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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295073	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Springs Healthcare and Rehab	8501 Del Webb Blvd Las Vegas, NV 89134

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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50289

Based on observation, interview, record review, and document review, the facility failed to ensure a resident was treated with dignity and respect by facility staff not assisting with resident hygiene for 1 of 4 sampled residents. This had the potential to cause psychosocial distress to the resident.

Findings include:

Resident #2 (R2)

R2 was admitted to the facility on [DATE], with diagnoses including traumatic hemorrhage of the cerebrum, type 2 diabetes mellitus, chronic obstructive pulmonary disease, muscle wasting and atrophy, and dysphagia.

R2 was observed in bed wearing a clean medical gown with the covers pulled up to the chest. The resident was not shaven and had a beard covering the face. There was no wheelchair or assistive device on the resident's side of the room.

On 10/23/2024 at 10:20 AM, R2 verbalized was admitted into the facility with very few clothes and the clothes which did come with the resident were too hot to wear so prefers to wear the gowns the facility provides. The resident verbalized the staff had shaved the resident about 3 weeks ago when the staff gave the resident a shower. The resident verbalized staff were going to shave the resident last week when the staff gave the resident a shower, but the staff didn't provide the facial shave to the resident at that time.

On 10/23/2024 at 10:48 AM, the Certified Nursing Assistant (CNA) [Employee 6 (E6)] verbalized R2 did not come to the facility with any clothes, so the staff had to utilize donated clothing for this resident. E6 explained residents are supposed to have their face shaved on their shower days by the CNA who is giving the shower. E6 stated for R2, the shower days are Tuesday and Friday evenings.

On 10/23/2024 at 11:26 AM, the Licensed Practical Nurse (LPN) [Employee 7 (E7)] confirmed R2 did not come to the facility with any clothes and the facility had to give the resident some donated clothes to wear. E7 also confirmed the CNAs are to complete the face shaving on the residents' shower days. E7 confirmed R2 had a thick beard and explained R2's beard grows fast and should be shaved at least weekly.

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's daily shower monitoring log did provide evidence the resident was receiving showers on the days R2 was scheduled to have a shower. However, these logs lacked any evidence the resident was also getting shaved on these shower days; nor was there any other CNAs or Nurses documentation the resident had received a facial shave. According to the facility's Nursing Services Policy and Procedure Manual for Long-Term Care (revised 2/2018), the Personal Care section under Bath & Shower/Tub documents after the resident has showered and is dry, staff are to assist with grooming and dressing as the resident needs. According to the facility's Operational Policy and Procedure Manual for Long-Term Care (revised 12/2016), the Resident Rights section documented residents had the right to be treated with respect, kindness, and dignity.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** 51397 Based on interview, record review and document review, the facility failed to assess, re-assess, and adequately monitor a resident with a change in condition for 1 of 4 sampled residents (Resident 3). The deficient practice: 1) resulted in an acute physical decline that contributed to the resident's emergent transport to the hospital where the resident passed away, and 2) placed facility residents who had a change in condition at risk for poor clinical outcomes. Findings include: Resident 3 (R3) R3 admitted was admitted on [DATE] with diagnoses including chronic heart failure. R3 did not have any cognitive deficits and was able to make needs well known. On [DATE] at 3:49 PM, R3's family member shared having received a call from R3 on [DATE], complaining of chest pain with shortness of breath (SOB). The family member stated a chest x-ray was ordered and revealed R3 had pleural effusions (fluid in the lungs). Family member stated the resident called again on [DATE] (2 days after the chest pain and shortness of breath episode) stating not feeling well with fatigue and had indigestion. Family member stated on[DATE], R3 was transported to the hospital for worsening shortness of breath. Family member verbalized the resident was in the emergency department (ED) for a short while, then transported to the intensive care unit (ICU) where R3 passed away on [DATE]. Review of R3's clinical notes from [DATE] to [DATE] revealed the following: A change in condition progress note dated [DATE] at 3:37 PM, documented R3 was observed having shortness of breath, postnasal drip and mid abdominal pain. The note documented the resident had not complained of these symptoms before. The note revealed R3 was given a breathing treatment, and the medical provider was notified who ordered a chest x-ray. No other notes regarding R3's condition were documented until the next day on [DATE] at 2:21 PM (over 22 hours later). Additionally, the note lacked documentation to show a focused or complete respiratory, cardiac or abdominal assessments were completed to establish a baseline, possible causes of R3's symptoms. A progress note dated [DATE] at 2:21 PM, the chest x-ray ordered on [DATE], revealed R3 had cardiac enlargement, pulmonary (lung) congestion and fluid in both lungs. The note documented the findings were consistent with congestive heart failure. The medical provider was notified who then ordered a water pill. The note lacked documentation to show if any focused or complete assessments or re-assessments were completed. No other notes regarding R3's condition were documented until the next day on [DATE] at 5:52 PM (over 26 hours later). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A progress note dated [DATE] at 5:52 PM, documented R3's oxygen saturations decreased while being repositioned in bed by care staff. The note documented R3's oxygen was removed for repositioning and oxygen levels dropped to ninety percent. When the repositioning was completed, the oxygen was replaced, and oxygen levels went up to ninety four percent. The note documented R3 was on three liters of supplemental oxygen with oxygen saturation percentages to be monitored. The note lacked documentation to show if the incident was reported or if any focused or complete assessments or re-assessments were completed. No other notes regarding R3's condition were documented until the next day on [DATE] at 11:52 AM (18 hours later). A progress note dated [DATE] at 11:52 AM, documented R3 was scheduled for discharge to an out of state nursing facility on [DATE]. No other notes regarding R3's condition were documented until the next day on [DATE] at 3:30 AM (15 hours later). A progress note dated [DATE] at 3:45 AM, documented at 3:30 AM, R3 had SOB and stated not feeling well. The note documented R3's blood pressure was ,d+[DATE] with oxygen saturations fluctuating between eighty-five to eighty nine percent with 3 liters of supplemental oxygen. The note showed R3's skin was cold, clammy and resident was hyperventilating. The note documented the medical provider was notified, R3 was given a breathing treatment who verbalized feeling a little better. The note documented R3's health would continue to be monitored and shift report was given to the incoming nurse. The note lacked documentation to show if any focused or complete assessments or re-assessments were completed. A progress note dated [DATE] at 10:22 AM, documented R3's family member was informed R3 was too unstable to be discharged as scheduled, due to low blood pressure and low oxygen saturation percentages. The note documented R3 was under observation. The note lacked documentation to show if any focused or complete assessments or re-assessments were completed. A progress note dated [DATE] at 4:49 PM, documented R3 was verbally responsive, on three liters of supplemental oxygen with an oxygen saturation of ninety-six percent. The note showed R3 was not in any respiratory distress and had a shower that morning. The note lacked documentation to show if any focused or complete assessments or re-assessments were completed. No other notes regarding R3's condition were documented until the next day on [DATE] at 9:03 AM (17 hours later). A change in condition progress note dated [DATE] at 09:03 AM, documented R3 complained of epigastric pain that radiated to the chest area. The note stated the medical provider was notified who ordered for R3 to be transported to the emergency department. 911 was called and resident was transported to the emergency department at 9:57 AM. A hospital progress note dated [DATE], showed R3 arrived at the hospital emergency department (ED) with shortness of breath. Testing completed in the ED revealed R3 had suffered a heart attack and was immediately sent to the intensive care unit. The note revealed R3 also had active congestive heart failure, continued to decline over the next three days and eventually passed away on [DATE] from cardiogenic shock (A cardiac condition when the heart cannot pump enough blood and oxygen to the brain and other vital organs. The condition is a life-threatening emergency, treatable if diagnosed right away. Late signs and symptoms of cardiogenic shock include a drop in blood pressure and slowing of peripheral pulses. Other symptoms include, sweating without activity and rapid breathing. Causes of cardiogenic shock included congestive heart failure and heart attack). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R3's care plan dated [DATE] identified R3 had pleural effusions (fluid in lungs). Goals included: R3 will maintain a patent airway as evidenced by clear lung sounds, oxygen saturation. Interventions included the following: 1. Assess lung sounds. Adventitious lung sounds such as wheezing, stridor, rhonchi, crackles can result from an accumulation of secretions or blocked airway. 2. Assess respirations. Note the depth, pattern and use of accessory muscles when breathing. Increasing rate, nasal flaring and accessory muscle use is an attempt to compensate for ineffective breathing. The care plan lacked documentation to show R3 had congestive heart failure (CHF) with specific goals with appropriate interventions. On[DATE] at 10:23 AM, a Licensed Practical Nurse (LPN) was asked to describe what the process was for a resident complaining of chest pain with SOB. The LPN stated assessing ABC's (Airway, breathing and circulation) was a priority. The LPN explained placing the resident on oxygen and checking oxygen levels by way of vital signs. LPN stated regarding the chest pain, checking orders and calling the medical provider for orders. LPN was not aware of any facility chest pain or congestive heart failure (CHF) protocol. LPN did not state performing any focused assessments such as assessing lung, heart sounds, performing a resident interview to obtain more information or follow up monitoring. On [DATE] at 10:39 AM, another LPN was asked the same question and explained getting vital signs, assessing if the pain was radiating, calling the medical provider and check for any medication orders for chest pain. LPN added did not assess lung sounds. LPN stated calling for emergency services if the resident was not responsive. On[DATE] at 1:15 PM, the Director of Nurses (DON) stated according to the progress notes, the resident started having SOB, postnasal drip and pain in stomach on [DATE]. DON explained R3 was given a breathing treatment, and a chest x-ray was ordered. DON stated the chest x-ray was done the next day on [DATE]. DON indicated the results of the x-ray showed R3 had CHF with pleural effusions. DON indicated on [DATE], the resident was complaining of stomach pain and sent out due to further decline. When asked if R3 should have gone to the hospital sooner, DON stated nurses could send a resident to the ED using their nursing judgment. DON agreed the nurses did not assess lung sounds, quality, duration and frequency of SOB. DON agreed most medical providers were not always in the facility and depended on the nurses to report more detailed clinical information, to make better clinical decisions. DON agreed the nurses could have sought further assessment from an RN on duty for more ongoing, clinical assessment and monitoring. DON stated there was no documentation to show evidence that the nurses provided adequate reassessment and monitoring. On [DATE] at 3:25 PM, the medical provider who recalled receiving notification R3 had SOB, explained ordering a chest x-ray and a medication on [DATE], to try and remove the fluid in R3's lungs. (continued on next page)

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F 0684

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Provider stated it was the expectation for the nurses to report back intervention effectiveness of R3's condition, but could only recall getting a report back 4 days later when the resident had decompensated and had to be sent to the ED for evaluation.

The provider indicated expecting nurses to assess each resident every shift which included obtaining vital signs and auscultation of the lungs which was basic nursing assessment. The provider indicated the nursing assessment and re-assessment was crucial as it served as the basis for physician's giving out appropriate treatment orders.

The provider stated nurses had the capacity to transfer residents that were unstable to the hospital for further evaluation based on their clinical judgement and was not aware R3 later died in the hospital. Provider agreed getting more detailed clinical information from the nurses may have changed the outcome.

On [DATE] at 4:56 PM, the Assistant Director of Staff Development (DSD) stated residents were assessed by licensed nurses on a daily basis. Nursing assessments included: vital signs, any change of condition. Assessments were typically done during medication pass on admission and when there was change of condition.

On [DATE] at 5:01 PM, the DSD indicated nurses were expected to perform assessments every shift, unless more frequent checks were ordered by the physician. These assessments would have included vital signs (BP, pulse, pulse oximetry, respirations, temperature, pain, breathing patterns especially in SOB). The DSD indicated auscultation of the lungs should be done every shift to assess for diminished lung sounds, crackles, wheezing, etc. The DSD stated nurses were the eyes and ears of the physicians who were not always in the facility. DSD stated nursing judgments were crucial and the basis of a physician's decision-making. Nurses are trained in the SBAR process. DSD also stated the facility followed the not documented/not done rule. Meaning, to say if assessments were not documented they were not done or if a physician notification was not documented then it was not done.

On [DATE] at 5:13 PM, the DSD reviewed R3's medical record and confirmed there was no documentation of daily nurses' assessment. According to the DSD the outcome may have been different if the physician notification and nursing assessments were completed in accordance with facility policies.

On [DATE] at 4:53 PM, DON stated the facility did not have a policy for nursing standards of practice. DON stated nurses used the Nevada Nurse Practice Act as the standards of practice.

Review of the facility policy titled Change in a Resident's Condition or Status, revised on ,d+[DATE], documented the following:

1. Prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant information for the provider.

Review of the facility policy titled Comprehensive Assessment and the Care Delivery Process, revised on , d+[DATE], documented the following: Assessment and information collection included (what, where and when?). The objective of the information collection (assessment) phase is to obtain, organize and subsequently analyze information about a resident.

Assess the resident:

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Gather relevant information from multiple sources including: - Observation - Physical assessment - Symptom or condition related assessment 2. Identify potential causes or contributing factors of problems and symptoms 3. Apply clinical reasoning to assessment information and determine most appropriate interventions. 4. Monitor results and adjust interventions to include, periodically reviewing progress Review of the facility policy titled Heart failure- Clinical Protocol revised ,d+[DATE], documented nurses will assess, document/report the following: - Vital signs - General physical assessment - Recent or current history of chest pain, dizziness or diaphoresis (sweating due to medical condition such as heart failure). Review of the facility policy titled Charting and Documentation revised [DATE], showed the following: - All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. - The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Complaint #: NV00072165