STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295052	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Las Vegas	6151 Vegas Drive Las Vegas, NV 89108

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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50289 Based on interview, record review, and document review, the facility failed to ensure the resident who had functional impairments was evaluated and appropriately discharged for 1 of 4 sampled residents (Resident 1). This failure could potentially lead to medical complications or adverse events which could result in hospitalization , prolonged illness, or even death. Findings included: Resident #1 (R1) Resident #1 (R1) was admitted on [DATE], with diagnoses including fracture of right pubis, urinary tract infection, protein-calorie malnutrition, abnormal posture, generalized weakness, and spondylolysis. R1 was admitted with a history of falling with injuries. R1 was alert and oriented and had a Brief Interview for Mental Status (BIMS) of 15/15 suggesting the patient was cognitively intact. An Occupational Therapy (OT) evaluation dated 10/16/2023, documented R1 had diagnoses of fracture of right pubis and generalized muscle weakness. The evaluation indicated R1 could perform toileting with maximum assistance, bathing with maximum assistance, lower body dressing with maximum assistance, and bed mobility with maximum assistance. A Physical Therapy (PT) evaluation dated 10/16/2023, documented R1 had diagnoses of fracture of right pubis and abnormal posture. The evaluation indicated R1 could perform bed mobility with maximum assistance. The evaluation also indicated R1 was dependent and could not perform transfers, ambulation, or wheelchair mobility in the patient's motorized wheelchair. A facility discharge summary dated 11/06/2023, documented R1 was contact guard assist with bed mobility, supervision to maximum assistance for activities of daily living (bathing and dressing), needed minimal assistance to complete transfers, and required maximum assistance for hygiene and toileting. The discharge summary indicated R1 was not continent of bowel and bladder, the skin was intact, no vision or hearing impairment, and no denture issues. The facility discharge summary documented the transfer or discharge was appropriate because R1's health had improved so the resident no longer required the services provided by the facility, and R1 was to be discharged to a group home with home health care OT, PT, and Nursing services ordered. The discharge summary indicated the discharge plan was discussed with the patient/family and the care team including case managers social services, and the therapy team. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Occupational Therapy (OT) discharge note dated 11/08/2023, documented R1 could perform toileting with maximum assistance, bathing with moderate assistance, and lower body dressing with supervision. A Physical Therapy (PT) discharge date d 11/07/2023, documented R1 could perform bed mobility with set up assistance, transfers with maximum assistance, and could maneuver the motorized wheelchair with supervision. The document also indicated R1 was dependent and could not perform ambulation or toilet transfers specifically. This document also recommended the resident required 24-hour caregiving. A Case Manager (CM) note dated 11/06/2023, documented the patient will discharge to group home with hospice at a specific address with the hospice marketer's name and phone number. The CM also documented the clinicals were sent via email to the home and hospice. On 10/08/2024 at 10:15 AM, the Case Manager (CM) revealed the CM did not know anything about the group home the resident was sent to besides what was written in the patient chart. The patient chart lacked documented evidence of completed discharge information. On 10/08/2024 at 10:30 AM, the Hospice Marketer revealed an interview with the hospice administrator was necessary to get the information needed. On 10/08/2024 at 10:36 AM, the Hospice Administrator revealed the facility where the patient was discharged to was not a group home. The facility the patient was discharged to, was an independent living home. The administrator revealed they provided hospice services to the patient inside this home. The administrator explained they provided a nurse 2 days a week and certified nursing assistants (CNAs) every day; but they do not provide 24-hour care. On 10/08/2024 at 11:00 AM, the Occupational Therapist (OT) revealed the OT believed the patient's discharge destination was a group home where the resident would be able to get some assistance. The OT explained the patient required one person to assist with transfers, especially the toilet because the resident could not stand and was only completing other transfers by scooting which could not be done, to the toilet. The OT stated the CM told therapy the resident was discharging to a group home. The OT stated if the resident was to be discharged to an independent living facility, the therapy goals would have been independent functional mobility, but this was never the goal because the resident was being discharged to a group home. The OT stated were not sure this was the safest or best place for the resident. On 10/08/2024 at 2:56 PM, the Social Services Director (SSD) revealed there is process in place for discharges. The SSD explained there is a discharge planning check-off document to make sure things are covered and do not get missed. The SSD indicated there is a group home sign off sheet the facility has for the group home to sign to show the group home did come in to evaluate the patient and can provide the care the resident needs. There is also an information sheet to be filled out to make the writing of the discharge easier. The SSD stated it is expected the person completing the discharge knows the resident so as to know what kind of care the resident will require, the therapy recommendations, and the family input if there is family. The SSD confirmed none of these forms/documents were found completed for this resident, nor was there any documented follow up for this resident after discharge. The SSD also stated the phrases group home and independent living home should not be used synonymously as they are not the same thing. The SSD also acknowledged the case management note was not clear enough and did not provide enough information for proper discharge documentation. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Transfers and Discharges dated 09/05/2024, documented the medical record should contain documentation or evidence of the patient's or resident representative's verbal or written notice of intent to leave the facility, a discharge care plan, and documented discussions with the resident, or if appropriate, the patient's representative, containing details of discharge planning and arrangements for post-discharge care. Complaint #NV00070132

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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** 50289 Based on interviews, record review, and document review, the facility failed to ensure a care plan was revised after a resident-to-resident incident for 1 of 4 sampled residents (Resident 3). The deficient practice had the potential to place the resident at risk for inappropriate care, supervision, and accidents. Findings include: Resident 2 (R2) and Resident 3 (R3) R2 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, dementia with psychotic disturbances, dementia with anxiety, depression, and schizophrenia. R3 was admitted to the facility on [DATE] with diagnoses including hepatic encephalopathy, cognitive communication deficit, altered mental status, alcohol abuse, depression, and anxiety disorder. A Nursing Event Note dated 09/11/2024 at 12:56 PM, documented a communication note which revealed R3 walked into the dining room in the unit. When R3 approached the doorway, there was another resident, R2 passing through at the same time. Resident 3 put up their hand to stop R2 and swung at R2. At which time R2 kicked R3 and then R3 kicked R2. A staff member from activities intervened and separated the two residents. No injuries were observed, and no complaints were offered. The residents were unable to recall the incident when asked. Video footage of the incident was viewed on 10/08/2024 in the afternoon. The video revealed R3 blocked R2 in the doorway so R2 rolled over both feet of R3 in the wheelchair. Both exchanged words and were swinging their arms at each other followed by R3 kicking R2 in the abdomen and then R2 returned the kick, hitting R3 in the shin. According to the facility's investigation documentation, R2 had been refusing medications on and off for the past week and was sent to the hospital after the incident where R2 was kicked in the abdomen due to the residents change in condition. An updated care plan dated 09/17/2024 documented R2 had a resident-to-resident altercation, and the facility was going to assess R2 for the appropriateness of continuing to stay in the secured unit. The facilities census documents revealed the resident was sent out on 09/11/2024 and returned to the facility on [DATE] into a different unit. The medical record lacked documented evidence the care plans for R3 were revised to include preventative strategies for the most recent resident-to-resident altercation in the care plans. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/08/2024 at 1:27 PM, the Minimum (MDS) Licensed Practical Nurse (LPN) Coordinator revealed the nurses event note of these residents' altercation would be an after effect note. This would also have constituted a resident change of condition. After the altercation incident, there would have been an interdisciplinary team meeting to discuss the situation and check the residents' cares to make sure they are still appropriate and see what else can be done. The MDS Coordinator then explained would wait for the quarterly to update the care plan. On 10/08/2024 in the afternoon, the Assistant Director of Nursing (ADON) indicated the resident care plan could be updated by anyone after the incident or upon readmission like it was for R2. The ADON further explained if there was already a care plan for the situation, the facility won't necessarily update it any further after an event. When asked if the current interventions for R3 were working, the ADON said the interventions had not worked since there had been another altercation. The ADON explained it was important to update the care plan as it is what steers the care to be given and without an updated care plan, monitoring the care can be difficult. The ADON confirmed it would have been nice if both resident's care plans would have been updated, however, there was no point person to make sure the care plans are completed. A facility policy titled Comprehensive Care Plans and Revisions (revised 09/11/2024) documented the facility should monitor the resident over time to help identify changes in the resident condition which may warrant an update to the person-centered plan of care. When these changes occur, the facility should review and update the plan of care to reflect the changes to care delivery.