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	05/27/2026

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 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** Based on interview, record review and document review, the facility failed to ensure 1) blood glucose (BG) levels were obtained on admission, 2) discharge summary recommendations for diabetes management were discussed or clarified with the attending physician, and orders for BG monitoring and Insulin sliding scale were obtained for a resident with type one diabetes mellitus, 3) BG levels were obtained during a change of condition, and 4) the facility had a clear diabetes management process or protocol for 1 of 40 sampled residents (Resident 161). The deficient practice potentially resulted in diabetic-related complication requiring hospitalization.Findings include:Resident 161 (R161) was admitted on [DATE], with diagnoses including type one diabetes mellitus, and encounter for surgical amputation of right toe due to gangrene.1) On [DATE] at 3:35 PM, a Registered Nurse (RN) recalled admitting R161 on the evening of [DATE]. The RN explained when residents with diabetes were admitted , a baseline blood glucose would be obtained. According to the RN, this value would be communicated to the physician and would guide the physician on whether to place the resident on a low sliding scale or the regular sliding scale unless the resident was not Insulin-dependent. The RN indicated the resident's baseline blood glucose value would also guide the physician on the frequency of BG monitoring orders for the resident. The RN acknowledged a BG check was not obtained when R161 was admitted due to an oversight on the part of the RN.On [DATE] at 10:38 AM, the medical records director confirmed there was no record a BG was obtained when R161 was admitted on [DATE] in the evening. The first BG check for the R161 was recorded on [DATE] at 9:10 AM with a result of 209 milligrams (mg) per deciliter (dl) (Reference range: 70 mg/dl to 99 mg/dl when fasting or under 140 mg/dl two hours after a meal).2) A review of the hospital Discharge summary dated [DATE], revealed R161 underwent amputation of the right third toe on [DATE]. R161 was receiving Insulin Glargine (long-acting) twice a day (BID) and Insulin Humalog (fast-acting) before meals (AC) and at bedtime (HS) following a sliding scale. R161's BG was monitored twice a day with the Insulin Glargine administration and before meals and at hour of sleep for the Insulin Humalog administration.The hospital discharge medication reconciliation dated [DATE], included Insulin Glargine (Lantus injection) 100 units/milliliter (ml) vial, 50 units subcutaneously daily. A free text med rec notes read please consider sliding scale insulin while at rehab facility. Please also consider splitting long-acting Insulin to twice daily.The medical record lacked documented evidence discharge recommendations to put R161 on an Insulin sliding scale and splitting the long-acting Insulin twice daily were communicated to the physician.The medical record lacked documented evidence the admitting nurse clarified, obtained and transcribed orders for BG checks for R161 and the frequency thereof. On [DATE] at 3:35 PM, the RN who admitted R161 on the evening of [DATE] explained the facility did not have an admissions nurse but all nurses were trained in the admission process. The RN indicated hospital discharge summaries were thoroughly reviewed for all newly admitted residents and discharge medications typically were transcribed as admission orders and may be changed by the physician on the next physician visit. The RN indicated it was possible the RN focused on R161's discharge medications and missed the free text rec notes in the hospital discharge summary. The RN acknowledged not reaching out to the physician on the evening of [DATE] to obtain clarification (continued on next page)

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	orders regarding the resident's Insulin orders and frequency of BG checks.On [DATE] at 11:14 AM, Licensed Practical Nurse (LPN1) explained the admitting nurse would enter admission orders based on the hospital discharge summary for newly admitted residents and the unit managers would review and confirmed the medication orders. LPN1 indicated BG checks were typically done with Insulin administration while diabetics who were not receiving Insulin had BG checks twice daily, once per shift.On [DATE] at 11:17 AM, LPN2 indicated nurses would follow hospital discharge medications which may or may not include Insulin for newly admitted residents with a diagnosis of diabetes. LPN2 would discuss and seek clarification with the physician with regards to diabetes medication orders and frequency of BG checks. LPN2 indicated even if a diabetic resident was not on Insulin, they would obtain orders to perform BG checks at least twice daily.On [DATE] at 11:23 AM Unit Manager 1 (UM1) explained admission orders were reconciled with the physician who typically followed hospital discharge medication orders. Diabetic residents who were not receiving Insulin should have BG checks at least twice daily while diabetic residents on Insulin would be checked per physician recommendations.On [DATE] at 11:37 AM, UM2 explained hospital discharge medications were entered and followed as admission orders and the physician decided whether to place diabetic residents on a low or regular sliding scale. If the frequency of BG checks were not specified, then BG monitoring would occur at least twice a day.On [DATE] at 12:19 PM, the Director of Nursing (DON) explained nurses would enter orders based on the hospital discharge summary and unit managers would review and confirm the orders the following day except for weekends. The DON indicated R161 only had a long-acting Insulin in the hospital discharge summary to be given at night, and the BG monitoring was embedded with this order.On [DATE] at 11:51 AM, R161's attending physician indicated expecting the admitting nurses to communicate hospital recommendations for an Insulin sliding scale with the physician. The physician indicated they would have absolutely agreed to follow hospital recommendations for an Insulin sliding scale and to divide the resident's long-acting Insulin into two administrations. The physician verbalized being under the impression the facility protocol was to perform BG checks at least three times a day for residents being admitted with a diagnosis of diabetes.The medical record revealed R161 who was admitted on 11/2025 at 9:30 PM and discharged to the hospital on [DATE] at 6:02 AM, had four BG checks taken, as follows:- On [DATE] at 9:10 AM, 209 mg/dl- On [DATE] at 8:49 AM,147 mg/dl- On [DATE] (no time available) 147 mg/dl- On [DATE] at 11:00 AM, 220 mg/dlOn [DATE] at 11:54 AM, the Clinical Quality Coordinator reviewed R161's medical record and confirmed the last BG check was on [DATE] at 11:00 AM (220 mg /dl) and there was no BG obtained when the change of condition was identified on [DATE] at 5:32 AM. The Clinical Quality Coordinator indicated many things could have led to the DKA namely; infection, multiple co-morbidities, amputation surgery and the resident could have eaten something to cause the hyperglycemia and DKA. 3) A nursing admission/readmission collection tool dated [DATE], revealed R161 was admitted with a diagnosis of type one diabetes mellitus, was alert and oriented to person and place, able to make needs known, exhibited no behaviors, and was able to sign consents.An alert note dated [DATE] (4:37 AM), documented R161 was trying to get out of bed all night and was constantly redirected back to bed to prevent fall.A health status note dated [DATE] (5:32 AM), documented R161 was being sent out to the hospital due to a change in condition. Specifically, R161's heart rate was 32 beats per minute, hands were cold, Oxygen saturation was 82 % (normal 95% to 100%) on room air, deep rapid respirations, unable to speak due to catching breath and was lethargic. Physician called.An event note dated [DATE] at 6:02 AM, documented R161 sent to hospital by emergency services.The medical record lacked documented evidence a blood glucose level was obtained when vital signs were taken during R161's change of condition.On [DATE] in the afternoon, the Regional Director of Clinical Services and Clinical Quality Coordinator were present when the Director of Nursing (DON) stated a BG check was not done during R161's change of condition because it was not yet time.On [DATE], in the morning, the Regional Director of Clinical Services and Clinical Quality Coordinator stated a BG check should have been obtained when R161 had a change of (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	condition, specifically altered mental status and abnormal vitals signs on [DATE] because the resident was a known diabetic.The facility's Changes in Resident's Condition or Status policy reviewed [DATE], documented a change of condition included a significant change in the resident's physical, mental, or psychosocial status, a deterioration of health or a life-threatening condition or clinical complications. The facility would utilize the Lippincott procedure.The Lippincott procedure: Change in status, identifying and communicating, long-term care, revised [DATE], documented the nurse would identify and address any changes from baseline in the resident's status early to avoid complications. Chronic diseases may lead to potentially life-threatening conditions so the nurse must keep up to date on monitoring for changes. The Table List for chronic conditions included monitoring for hypoglycemia or hyperglycemia for residents with diabetes.4) On [DATE] at 1:00 PM, the Regional Director of Clinical Services confirmed the facility did not have a diabetes management protocol but went by physician's orders.A history of present illness dated [DATE], revealed R161 arrived at the hospital by emergency medical services (EMS), the resident was confused and had altered mental status. R161's blood glucose level was greater than 600 mg/dl at 9:08 AM and was recorded at 807 mg/dl at 9:13 AM. R161 had severe confusion found to be in diabetic ketoacidosis (DKA - a life-threatening medical emergency which occurs when the body lacks Insulin to convert blood sugar into energy. Without Insulin, the body starts breaking down fat, producing acids called ketones making the blood dangerously acidic) requiring intensive care unit (ICU) level admission.An independent history provided by emergency medical services (EMS) dated [DATE], revealed R161 came from a skilled nursing facility and had been confused since 2:00 AM, R161 was typically oriented x 2 to 3 but zero for EMS.A hospital Discharge summary dated [DATE], revealed R161 was admitted to the hospital on [DATE] with acute encephalopathy likely metabolic in the setting of DKA and stress hyperglycemia. R161 was started on an Insulin drip, placed on a DKA protocol and moved to the ICU for further assessment and management. R161 was intubated due to altered mentation and respiratory failure. Palliative care was discussed and R161 was discharged to hospice care on [DATE].A report received by the State Agency on [DATE], revealed R161 expired on [DATE] under hospice care.The facility's Admissions policy revised [DATE], documented the facility would provide uniform guidelines for admission or residents to the facility. Prior to admission, the resident would be evaluated for physical, emotional and social needs through a pre-admission screening process. The referral will contain medical findings, diagnoses, treatment to follow, prescribed diet, medication and treatment orders, short- and long-term goals and signed orders for immediate care. This should be available at the time of admission. A physician must personally approve in writing a recommendation that an individual be admitted to the facility, each resident must remain under the care of a physician, who would provide orders for the resident's immediate care and needs.Complaint 2992873

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure physician orders were followed for an indwelling catheter for 1 of 40 sampled residents (Resident 2). The deficient practice placed the resident at risk for a urinary tract infection (UTI).Findings include:Resident 2 (R2) was admitted on [DATE], with diagnoses including paraplegia, obstructive uropathy and urine retention.On 05/18/2026 in the morning, R2 was rolled to right side while the wound care nurse provided treatment to a sacral wound. A covered urinary bag was observed hanging on the right side of the bed.A physician order dated 04/07/2026, documented indwelling catheter to straight drainage. Size: 18 French Bulb: 10 cubic centimeters. Change for infection, obstruction or when the closed system was compromised as needed for stage four sacral wound.A physician order dated 04/07/2026, documented to perform catheter care every shift.On 05/21/2026 at 9:35 AM, the Unit Manager explained R2 was a paraplegic with an infected sacral pressure ulcer requiring use of a Foley catheter. The Unit Manager reviewed R2's medical record and indicated there was no documentation the Foley catheter had been replaced since admission. The Unit Manager entered R2's room and indicated needing to obtain information from the resident.On 05/21/2026 at 11:54 AM, the Unit Manager indicated R2 had a 16 French Foley catheter with orange port. R2 informed the Unit Manager the catheter was exchanged last week per resident's request and R2 themselves requested staff to use a 16 French Foley catheter.The medical record lacked documented evidence of the resident's request for a Foley catheter exchange using a 16 French Foley was recorded and a physician order was obtained for insertion of a 16 French catheter.The medical record lacked documentation catheter care was being provided every shift.On 05/21/2026 in the afternoon, the Unit Manager acknowledged physician orders were not followed when R2 was observed to have a 16 French catheter while the order was for a size 18 French. The Unit Manager could not speak as to why orders for catheter care every shift were not transmitted to the residents' medication administration record (MAR) so there was no documentation this was being provided routinely every shift.On 05/21/2026 at 10:31 AM, the Director of Nursing (DON) confirmed physician order were not followed based on the Unit Manager's direct observation of R2 having a 16 French Foley catheter. The DON confirmed there was no documentation of the resident's Foley catheter removal and insertion as well as routine catheter care. The DON explained documentation of catheter care did not transmit to the MAR because of an error in entering the batch order which stated, no documentation requirements. According to the DON, the resident was placed at risk for a urinary tract infection (UTI) and other catheter-related complications.The facility's Indwelling Urinary Catheter Foley Management reviewed 09/04/2025, documented based on comprehensive assessment of a resident, the facility must ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive care plan and resident's choices. Refer to [NAME] Procedural Guidance on routine care.The Lippincott procedure: Indwelling Urinary Catheter Removal and Insertion policies (undated), outlined documentation requirements to include, indication for use, assessment findings, date and time of procedure, urine characteristics, any complications, size and type of catheter and amount of sterile water in the catheter balloon.

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F 0711 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review, the facility failed to ensure the attending physician conducted an independent, thorough review of a hospital discharge summary for a resident admitted with Type one diabetes mellitus for 1 of 40 sampled residents (Resident 161). The deficient practice resulted in the resident experiencing diabetic-related complications which required rehospitalization. Findings include:Resident 161 (R161) was admitted on [DATE], with diagnoses including type one diabetes mellitus, and encounter for surgical amputation of right toe due to gangrene.The hospital Discharge summary dated [DATE], revealed R161 underwent amputation of the right third toe on [DATE]. R161 was receiving Insulin Glargine (long-acting) twice a day (BID) and Insulin Humalog (fast-acting) before meals (AC) and at bedtime (HS) following a sliding scale. R161's BG was monitored twice a day with the Insulin Glargine administration and before meals and at hour of sleep for the Insulin Humalog administration.The hospital discharge medication reconciliation dated [DATE], included Insulin Glargine (Lantus injection) 100 units/milliliter (ml) vial, 50 units subcutaneously daily. A free text med rec notes read please consider sliding scale insulin while at rehab facility. Please also consider splitting long-acting Insulin to twice daily.The medical record lacked documented evidence discharge recommendations to put R161 on an Insulin sliding scale and splitting the long-acting Insulin twice daily were reviewed and addressed by the attending physician.On [DATE] at 11:51 AM, R161's attending physician indicated expecting the admitting nurses to communicate hospital recommendations for an Insulin sliding scale. The physician indicated they would have agreed to follow hospital recommendations for an Insulin sliding scale and to divide the resident's long-acting Insulin into two administrations. The physician verbalized being under the impression the facility protocol was to perform BG checks at least three times a day for residents being admitted with a diagnosis of diabetes.A health status note dated [DATE] (5:32 AM), documented R161 was being sent out to the hospital due to a change in condition. Specifically, R161's heart rate was 32 beats per minute, hands were cold, Oxygen saturation was 82 % (normal 95% to 100%) on room air, deep rapid respirations, unable to speak due to catching breath and was lethargic. Physician called.A hospital Discharge summary dated [DATE], revealed R161 was admitted to the hospital on [DATE] with acute encephalopathy likely metabolic in the setting of DKA and stress hyperglycemia. R161 was started on an Insulin drip, placed on a DKA protocol and moved to the ICU for further assessment and management. R161 was intubated due to altered mentation and respiratory failure. Palliative care was discussed and R161 was discharged to hospice care on [DATE].A report received by the State Agency on [DATE], revealed R161 expired on [DATE] under hospice care.On [DATE] in the morning, the Regional Director of Clinical Services and the Clinical Quality Coordinator indicated physicians had an obligation to conduct a thorough independent review of the hospital discharge summary to include discharge medications, treatment services received at the hospital and free text recommendations and not merely rely on nurses.The facility's Physician Services policy reviewed [DATE], revealed each resident was supervised by a licensed physician to provide quality medical care, routine scheduled physician visits, monitor resident care and make changes as needed. Physician services include but are not limited to resident evaluation - physicians complete, sign and date comprehensive assessment history and physician within 72 hours within 24 hours prior to all admissions to the facility.Complaint 2992873