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	11/22/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50289 Based on clinical record review, document review and interview, the facility failed to ensure residents were provided information about the right to formulate an advanced directive for 2 of 31 sampled residents (Resident #74 and Resident #5). The deficient practice has the potential to deprive residents of their right for self-determination. Findings Include: Resident #74 (R74) R74 was admitted to the facility on [DATE], with diagnoses including Guillain-Barre Syndrome, multiple sclerosis, systemic lupus erythematosus, and unspecified dementia. R74's social services progress note dated 07/29/2024 documented the resident was alert and oriented times three and scored a 15/15 on the Brief Interview for Mental Status (BIMS) exam, meaning the resident is cognitively intact. The note also states the resident can make their own decisions. A resident document titled Physician Order for Life-Sustaining Treatment (POLST) dated 08/06/2018 was filled out by R74's ex-spouse as Do Not Attempt Resuscitation and was signed by the provider. On 11/20/2024 at 3:00pm, R74 revealed were unaware of what advanced directives were. Advanced directives were explained to the resident. R74 stated no one had talked to them about advanced directives until this day. R74 stated if something were to happen, the resident wanted the facility staff to attempt to resuscitate. Resident #5 (R5) R5 was originally admitted to the facility on [DATE], with diagnoses including aneurysm of artery of lower extremity, acute embolism and thrombosis of unspecified deep veins of left lower extremity, and peripheral vascular disease. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's social services progress note dated 10/03/2024 documented the resident has aphasia and is nonverbal and unable to complete the Brief Interview for Mental Status (BIMS). Questions asked in yes or no format where the resident can use gestures of nodding of head were used. The resident does have difficulty making themself understood only using gestures and no other communication. R5 can use gestures to make concrete needs known. The note also states the resident can usually understand information but needs a little extra time to integrate information. A resident document titled Physician Order for Life-Sustaining Treatment (POLST) dated 12/02/2021 was filled out by R74's niece as Do Not Attempt Resuscitation and was signed by the provider. A resident document titled Admission Record (face sheet) documented the resident was the responsible party and the niece was the emergency contact. R5's medical record lacked documentation the resident gave permission for the niece to make medical decisions on their behalf or the niece was the power of attorney for healthcare or the guardian for the resident or the resident was incompetent to make decisions. On 11/20/2024 at 2:39 PM, the Director of Social Services acknowledged the resident had no other family or friends and the facility would first have to get a psychological evaluation to see if the resident is competent to make decisions regarding a power of attorney as the staff feel the resident has moderately impaired decision-making abilities. The facility policy titled, Advance Directives and Advanced Care Planning revised 08/02/2022, documented residents have the right to self-determination regarding their medical care. This includes the right of an individual to direct his or her own medical treatment, including the right to execute or refuse to execute an advanced directive. A resident who has not been declared incompetent has the right to designate a representative to exercise the residents' rights to the extent those rights are delegated to the representative. Each time the resident is admitted to the facility, quarterly, and when a change in condition is noted in the resident condition, the facility should review the advanced directive and advanced care planning information.

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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 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **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 appropriate state mental health authority was notified promptly following a change in condition for 1 of 31 sampled residents (Resident #81). The deficient practice had the potential to deprive the resident of concern and other residents of necessary behavioral health services. Findings include: Resident 81 (R81) R81 was readmitted on [DATE], with diagnoses including schizoaffective disorder, unspecified dementia with behavioral disturbance, major depressive disorder, and bipolar disorder. On 11/19/2024 in the afternoon, R81 stated the pureed food was horrible and they rarely eat it. R81 stated had been back to the hospital a couple times since admitted to the facility. The resident had no issues with laundry and housekeeping, was receiving and happy with physical therapy, occupational therapy, and the nursing care. The resident indicated liked participating in the Activities Department events to get out of their room. R81 tended to jump from one thing to another randomly. A PASARR level one document dated 01/29/2020, revealed R81 did have the dementia diagnosis, however, no other mental illness (MI), intellectual disability, (ID) mental retardation (MR) or any related condition (RC) and was deemed appropriate for nursing facility placement. A review of the resident's medical notes revealed R81's schizoaffective disorder was diagnosed on [DATE] and the resident's major depressive disorder was diagnosed on [DATE]. A review of the resident's physician progress notes on 3/29/2022 and 03/31/2022 revealed R81's bipolar disorder was diagnosed on these physician notes; however, it had not been added to the list of diagnoses in the Point Click Care (PCC) Medical Records System. A nurse's progress note dated 05/19/2024 at 08:55 AM, documented R81 was involved in a resident-to-resident altercation where R81 punched another resident in the face causing the other resident to lose a tooth. The note documented R81 stated they were hit first but had managed to knock the other resident's tooth out. Documentation revealed R81 was seen by psychiatric services within minutes of the incident and had given the order to complete a Legal Discharge for R81 to a psych ER for acute treatment. On 11/21/2024 at 9:30 AM, the Medical Records Director (MRD) acknowledged the resident diagnoses are entered by the medical records department. The MRD was not sure why the Bipolar Diagnosis had not been added since the physicians had diagnosed the disorder and the facility had been documenting this diagnosis in the resident's Modified Data Set (MDS). The MRD acknowledged the diagnosis should have been added to the residents list of Diagnoses in PCC. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/2024 at 10:10 AM, the Medicaid Eligibility Specialist (MES) explained was responsible for referring residents who met criteria for PASARR II by completing the PASARR referral in the PASARR system. When asked if a residents' diagnoses of schizoaffective disorder, major depressive disorder, and bipolar disorder would be representative of mental illness, intellectual disability, or a related condition which the Medicaid Service Manual documents a PASARR II must be completed for, the MES explained this was not necessarily the case. The MES explained if the resident had also been diagnosed with dementia, the dementia diagnosis would override the other diagnoses. The MES continued to explain the only thing which would necessitate a PASARR II referral for this type of dementia resident is a Legal Discharge for a psych change of Condition. The MES confirmed R81 did have a Legal Discharge due to a psych change of condition and a referral for a PASARR II should have been completed. The Division of Health Care Financing and Policy- Medicaid Services Manual- for Nursing Facilities Policy dated 05/01/2015, documented when an individual has been identified with possible indicators of mental illness, intellectual disabilities or related condition, a PASARR Level II screening must be completed to evaluate the individual and determine if nursing facility services and/or specialized services are needed and can be provided in the nursing facility. Examples include: a resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting a presence of a mental disorder (where dementia is not the primary diagnoses), or an intellectual disability or related condition was not previously identified and evaluated through PASARR. Social services would be responsible for keeping track of each resident's PASARR screening status and referring to appropriate authority. A facility document titled Pre-admission Screening and Resident Review (PASARR) revised on 10/06/2022, revealed the need to refer residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon significant change in status. Also, the facility must notify the appropriate state mental health authority or state intellectual disability authority promptly after a significant change in the mental or physical condition of a resident who has a mental illness or intellectual disability for resident review.

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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 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 elopement for 1 of 31 sampled residents (Resident 167). The deficient practice placed the resident at risk for inappropriate care, supervision, and accidents. Findings include: Resident 137 (R137) R137 was originally admitted to the facility on [DATE] with diagnoses including seizures, epilepsy, autistic disorder, schizophrenia, and anxiety disorder. A Nursing Progress Event Note dated 11/03/2024 at 7:10 PM, revealed the nurse was giving medications when R137 approached the nurse to call their mother around 8:00 PM. The note revealed the following information: At around 8:10 PM the CNA opened the front door remotely for a resident family member and the family member advised there was a resident outside wearing a red shirt. The CNA went outside to check and found R137 in the street in front of the building to the right. The CNA called for help and three CNAs brought R137 back to the building. At 9:15 PM the nurse called the physician to get an order for a Wonder Guard. At 9:15 PM the nurse went to the resident's room and the resident was not there. Staff looked for the resident again, and another nurse found R137 outside again. The nurse and a CNA brought R137 back inside at 9:40PM. At 11:30 PM, the CNA informed the nurse could not find R137. Staff looked outside and found R137 in front of the building at the right side near the bushes. R137 had refused to allow the staff to put the Wonder Guard on their leg and became aggressive toward staff. By 1:00 AM on 11/04/2024, R137 was asleep. According to the facility's investigation documentation, there is no evening. Staff buzz in visitors remotely in the evening due to no receptionist. When the door opens, the maglock does not close the door immediately, it stays open for at least a minute. It was thought the elopement occurred when the door was opened for a visitor or a food delivery person. A care plan for risk for elopement had documented R137 had an elopement. However, the care plan had not been revised with new interventions dated on or around 11/03/2024 documenting new preventative strategies to prevent future elopements. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/2024 at 7:59 AM, the Unit Manager (UM) acknowledged the care plan is the guide for how a person is taken care of in the facility and also acknowledged the current interventions had not worked in this event where R137 had eloped three times in four hours. The UM stated the care plan needs to be updated with new interventions to try to keep the resident safe in the facility. The UM acknowledged R137's care plan had not been revised with new interventions. On 11/21/2024 at 7:20 AM, the Director of Nursing (DON) revealed they would have expected new interventions to have been added to R137's care plan. A facility policy titled Comprehensive Care Plans and Revisions revised 03/02/2022 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 to include additional interventions on existing problems.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50289 Based on observation, interview, and document review, the facility failed to ensure stored foods were stored properly and ice machines were properly cleaned for 3 of 5 ice makers in the facility. This deficient practice posed a potential risk to safety and health standards which could lead to contamination and place residents at risk of foodborne illness. Findings include: On 11/19/2024 in the morning, there was an open bottle containing blackberry sauce in the dry food storage area with an expiration date of June 10, 2024. The Dietary Director explained the blackberry sauce should have been discarded. On 09/04/2024 in the morning, there was an ice machine in the kitchen with brownish spots on the inner ice shield, debris buildup on the metal lip between the lid and the opening of the ice chamber, and debris buildup of the front grill covering the filter of the ice machine. There was an ice machine in the 300-hall nourishment room with a debris buildup on the ice spout of the machine. There was another ice machine in the 400-hall nourishment room with a debris buildup on the ice spout of the machine. The Dietary Director explained the ice machines are cleaned periodically and were recently cleaned. On 11/22/2024 in the afternoon, the nourishment room ice machines were inspected again showing debris buildup on the ice spout of the 300 and 400 hall machines. A facility document titled Ice Machines revised 06/12/2023, revealed ice machines should be maintained in a clean and sanitary state following infection prevention and control guidelines. A facility document titled Food Safety revised 04/26/2023 revealed under dry storage, opened packages of food are resealed tightly to prevent contamination of the food item and use by date will be used. Food not safe for consumption or if the safety of the food is in question, it will be removed from storage.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 37718 Based on interview and document review, the facility failed to ensure employee records contained evidence of current Nevada Automated Background System (NABS) clearance per Nevada Revised Statutes (NRS) 449.124, for 4 of 19 employee records reviewed (Employees 4, 5, 6 and 7). The deficient practice had the potential to allow unqualified employees to provide care for residents. Findings include: NABS Clearance regulatory language at NRS 449.123 documented the Administrator, or the person licensed to operate a facility, shall ensure information concerning the background and personal history of each employee, or contractor who worked at the facility was completed as soon as practicable and at least once every five years after the date of the initial investigation. NRS 449.124 documented each facility shall maintain records of the information concerning its employees which included, 1) a copy of the fingerprints submitted to the Central Repository for Nevada Records of Criminal History or proof of electronic fingerprint submission and a copy of the written authorizations provided by the employee, 2) proof the employees' fingerprints were submitted to the Central Repository, and 3) any other documentation of the information collected pursuant to NRS 449.123. On 11/21/2024, a review of 19 employee records conducted with the Staff Developer revealed the records of Employees 4, 5, 6 and 7 lacked evidence fingerprint-based background checks had been initiated and completed within five years from the prior screening date. -Employee 4 was hired as a Licensed Practical Nurse. The latest finger-print based background check with NABS clearance letter was completed on 09/20/2019. -Employee 5 was hired as a Certified Nursing Assistant (CNA). The latest finger-print based background check with NABS clearance letter was completed on 06/11/2019. -Employee 6 was hired as a CNA. The latest finger-print based background check with NABS clearance letter was completed on 10/17/2019. -Employee 7 was hired as a Maintenance Assistant. The latest finger-print based background check with NABS clearance letter was completed on 05/15/2019. On 11/21/2024 at 12:09 PM, the Staff Developer verbalized being responsible for ensuring each employee's screening was completed on hire and then every five years. The Staff Developer revealed fingerprints and clearance letter from NABS showing current eligibility for hire was to be documented in each employee record. (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Staff Developer verbalized Employees 4, 5, 6 and 7 did not have a current (less than 5-year-old) NABS clearance letter. The Staff Developer indicated some employees had fingerprints done which had not been submitted to NABS as of yet. The Staff Developer indicated the fingerprinting process should have been initiated sooner so as to obtain NABS clearance for Employees 4, 5, 6, and 7 within the required time frame. The Staff Developer stated it was an oversight on the facility's part. On 11/21/2024, in the afternoon, the Administrator indicated a completed fingerprint-based background check with a NABS clearance letter confirming current eligibility was required for all employees. The Administrator verbalized the facility was expected to abide by state laws. The policy and procedure titled Licensure and Compliance with Federal, State, Local Laws, and Professional Standards, revised 04/17/2021, indicated the facility provided services in compliance with State laws, regulations, and codes. The policy and procedure titled Background Screening Policy: Associates, dated 08/20/2018, indicated background checks would be conducted to determine eligibility in accordance with relevant state laws.