

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295046	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2026
NAME OF PROVIDER OR SUPPLIER Boulder City Hospital Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 901 Adams Blvd. Boulder City, NV 89005	
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and document review the facility failed to ensure a resident was treated with dignity and respect by allowing an inappropriate signage to be posted for 1 of 12 sampled residents (Resident 9). This deficient practice had the potential to compromise the resident's privacy. Findings include: On 05/05/2026 at 12:50 PM, two hand-written notes posted on R9's wall documented NPO nothing by mouth and please be careful when changing (NAME) because the orange cap on his tube feed keeps getting lost and then he gets tube feed all over him. On 05/05/2026 at 1:00 PM, a Registered Nurse (RN), indicated the signage should not be posted on the wall with personal information. The RN indicated it was considered a dignity issue. On 05/05/2026 at 1:14 PM, a Certified Nursing Assistant (CNA), indicated signage of resident's personal information should not be posted on the wall. The CNA confirmed having personal information posted is a breach in the residents' privacy and is a dignity concern. On 05/05/2026 at 1:30 PM, the Director of Nursing (DON) confirmed having a sign posted with resident information is a dignity concern and is against facility policy. The facility policy titled Residents Rights dated 01/20/2026 documented, residents have the right to privacy over their personal and clinical records. Residents privacy would include protected health information, personal care and medical treatments.		

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	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** Based on observation, interview, record review, and document review, the facility failed to ensure a two-person assist was provided during a resident transfer and the resident's injury was timely reported to the assigned licensed nurse for 1 of 20 sampled residents (Resident 1).The deficient practice had the potential to result in further injury, delayed assessment and treatment, increased risk of infection, and other complications.Findings include:Resident 1 (R1) was admitted on [DATE], with diagnoses including weakness.The Minimum Data Set (MDS) dated [DATE] identified R1 had severe cognitive impairment. R1's interim functional status assessment documented the resident was dependent for chair/bed-to-chair transfer and toilet transfer requiring the assistance of two or more helpers.A Skin Assessment, provided by the facility in photocopy form with a partially cut image resulting an unclear date. The Skin Assessment documented a wound to R1's left arm during the AM shift. The Skin Assessment was signed by a Certified Nursing Assistant (CNA) and a Licensed Nurse.A facility report documented on 04/18/2026 at approximately 6:00 PM, R1 was observed in bed with a skin tear to the left upper forearm covered with dressing. Nursing staff identified there was no prior documentation or physician order for R1's identified injury. The report indicated the Director of Nursing (DON) was notified, and treatment was initiated after obtaining a provider order. The report revealed the facility conducted an investigation including staff interviews, record review, and a review of video surveillance. Investigation findings indicated the injury likely occurred on 04/17/2026 during a transfer from chair to bed performed by a CNA. R1 was unable to recall the cause of the injury and denied pain or that any staff harmed them. R1 indicated they felt safe at the facility and exhibited no psychosocial distress.On 05/05/2026 at 11:20 AM, R1 was verbally alert with confusion. When asked about the injury that occurred last month, the resident responded, I don't know. R1's bilateral arms were covered with protective sleeves; and a white bandage was noted on the left forearm beneath the sleeve.On 05/07/2026 at 1:35 PM, three Certified Nursing Assistants (CNAs) assigned to R1 on 04/17/2026 and 04/18/2026 were interviewed regarding R1's left arm injury. The CNAs acknowledged awareness of the incident. CNA1 and CNA3 indicated R1 was alert with episodes of confusion. CNA1 verbalized R1 was fragile, dependent for care, unable to safely transfer independently, and routinely required a two-person assist and/or Hoyer lift during transfers due to fearfulness, resistance during movement, frailty, and inability to assist with transfers. CNA1 indicated an agency CNA assigned to R1 transferred the resident without assistance despite R1's baseline two-person assist requirement and failed to immediately report the skin tear to nursing staff after the transfer. CNA2 indicated the facility investigation and video surveillance findings identified an agency CNA as the individual involved in the transfer when the injury occurred. CNA2 acknowledged the agency CNA failed to follow transfer assistance requirements, failed to report the injury timely, and provided wound treatment outside the CNA scope of practice. CNA3 verbalized the facility expectations required immediate reporting of any resident injury to the licensed nurse. The CNAs confirmed the agency CNA had frequently worked at the facility prior to the incident but was no longer observed working at the facility following R1's injury.On 05/07/2026 at 1:48 PM, the Social Worker indicated awareness of R1's injury and assisted with the investigation by interviewing residents and staff, ensuring the resident's well-being, and assessing for psychosocial distress following the incident. The Social Worker was not present during the initial investigation because the incident occurred over the weekend. The Social Worker indicated investigation findings revealed an agency CNA caused a skin (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tear to R1 during a transfer and subsequently failed to immediately report the injury to nursing staff. The Social Worker indicated the agency CNA was no longer permitted to work at the facility following the incident. The Social Worker indicated the failure to report the injury could be considered resident neglect. The Social Worker indicated the late reporting prevented prompt nursing assessment, treatment, physician notification, and implementation of interventions. The Social Worker indicated staff were expected to immediately report resident injuries to the licensed nurse. The Social Worker further indicated R1 did not demonstrate psychosocial distress related to the incident. On 05/05/2026 in the afternoon, the Director of Nursing (DON) indicated R1 was identified with a skin tear to their left arm on 04/18/2026. The DON indicated an agency CNA transferred R1 from chair to bed without assistance. The DON confirmed R1's baseline requirement for a two-person assist with the use of a Hoyer lift due to inability to transfer independently. The DON indicated video surveillance showed sufficient staffing was available, however the agency CNA failed to request assistance. The DON indicated the facility initiated an investigation for the injury of unknown origin, which included staff interviews, resident interviews, laboratory staff interview, staffing review, record review, and video surveillance review. The DON indicated video surveillance showed R1 without visible skin tear prior to entering the room with the agency CNA and later showed the agency CNA retrieving treatment supplies from the treatment cart after completing the transfer. The DON indicated the agency CNA failed to report R1's injury to nursing staff. Nursing staff later identified a dressing in place on R1's left arm; however, there was no corresponding documentation or treatment order in the medical record. The DON explained R1's injury was subsequently assessed, the physician and responsible party were notified, and treatment orders were initiated. The DON indicated the agency CNA provided inconsistent statements during the investigation and could not identify another staff member allegedly present during the transfer. The DON indicated the facility determined the skin tear likely occurred during the transfer from chair to bed performed by the agency CNA on 04/17/2026. The DON further indicated the agency CNA failed to timely report the injury to the Licensed Nurse. The DON indicated the agency CNA was reported to the agency and would no longer be permitted to work at the facility. On 05/07/2026 in the afternoon, the Risk Manager indicated the facility thoroughly investigated R1's injury of unknown origin. The Risk Manager indicated law enforcement was involved, and the agency CNA was reported to the Board. The Risk Manager confirmed the investigation findings and identified the transfer requirement was not followed, as R1 required two-person assistance with transfers. The Risk Manager indicated the agency CNA failed to obtain assistance during the transfer and failed to timely report R1's injury, which was later discovered when a dressing was observed on R1's left forearm during the investigation. A facility policy titled Resident Rights - Abuse, revised 02/11/2011, indicated residents have the right to be free from all forms of abuse, including physical abuse. The policy indicated the facility must implement procedures to protect residents from abuse, neglect, and mistreatment.		

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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 observation, interview, record review, and document review, the facility failed to ensure the appropriate isolation precaution signage was used and appropriate personal protective equipment (PPE) worn while obtaining blood from the central intravenous line access for 1 of 20 sampled residents (Resident #37).The deficient practice had the potential to increase the risk of cross-contamination, transmission of infectious organisms, and infection to the resident, staff, and others within the facility. Findings include:Resident 37 (R37) was admitted on 04/30 2026, with diagnoses including urinary tract infection.On 05/05/2026 at 11:01 AM, an implanted port was noted on R37's right upper chest with a transparent dressing dated 05/04/2026. Intravenous (IV) antibiotic medication was infusing at the time of observation. Enhanced Barrier Precautions (EBP) signage was posted at the door, and a personal protective equipment (PPE) bin with supplies was available at the room's entrance.On 05/06/2026 at 2:40 PM, contact precautions signage was posted by R37's room door. The signage indicated to wear a gown and gloves prior to entering the resident's room, PPE supplies were available in the bin except for a mask. A Registered Nurse was observed drawing blood from the IV port on R3's chest without a gown. On 05/06/2026 at 2:50 PM, the same RN explained R37 was on contact isolation precautions due to body fluids infection. The RN explained R37 had not been turned or repositioned; therefore, a gown had not been worn while staff attempted to complete the blood draw procedure. The RN was observed going in and out of the room while continuing the procedure, including repeatedly accessing R37's chest intravenous (IV) port, filling multiple blood collection vials directly from the IV port without wearing a gown, and flushing the IV port at the completion of the procedure.On 05/06/2026 at 2:55 PM, a Charge Nurse (CN) explained when a resident was on contact isolation should wear a gown, gloves and mask were required depending on what kind of precautions. The CN was uncertain why R37 was on isolation and acknowledged there was no order in place. The CN could not differentiate the difference between EBP and contact precautions or transmission-based precautions (TBP).On 05/06/2026 at 3:10 PM, another RN indicated the EBP and TBP precautions are the same with gloves and mask should have been used upon entering the resident's room to prevent contamination.On 05/06/2026 at 3:20 PM, the Director of Nursing indicated R37 should have been on EBP not and not contact precautions. The DON indicated recently the facility provided education to staff regarding the types of precautions. The DON advised the staff to remove the contact precautions signage and change to EBP. The DON indicated a gown should have been worn when caring with R37's IV line.A facility policy titled Guidelines for Isolation Precautions revised 02/23/2024, indicated Enhanced Barrier Precautions (EBP) required staff to wear gown and gloves during high-contact resident care activities to reduce the transmission of multidrug-resistant organisms (MDROs). The policy identified device care or use, including central lines, as a high-contact resident care activity requiring gown and gloves. The policy further indicated residents with any skin opening requiring a dressing and/or indwelling medical devices were at increased risk for MDRO transmission and healthcare workers should anticipate wearing gown and gloves during such care activities.		