STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295076	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of South Las Vegas	2325 E. Harmon Ave. Las Vegas, NV 89119

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 51395 Based on observation, interview and document review, the facility failed to ensure medications were secured in 1 of 2 central supply rooms. The deficient practice had the potential risk of unauthorized access to medications, theft, or misuse of medication within the facility. Findings include: On 01/22/2025 at 10:28 AM, the central supply room, across from the nurse's station, on the 100-hall had the door propped open with a silver dumbbell weight. The central supply room contained a variety of items such as: medication and wound care dressings. There were two medication carts located on the right side as you enter the room. A brown medication cart was located under a wall mounted cabinet. The medication cart was unlocked with keys hanging out of the cart lock. The top drawer of the brown medication cart contained the following: - Vitamin C (nutritional supplement): five bottles. - Vitamin B12 (nutritional supplement): two bottles. - Coenzyme Q10 (nutritional supplement): three bottles. - Floranex (probiotic): seven bottles. The second drawer contained the following: - Benadryl (antihistamine)- four boxes. - Omeprazole (gastric acid reducer): three boxes. - Geri-Lanta (antacid): six bottles. A second medication cart, located to the left of the brown medication cart, was blue and white in color. The medication cart was unlocked. The second drawer contained the following: (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295076	A. Building B. Wing	01/22/2025

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Antacid tablets (relieves indigestion): three bottles. - Omeprazole (gastric acid reducer): four bottles. - Biotin (nutritional supplement): five bottles. - Nexium (gastric acid reducer): five bottles. - Thermotabs (mineral supplement): four bottles. On 01/22/2025 at 10:28 AM, an Occupational Therapy student entered the central supply room, and verbalized were getting supplies for a resident. The student verbalized the door to the central supply room is not normally propped open. On 01/22/2025 at 10:34 AM, a Licensed Practical Nurse (LPN) on the 100 hall, stated the central supply room door was not to be left unlocked and should not have been propped open. The LPN verbalized the central supply room was where the facility stored medications and other supplies. The LPN explained the central supply room should not be accessible and by leaving the central supply room door open anyone can enter and there was a risk of an accidental overdose or someone getting medications they do not have an order for. On 01/22/2025 at 10:45 AM, a Licensed Nurse on the 200 hall, stated the central supply room was to remain locked. The central supply room was used to store over the counter medications, wound care supplies, and other supplies needed for residents. By keeping the central supply room door locked it prevents just anyone from entering the room. On 01/22/2025 at 2:15PM the Director or Nursing (DON) stated the central supply room, located on the 100 hall, contained various supplies such as over the counter medications and wound care supplies. The DON verified the central supply room was to remain locked. The DON verbalized the rationale for keeping the room locked was to ensure residents and family members do not have access to enter and obtain supplies or medications. The facility policy titled Storage and Expiration Dating of Medications and Biologicals, with a revision date of 08/07/2023, documented the facility would ensure all medications and biologicals, including treatment items, were to be securely stored in a locked cabinet/cart or locked medication room that was inaccessible by residents and visitors.

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	295076	A. Building B. Wing	01/22/2025

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51395 Based on interview, record review and document review, the facility failed to complete a nutritional assessment including food preferences within 72-hours of admission per facility policy for 1 of 2 sampled residents (Resident 2). The failure to honor resident food preferences could potentially cause residents to lose interest in eating their meals. Findings include: Resident 2 Resident 2 was admitted on [DATE] and discharged on [DATE], with diagnoses including lupus and mild kidney injury. Review of the resident's medical record revealed a nutrtional assessment and food preferences were not documented. A physician's order dated 12/05/2024, documented a regular diet, regular texture, thin liquid consistency. On 01/22/2025 at 2:55 PM, the Dietary Director verbalized a dietary staff member would meet with a newly admitted resident within 24 hours to obtain the resident's food preferences. The information obtained about food preferences would be documented in the resident's medical record. On 01/22/2025 at 3:30 PM, a staff member from medical records acknowledged R2's medical record did not contain documentation of food preferences. The facility policy titled Nutrition Assessment, with a revision date of 12/16/2021, documented the Director of Food and Nutrition Services, Registered Dietician, or designee would visit residents within 72 hours of admission, to obtain food and beverage preferences, and complete the appropriate sections of the electronic nutrition assessment.