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 03/13/2026

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 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, record review and document review, the facility failed to revise the comprehensive care plan when modifications were made to a resident's nephrostomy tube for 1 of 40 sampled residents (Resident 29) and when a resident returned from the hospital under hospice care with a change in code status for 1 of 40 sampled residents (Resident 227). The deficient practice had the potential to negatively impact on the quality of care the residents received.Findings include: Resident 29 (R29) was admitted on [DATE] and readmitted on [DATE], with diagnoses including hydronephrosis with renal and ureteral calculus obstruction, encounter to nephrostomy and other artificial openings of urinary tract.A care plan initiated 02/15/2025, revealed R29 was admitted with bilateral nephrostomy tubes with a goal of having no signs and symptoms of infection by checking tubing for kinks, monitoring and recording output, monitoring discomfort and notifying physician if no urine output.A hospital Discharge summary dated [DATE], revealed R29 was admitted with bilateral nephrostomy tubes and the left nephrostomy tube was exchanged with a stent by interventional radiology. R29 to return to skilled nursing facility with a right-sided nephrostomy tube. The medical record lacked documented evidence R29's care plan was updated to reflect removal of left nephrostomy tube.On 03/11/2026 at 2:52 PM, the Unit Manager indicated R29's care plan for nephrostomy was not updated when R29 returned with only one nephrostomy tube. The Unit Manager indicated this would have been a good time to review R29's care plan to identify and include interventions which were lacking such as cleansing site with normal saline and changing dressing every one to three days per facility policy.Resident 227 (R227) was admitted on [DATE] and readmitted on [DATE], with diagnoses including malignant neoplasm of the bronchus or lung. A physician's order for life-sustaining treatment (POLST) dated 12/19/2025, revealed R227 did not have decisional capacity and a family member elected full code or attempt resuscitation in the event of cardiopulmonary arrest.A History and Physical dated 01/01/2026, revealed R227 returned to the facility on [DATE] following hospitalization for acute chronic hypoxic respiratory failure. The physician previously discussed hospice which the resident and family declined. After being medically stabilized at the hospital, R227 returned to the skilled nursing facility under hospice care.A hospice do not resuscitate (DNR) election form dated 12/29/2025, revealed R227's family member agreed to allow natural death do not perform medical procedure to try to restart heart.The medical record lacked documented evidence R227's comprehensive care plan was updated to reflect R227's hospice status and R227's change in code status.On 03/13/2026 at 11:06 AM, the Director of Nursing (DON) confirmed R227's comprehensive care plan was not updated to reflect changes in the resident's condition specifically code status from full code to DNR and hospice election while at hospital. The facility's Comprehensive Person-Centered Care Plan policy revised December 2016 revealed assessments of residents were ongoing and care plans were revised as information regarding the residents and the residents' condition changed.Complaint 272374

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review, the facility failed to ensure physician's order for life-sustaining treatment (POLST) was made available to emergency personnel for a hospice resident and failed to maintain hospice paperwork in the facility in accordance with the facility policy and hospice agreement for 1 of 40 sampled residents (Resident 227). The deficient practice resulted in confusion among staff and emergency personnel and placed hospice residents at risk for advanced directives not being honored at end of life.Findings include: Resident 227 (R227) was admitted on [DATE] and readmitted on [DATE], with diagnoses including malignant neoplasm of the bronchus or lung. A POLST dated [DATE], revealed R227 did not have decisional capacity and a family member elected full code or attempt resuscitation in the event of cardiopulmonary arrest.A History and Physical dated [DATE], revealed R227 returned to the facility on [DATE] following hospitalization for acute chronic hypoxic respiratory failure. The physician previously discussed hospice which the resident and family declined. After being medically stabilized at the hospital, R227 returned to the skilled nursing facility under hospice care.A physician order dated [DATE], documented R227 under hospice care with primary diagnosis metastatic lung cancer. A general note dated [DATE], revealed R227 was found unresponsive by a nurse during morning rounds at approximately 6:00 AM. R227's still had vital signs, and hospice was notified of R227 being unresponsive and the facility nurse asked hospice to confirm R227's do not resuscitate (DNR) status. Hospice referred facility nurse to page three of the care plan which stated R227 was a DNR. R227's family was present and started doing compressions on R227 and called emergency services. Emergency services arrived at 10:05 AM and transported R227 to hospital at 10:20 AM.The medical record lacked documented evidence, a DNR POLST, and other hospice paperwork were maintained by the facility and made available to emergency services.On [DATE] at 12:37 AM, a certified nursing assistant (CNA) recalled being assigned to R227 as a sitter on [DATE] but the CNA was pulled away to provide another resident with a shower and could not speak to the event. Upon returning to the room, the CNA indicated R227 had already been sent to the hospital.On [DATE] at 9:03 AM, the Registered Nurse (RN) assigned to R227 on the day of the incident recounted doing morning rounds at start of shift and found R227 unresponsive. The RN indicated R227 appeared peaceful with no distress with presence of vital signs. The RN sought assistance from a Licensed Practical Nurse (LPN) to contact the hospice provider and R227's family. The RN recalled R227 did not have a DNR POLST in the hospice binder and the hospice provider was only able to provide a DNR election form which took a while to be received by the facility. The RN recounted the family had panicked over the resident's unresponsive state and began doing compressions while another family member called 911. The RN confirmed emergency personnel were requesting to see hospice documents and R227's DNR POLST but the facility was unable to provide this which led to the resident being transported to the hospital.On [DATE] at 9:21 AM, the Unit Manager indicated being off duty on [DATE] but was constantly receiving updates on R227's situation. R227 confirmed there was no DNR POLST in the hospice binder and hospice personnel faxed a DNR hospice election form which was signed by R227's family member and did not have a physician's signature. The Unit Manager indicated the facility was informed R227 expired shortly after arriving at the hospital. On [DATE] at 10:53 AM, an attempt to contact the hospice provider was unsuccessful.The hospice program policy dated revised [DATE], documented it was the responsibility of the facility to obtain and maintain the following information from hospice:- most recent care plan including advanced directives- hospice election form- physician certification of terminal illness/recertification- names and contact information of hospice personnel- instructions on how to access hospice's 24-hour on call system- hospice medications- hospice physician other ordersOn [DATE] at 10:53 AM, the Director of Nursing (DON) reviewed R227's medical record and (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated R227 was initially admitted on [DATE] as a full code and not a hospice resident. According to the DON, R227 was transferred to the hospital on [DATE] and returned to the facility on [DATE] under hospice care. The DON reviewed R227's hospice book and confirmed the following required information was missing namely, the hospice election form, physician certification for terminal illness, advanced directives to include a POLST reflecting DNR status. A hospice DNR election form dated [DATE], revealed R227's family member agreed to allow natural death do not perform medical procedure to try to restart heart.On [DATE] at 11:02 AM, the DON indicated the hospice provider who had oversight of R227 was responsible for completing a DNR POLST from R227's family member and clarified a DNR hospice election form was not an acceptable substitute in this state because the election form lacked a physician's order.The hospice agreement dated [DATE], documented when a resident admits into hospice, the hospice program, hospice and facility jointly developed and agreed on a hospice plan of care. Hospice and facility shall maintain a copy of each resident's hospice plan of care in the respective clinical records by each party. Coordinated care plans for residents receiving hospice services would include care and services to include advanced directives. Complaint 272374