS Director revealed R58's quarterly MDS was completed on 09/08/2025 and transmitted to CMS on 09/09/2025. The MDS Director confirmed R58's quarterly MDS should have been completed on 08/20/2025, or 14 days after the ARD of 08/06/2025. The MDS Director acknowledged R58's quarterly MDS was not completed on time.The MDS Director was the only person in the department (MDS). The MDS Director indicated being a licensed practical nurse and had to wait for a registered nurse to sign the MDS assessments for its completion.The CMS Resident Assessment Instrument (RAI) Omnibus Budget Reconciliation Act (OBRA)-required Assessment Summary (assessment conducted using the RAI and the MDS to develop standardized care plans, ensuring residents would receive appropriate and quality care in long-term care facilities) dated October 2017, documented the quarterly MDS should have been completed no later than ARD plus 14 calendar days. The facility's policy titled Resident Assessments, revised in October 2023, documented that the resident assessment coordinator was responsible for ensuring that the interdisciplinary team would conduct timely and appropriate resident assessments.

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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** Based on interviews, record review, and document review, the facility failed to ensure comprehensive, resident-centered care plans were developed and implemented for ventilator use and tracheostomy care for 3 of 32 sampled residents (Residents 1, 4, and 10). The deficient practice had the potential to result in unmet respiratory care needs, inadequate staff direction, and compromised resident safety. Findings include: 1) Resident 1 (R1) was admitted on [DATE] and readmitted on [DATE] with diagnoses including chronic respiratory failure, and protein-calorie malnutrition. On 09/09/2025 at 10:20 AM, the resident was lying in bed ventilator dependent and receiving tube feeding, eyes closed. On 09/10/2025 at 9:15 AM, the resident was lying in bed ventilator dependent and receiving tube feeding, eyes closed.09/11/2025 10:35 AM, the resident was lying in bed ventilator dependent and receiving tube feeding, eyes closed. The medical record lacked documented evidence of a care plan for management of ventilator and tracheostomy. 2) Resident 4 (R4) was admitted on [DATE] and readmitted on [DATE] with diagnoses including respiratory failure, and dependence on respirator.The medical record revealed the care plan included enhanced barrier precautions due to the use of a ventilator and tracheostomy, no other care plan regarding the management was included. 3) Resident 10 (R10) was admitted on [DATE] with diagnoses including anoxic brain damage and chronic respiratory failure. On 09/09/2025 at 8:20 AM, R10 was lying in bed ventilator dependent and receiving tube feeding, eyes closed. On 09/10/2025 at 10: 15 AM, R10 was lying in bed ventilator dependent and receiving tube feeding, eyes closed.On 09/11/2025 at 10:35 AM, R10 was lying in bed ventilator dependent and receiving tube feeding, eyes closed. The medical record revealed there was no care plan in place for the care and management of tracheostomy and ventilator. On 09/10/2025 at 12:37 PM, a Respiratory Therapist (RT) indicated the care plan was developed based on the comprehensive assessment completed and should include the care and management of ventilator and tracheostomy.On 09/12/2025 at 8:45 AM, the Minimum Data Set Coordinator (MDS) explained that all disciplines were involved in completing the MDS which was a comprehensive assessment. The MDS was one tool used to help develop the overall care plan for each resident. The MDS Coordinator indicated that if a resident was identified as having a ventilator or tracheostomy it should be in the care plan as the care plan was a comprehensive plan for each resident. The MDS Coordinator acknowledged there was no care plan for the care and management of ventilators and tracheostomy for the residents of concern.On 09/12/2025 at 8:57 AM, the RT Director, was not directly involved in the MDS assessment. The RT Director explained being involved in the development of a care plan and would ensure the ventilator dependent residents had a care plan for the care and management of the ventilator and tracheostomy. Each care plan should be resident specific including ventilator setting and respiratory needs for residents with a ventilator and tracheostomy. The RT Director confirmed there was no care plan for the residents of concern and there should be. On 09/12/2025 at 1:10 PM, the Director of Nursing acknowledged there were no care plans specific to ventilators and tracheostomy for the residents of concern. Care plans should be resident centered which would include the care and management of the ventilator and tracheostomy for the residents of concern to ensure there was adequate direction of care for staff.The facility policy titled Care Plan Comprehensive dated August 2021, documented an individualized comprehensive care plan would include measurable objectives and timetable to meet the resident's medical, physical, mental and psychosocial needs and would be developed for each resident. The care plan should incorporate identified problem areas and identify professional services responsible for each element of care.

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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** Based on observation, interview, and record review, the facility failed to revise a comprehensive person-centered care plan after a new skin condition was identified for 1 of 32 sampled residents (Resident 89). The deficient practice had the potential to place the resident at risk for delayed treatment, infection, and discomfort.Findings include:Resident 89 (R89) was admitted [DATE], with diagnosis including type 2 diabetes mellitus with hyperglycemia, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and major depressive disorder recurrent severe with psychotic symptoms. On 09/09/2025 at 10:16 AM, R89 was observed in bed with both legs exposed from the knees down. Multiple skin lesions (abnormal or damaged areas of skin) were present on both legs, greater in number on the left leg than the right leg. The lesions included scabbed areas and multiple linear scratch marks, some appeared bright red and fresh, some were darker red and scabbed. R89 reported both legs itched very much and R89 could not help but scratch them. R89 stated staff were not applying any treatment, creams, or other interventions to the affected skin and reported nothing was being done for R89's legs.A Body Check dated 03/04/2025, documented multiple scratches on left knee.A Body Check dated 03/14/2025, documented scabbing bilateral lower extremities.A review of R89's medical record revealed Body Checks, from initial identification of skin issues on 03/04/2025 and 03/14/2025, consistently documented the resident's existing skin condition through Body Check dated 08/25/2025. The description of the skin condition found in the Body Checks included multiple scratches, scabbing, dry skin, knee scabs, and old scabs. R89's medical record lacked documented evidence of physician orders for current treatment, medication, or topical interventions to treat R89's skin condition.A Care Plan dated 06/19/2025, lacked documented evidence R89's current skin condition was identified, care planned, including goals and interventions. On 09/10/2025 at 1:11 PM, a Licensed Practical Nurse (LPN), explained R89's care plan should have been updated when the first signs of the wounds and scratches on the legs were identified.On 09/10/2025 at 1:37 PM, the Director of Nursing (DON), confirmed R89's care plan was not updated to include the existing skin condition. The DON acknowledged R89's care plan should have been revised and updated to reflect the existing skin condition, goals and interventions.A facility policy titled Care Plan Comprehensive effective 08/25/2025, documented each resident's comprehensive care plan was designed to incorporate identified problem areas. The Interdisciplinary Team was responsible for evaluating and updating the care plans.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review, the facility failed to ensure a resident was assisted with meals in accordance with the assessment and care plan for 1 of 32 residents (R111). The deficient practice had the potential for residents not to maintain good nutrition.Findings include:Resident 111 (R111) was admitted on [DATE] and discharged on 09/27/2024, with diagnoses including dysphagia, cerebrovascular disease, and muscle weakness.R111's admission Minimum Data Set (MDS) assessment dated [DATE], documented the resident required supervision or touching assistance with eating (the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal was placed before the resident). The coding for supervision or touching assistance was 04, where the staff would provide verbal cues and/or touching/steadying and/or contact guard assistance as resident completed the activity (eating). R111's care plan documented the interventions/assistance for activities of daily living (ADL) which included providing the resident with supervision assist of one person for eating.The Documentation Survey Report (ADL charting) for September 2024, lacked documented evidence that R111 was provided with meal assistance on the following dates:- 09/05/2024 for breakfast and lunch- 09/08/2024 for breakfast and lunch- 09/11/2024 for breakfast and lunch- 09/12/2024 for breakfast and lunch- 09/13/2024 for lunch- 09/15/2024 for breakfast and lunch- 09/16/2024 for breakfast- 09/18/2024 for breakfast and lunch- 09/21/2024 for breakfast and lunchThe Documentation Survey Report for August 2024 and September 2024, documented the coding for R111's meal (eating) was mostly 5 (Set up or clean-up assistance. The staff would set up or clean up; the resident completed the activity. The staff assisted only prior to or following the activity.)On 09/12/2025 at 11:13 AM, the MDS Director indicated R111's admission MDS dated [DATE], documented the resident required supervision or touching assistance with eating, and the code was 04. The MDS Director explained that the certified nursing assistants (CNA), or licensed nurses should have been in the room with the resident to supervise the resident while eating. The CNAs should have been coding the level of assistance provided to the resident during meals. The MDS Director revealed the CNAs were expected to document in the ADL charting every meal.The MDS Director explained R111's care plan documented to provide the resident with supervision assistance of one person for eating. The MDS Director acknowledged the coding for R111's meal or eating in the ADL charting should have been 04. The MDS Director confirmed the CNAs had documented the code 5 in R111's ADL charting with meal which meant set up or clean-up assistance was provided and not supervision (04) per the resident's care plan. The MDS Director acknowledged the care plan was not followed.The MDS Director confirmed there was no documentation of the meal assistance provided to R111 during the above-mentioned dates for the month of September 2024. The MDS Director explained the boxes corresponding to those dates were left blank, and the other dates had a coding of 5 most of the time. The MDS Director indicated there was no documentation the resident had refused meals which could have been coded as 07.On 09/12/2025 at 11:44 AM, a CNA indicated being informed of the required level of assistance with meals for each resident through the hand off report from the previous shift. The required meal assistance was documented in the point-of-care (POC) charting in the kiosk (electronic charting) where the CNAs documented the ADL charting for each resident. The CNA explained verifying in the POC charting the level of meal assistance required for each resident such as supervision, set up help only, or 1:1 meal assistance. The CNA indicated the level of meal assistance provided to each resident should have been documented every meal. The CNA confirmed R111's ADL charting for eating was incomplete because some dates were left blank.On 09/12/2025 at 1:58 PM, the Director of Nursing (DON) explained the CNAs were expected to follow the ADL level of assistance including eating indicated in the POC such as moderate assistance, supervision, set-up help only, or dependent and document in the ADL charting every meal. The DON confirmed R111's ADL documentation for (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	eating, including meal percentage, was incomplete.The facility's policy titled Activities of Daily Living (ADLs), Supporting revised in March 2018, documented the residents who were unable to carry out activities of daily living independently would receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Appropriate care and services would be provided for residents who were unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with dining (meals and snacks).Complaint 2282565

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure treatment was provided for a resident with an identified skin condition for 1 of 32 sampled residents (Resident 89). The deficient practice had the potential to place the resident at risk for delayed healing, worsening of the skin condition, and infection.Findings include:Resident 89 (R89) was admitted [DATE], with diagnosis including type 2 diabetes mellitus with hyperglycemia, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and major depressive disorder recurrent severe with psychotic symptoms. On 09/09/2025 at 10:16 AM, R89 was observed in bed with both legs exposed from the knees down. Multiple skin lesions (abnormal or damaged areas of the skin) were present on both legs, greater in number on the left leg than the right leg. The lesions included scabbed areas and multiple linear scratch marks, some appeared bright red and fresh, some were darker red and scabbed. R89 reported both legs itched very much and R89 could not help but scratch them. R89 stated staff were not applying any treatment, creams, or other interventions to the affected skin and reported nothing was being done for R89's legs.A review of R89's medical record revealed Body Checks, from initial identification of skin issues on 03/04/2025 and 03/14/2025, consistently documented the resident's existing skin condition through Body Check dated 08/25/2025. The description of the skin condition found in the Body Checks included multiple scratches, scabbing, dry skin, knee scabs, and old scabs.A Quarterly Interdisciplinary Care Conference dated 09/04/2025, lacked documented evidence that the resident's skin condition was discussed. The pressure injury/skin problem status section of the form was left blank. R89's medical record lacked documented evidence of physician orders for current treatment, medication, or topical interventions to treat R89's skin condition. R89's medical record lacked documented evidence that the resident was assessed or treated by the wound care team from 02/24/2025 through 09/09/2025. R89's Progress Notes lacked documented evidence treatment was provided for the existing skin condition.On 09/10/2025 at 11:39 AM, a Wound Care Nurse reported R89 had previous skin issues which were resolved in February 2025. The Wound Care Nurse reported did not receive any prompts or notification of R89's existing skin condition from February 2025 through 09/10/2025. The Wound Care Nurse explained when nursing identified R89's skin condition, a change of condition assessment should have been initiated which included notifying the physician and the wound care team. The Wound Care Nurse confirmed R89 had not received treatment from the wound care team for the existing skin condition. On 09/10/2025 at 11:54 AM, a Wound Treatment Nurse explained the expectation was on initial identification of R89's skin condition, nurses should have notified the wound care team to complete an evaluation. The Wound Treatment Nurse denied receiving notification of R89's skin condition. The Wound Treatment Nurse explained that the wound care team depended on communication from nursing to identify concerns. The Wound Treatment Nurse explained the consequences of not treating R89's skin condition included R89 continued to itch and scratch, possible infection and worsening of condition. On 09/10/2025 at 1:08 PM, a Certified Nursing Assistant (CNA), reported R89 complained of itching. The CNA had reported R89's complaint about itchy skin to a nurse. On 09/10/2025 at 1:11 PM, a Licensed Practical Nurse (LPN), explained R89 had an ongoing issue of itchy skin. The LPN confirmed R89 did not have any physician orders for treatment or medication for the existing skin condition. The LPN acknowledged new wounds and scratches should have been reported to the treatment or wound care nurse when the first signs of the skin condition were identified. On 09/10/2025 at 1:37 PM, the Director of Nursing (DON), explained R89's skin condition should have been reported immediately when identified to the physician for a treatment order, and the wound care nurse for a consult. The DON acknowledged notification was not done. The DON confirmed R89 did not have a physician order for treatment or medication to treat the skin condition.A facility policy titled Skin Integrity Management effective 05/26/2025, documented the purpose was to provide safe and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	effective care to prevent the occurrence of pressure ulcers, manage treatment, and promote healing of all wounds. The implementation of an individual patient's skin integrity management occurs within the care delivery process. Staff continuously observe and monitor patients for changes and implement revisions to the care plan. Identify patient's skin integrity status and need for prevention intervention or treatment modalities through review of all appropriate assessment information.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295040	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Joseph Transitional Rehabilitation Center	2035 W. Charleston Blvd. Las Vegas, NV 89102

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review, the facility failed to ensure wound care treatments were implemented as ordered for 1 of 32 sampled residents (Resident 1). The deficient practice had the potential to result in delayed healing, infection, and other negative outcomes for a resident with identified wound care needs. Findings include: Resident 1 (R1) was admitted on [DATE] and readmitted on [DATE] with diagnoses including pressure ulcers, osteomyelitis, and protein-calorie malnutrition. On 09/09/2025 at 10:20 AM, R1 was lying in bed ventilator dependent and receiving tube feeding, eyes closed and wound dressing saturated.On 09/10/2025 at 9: 15 AM, R1 was lying in bed ventilator dependent and receiving tube feeding, eyes closed and wound dressing saturated.On 09/11/2025 at 10:35 AM, R1 was lying in bed ventilator dependent and receiving tube feeding, eyes closed and wound dressing saturated.A Physician Order dated 09/08/2025 documented to give protein oral liquid 30 milliliters (mL) enterally every 12 hours for skin healing. A Physician Order dated 09/08/2025 documented wound culture right hip wound. A Physician Order dated 08/26/2025 documented to provide wound care to left buttock. Cleanse with Dakins solution, apply silver alginate and then cover with foam dressing three times a week and as needed. Every Monday, Wednesday, and Friday. A Physician Order dated 08/25/2025 documented to provide wound care to the lower right leg. Cleanse site with normal saline solution, pat dry, apply Medi-honey and cover with foam dressing. Every day shift every Monday, Wednesday, and Friday and as needed. A Physician Order dated 08/25/2025 documented to provide wound care to right buttock. Cleanse with Dankins solution, apply calcium alginate, cover with foam dressing three times a week and as needed when soiled or saturated. Every day shift every Monday, Wednesday, Friday and as needed. A Physician Order dated 08/19/2025 documented to provide wound care to right lateral leg. Cleanse site with normal saline solution pat dry, apply xeroform and cover with dry dressing. Every day for skin tear. A Physician Order dated 08/19/2025 documented to provide wound care to left medial leg. Cleanse site with normal saline solution, pat dry, apply xeroform and cover with dry dressing. Every day for skin tear.A Physician Order dated 07/28/2025 documented to provide wound care to right lateral ankle. Cleanse site with normal saline solution, pat dry, apply Medi-honey and cover with foam dressing. Every Monday, Wednesday, Friday, and as needed. A Physician Order dated 07/08/2025 documented to provide wound care to right heel. Cleanse site with normal saline solution, pat dry, apply silver alginate and cover with foam dressing three times a week and as needed. Every day shift every Monday, Wednesday, and Friday for a stage three pressure ulcer. A Nursing Order dated 05/09/2025 documented to apply bilateral heel protectors when in bed for wound management. A review of the medical record revealed no documentation wound care treatment was provided on the following dates: 08/15/2025, 08/21/2025, 08/25/2025, 08/28/2025, 08/30/2025, 09/03/2025, 09/06/2025, 09/07/2025On 09/12/2025 at 9:13 AM, the wound care Licensed Practical Nurse (LPN) indicated wound care was provided 7 days a week between two wound care nurses with overlapping coverage. One nurse would work Monday - Friday and another works Wednesday - Sunday. The floor nurses would be responsible for as needed wound care changes after 3 PM when the wound nurses were out of the building. The wound care nurse explained that the wound team provided care for residents in the vent unit as well. These residents were vulnerable and missing wound care dressing changes could result in additional complications such as additional wounds or infections. The wound care nurse acknowledged the missing dates in the treatment administration record and indicated it was most likely due to documentation errors. The wound care nurse could not provide any further documentation to confirm wound care treatments were performed on the dates in question.On 09/12/2025 at 11:31 AM, the Director of Nursing (DON) indicated a blank box in the treatment administration record would mean the ordered care was not provided and documented in the electronic health record. The DON explained the expectation was staff accurately record completed (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatments in the medical record. The facility policy titled Skin Integrity Management dated May 2021revealed to provide safe and effective care to prevent the occurrence of pressure ulcers, manage treatment, and promote healing of all wounds. Perform daily monitoring of wounds or dressings for presence of complications or declines and document.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all required sections of the Provider Order for Life-Sustaining Treatment (POLST) form were completed for 4 of 32 residents (Resident 5, 50, 74, and 89), and failed to ensure resident's Power of Attorney (POA) documentation was present in the medical record for 3 of 32 sampled residents (Resident 1, 4, and 5). The deficient practice had the potential to result in the resident's treatment preferences and decision-making authority not being known or honored. Findings include:1) Resident 1 (R1) was admitted on [DATE] and readmitted on [DATE] with diagnoses including chronic respiratory failure, pressure ulcers, osteomyelitis, and protein-calorie malnutrition. The medical record revealed the resident had a Provider Order for Life Sustaining Treatment (POLST) which indicated the resident wanted full treatment in case of emergency which was signed by the physician. In the section to be signed by the durable power of attorney and/or guardian a family member signed. The form indicated the resident lacked decisional capacity to sign. The medical record lacked documented evidence R1 had a legal guardian, durable power of attorney, or healthcare surrogate to sign and make decisions for R1. 2) Resident 4 (R4) was admitted on [DATE] and readmitted on [DATE] with diagnoses including respiratory failure, and dependence on respirator. The medical record revealed the resident had a Provider Order for Life Sustaining Treatment (POLST) which indicated the resident wanted full treatment in case of emergency which was signed by the physician. In the section to be signed by the healthcare surrogate a family member signed. The form indicated the resident lacked decisional capacity to sign. The medical record lacked documented evidence that R4 had a legal guardian, durable power of attorney, or healthcare surrogate to sign and make decisions for R4. 3) Resident 5 (R5) was admitted on [DATE] with diagnoses including acute and chronic respiratory failure, neuromuscular dysfunction of bladder, and urinary tract infection. A Brief Interview for Mental Status (BIMS) assessment indicated R5 had a BIMS of 13/15 indicating the resident was cognitively intact. The medical record revealed the resident had a Provider Order for Life Sustaining Treatment (POLST) which indicated the resident wanted full treatment in case of emergency which was signed by the physician. In the section to be signed by the durable power of attorney and/or guardian a family member signed. The form did not indicate if R5 lacked decisional capacity to sign. The medical record lacked documented evidence that R5 had a legal guardian, durable power of attorney, or healthcare surrogate to sign and make decisions for R5. On [DATE] at 9:05 AM, the Social Services Director explained advanced directives include a living will and allows caregivers to know what the resident's wishes were if the resident was unable to express on their own. Nevada POLST was one example of advanced directives, however if it was not (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accurate it would be considered null and void. The Social Services Director indicated there was no documentation to verify if the residents of concern had a durable power of attorney or legal guardianship and should not be signed as such without providing the correlating documents. 4) Resident 50 (R50) was admitted [DATE], readmitted [DATE], with diagnosis including fracture of part of the neck of the left femur, rheumatoid arthritis, and age-related cognitive decline. R50's electronic medical record documented Code Status: Attempt Resuscitation/Cardiopulmonary Resuscitation (CPR), Full Treatment. A Provider Order for Life-Sustaining Treatment (POLST) form, documented attempt cardiopulmonary resuscitation (CPR). R50's POLST form did not have the required section completed to indicate whether the resident had the decisional capacity to understand and communicate their health care preferences for the treatment options listed on the medical order, did not have a physician signature and information, the printed resident's name and date resident signed. 5) Resident 74 (R74) was admitted [DATE], readmitted [DATE], with diagnosis including acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, and chronic pain syndrome. R74's electronic medical record documented Code Status: Do not Resuscitate (DNR).A Provider Order for Life-Sustaining Treatment signed by R74 on [DATE] documented do not resuscitate (allow natural death). R74's POLST form did not have the required section completed to indicate whether the resident had the decisional capacity to understand and communicate their health care preferences for the treatment options listed on the medical order. 6) Resident 89 (R89) was admitted [DATE], with diagnosis including type 2 diabetes mellitus with hyperglycemia, hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, and major depressive disorder recurrent severe with psychotic symptoms. R89's electronic medical record documented Code Status: Full Code. A Provider Order for Life-Sustaining Treatment (POLST) form dated [DATE] documented to attempt cardiopulmonary resuscitation (CPR). R89's POLST form did not have the required section completed to indicate whether the resident had the decisional capacity to understand and communicate their health care preferences for the treatment options listed on the medical order, and did not have a resident or representative signature, printed name, or date of signature. On [DATE] in the afternoon, the Director of Nursing acknowledged POLST forms for R50, R74, and R89 were incomplete and missing the required information listed above. The DON explained POLST forms should have been completed with all required information to ensure residents' wishes were known and honored. A facility policy titled Health Care Decision Making effective [DATE], documented the purpose was to provide patients with the opportunity and knowledge necessary to make his/her health care decisions known. To ensure that patient's wishes concerning health care decisions were communicated to all staff so that patient's rights would be honored, and their wishes would be executed at the appropriate time.

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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. Based on interview and record review, the facility failed to ensure the Water Management Plan was completed and implemented.Findings include: The facility's Water Management Plan (WMP) was reviewed and lacked information regarding the validation process which establishes procedures to confirm the water management program effectively controls the hazardous conditions throughout the building's water system.On 09/10/2025, the Maintenance Director indicated the hot water temperatures were tested at the water heaters to ensure the temperatures were above 113 degrees Fahrenheit, but did not document the temperature results. The Maintenance Director revealed the facility did not test residual disinfectant levels.