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	08/09/2024

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 50289 Based on observation, interview, record and document review, the facility failed to ensure comprehensive care plans were implemented for the management of falls for 1 of 24 sampled residents (Resident 50). The deficient practice had the potential for staff not to provide personalized care for the resident. Findings include: Resident 50 (R50) R50 was a long-term resident at the facility, with diagnoses including cholecystectomy and dementia. R50's medical records revealed a fall at the facility on 03/10/2024 at 1:15 PM. R50's comprehensive care plan revised on 03/10/2024, addressed the resident's fall and goals and interventions. The comprehensive care plan lacked implementation to monitor and care for the resident fall management. R50's medical records revealed a physical therapy consultation was suggested in the care plan on 03/10/2024, to consult for strength and mobility. On 08/08/2024 at 1:10 PM, the director of rehabilitation (DOR) explained during the Clinical Inter Disciplinary Team (IDT) meeting, if it is suggested for a therapy screening, the screen request gets put into the care plan and then it is put on the therapist's schedule to complete the following day. When the screen is completed, if it is recommended to pick up the patient, they will complete the evaluation the next day. The screening form then gets scanned into the document section of the facility's electronic documentation system for the resident and a hard copy is stored in therapy. The DOR confirmed there had not been a screening documented for this resident stored in the documentation system nor in a hard copy stored in therapy. On 08/08/2024 at 12:35 PM the director of nursing (DON) confirmed a screening was asked for in the resident care plan dated 03/10/2024. The DON stated it is expected the therapy screen/evaluation should take place within 3 to 5 business days, but preferably 72 hours from the date the screening was asked for. The DON acknowledged the screen/evaluation had not taken place for seven weeks. (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: 295076	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/09/2024
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Fall Management, reviewed 9/22/2023, documented the facility is to monitor the effectiveness of the interventions and modify the care plan as necessary, in accordance with current professional standards of practice.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interview, record review, and document review, the facility failed to ensure scheduled showers were provided to dependent residents for 1 of 24 sampled residents (Resident 246) and 2 unsampled residents (Residents 215 and 213). This deficient practice could potentially compromise resident hygiene and comfort, and increase the risk of skin breakdown and infections. Findings include: A facility policy titled Activities of Daily Living dated 02/12/2024, indicated residents would receive assistance as needed to complete activities of daily living (ADLs), including bathing. Any change in the ability to perform ADLs would be reported to the nurse. Resident 246 (R246) R246 was admitted on [DATE], with diagnoses including dementia, difficulty in walking, and muscle weakness. A Care Plan dated 07/24/2024, documented a self-care performance deficit for R246 related to dementia and disease process. Interventions included substantial assistance from one person. A Care Plan dated 07/25/2024, documented the need for assistance with activities of daily living (ADLs) to maintain or attain the highest level of function for R246. Interventions included providing assistance with ADLs as needed. On 08/06/2024 at 10:47 AM, R246 was in bed and verbally responsive. R246's hair was disheveled and resident was unshaven. A family was present at the bedside and verbalized only one shower had been provided since admission, with no sponge or bed baths during the missed showers. The family also verbalized R246 was dependent on staff for ADLs, including showers. Both the family and R246 expressed a desire to have the showers scheduled as planned. R246's medical record lacked documented evidence of a completed scheduled shower or any refusal by R246 on 08/02/2024 (the previous Friday). On 08/09/2024 at 7:55 AM, the Director of Staff Development (DSD) indicated R246's shower schedule was on Tuesdays and Fridays. The DSD confirmed there was no documented evidence of R246 receiving a shower or sponge bath on 08/02/2024, nor any record of refusal. On 08/09/2024 at 12:36 PM, the Director of Rehabilitation Services (DORS) indicated R246 was evaluated on 07/24/2024, and the assessment showed substantial assistance was required for bathing. The DORS confirmed R246 could not shower independently and was dependent on staff for assistance. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/09/2024 at 12:49 PM, a Certified Nursing Assistant (CNA) explained the shower should have been provided twice a week. The shower schedule appeared in the plan of care (POC) each day, and the actual shower tab displayed the residents own schedule. The CNA explained if a resident refused, the nurse would be informed, a reoffer made, and documentation completed. The CNA demonstrated on the tablet how to access the schedule and the POC. The CNA indicated the residents' shower schedules could be accessed either on the tablet or on the computer at the nurse station. Resident 215 (R215) R215 was admitted on [DATE], with diagnoses including dementia, fracture of upper end of the humerus (long bone in the arm) and lumbar vertebra, difficulty in walking and generalized muscle weakness. R215's ADL flowsheet for November 2023, lacked documented evidence that a shower or bed bath was provided on the following dates: -11/09/2023 (Thursday) -11/14/2023 (Tuesday) -11/16/2023 (Thursday) -11/21/2023 (Tuesday) -11/23/2023 (Thursday) R215's medical records lacked documented evidence of any refusal of a shower by R215. On 08/09/2024 at 7:58 AM, the DSD indicated R215 was admitted on [DATE], with the shower schedule on Tuesdays and Thursdays. The DSD confirmed there was no documentation showers were provided on 11/09/2023, 11/14/2023, 11/16/2023, 11/21/2023 and 11/23/2023. The DSD verified and confirmed there was no documentation of R246's refusal with showers, sponge or bed bath. On 08/09/2024 at 12:36 PM, the DORS revealed R215 was evaluated and the assessment indicated substantial assistance was required for bathing. The DORS indicated R215 could not shower independently and was dependent on staff for assistance. On 08/09/2024 at 2:08 PM, the Unit Manager (UM) explained the shower schedule was based on the resident's preference and should have been offered and provided at least twice a week. The UM confirmed the CNA was aware of how to access the POC. The UM verbalized showers were expected to be provided as scheduled and documented. The UM also mentioned if a resident refused, a bed bath or sponge bath should have been reoffered. 33980 Resident 213 (R213) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R213 was admitted on [DATE] and discharged on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left-dominant side, difficulty in walking, and muscle weakness. The Medicare 5-Day Minimum Data Set (MDS) assessment dated [DATE], documented the following: - R213 had impairment on one side of upper and lower extremity. - R213 required substantial/maximal assistance with shower/bath. The Activities of Daily Living (ADL) flowsheet documented the type of bath and the corresponding code such as SW - Shower, BB - Bed Bath, SB - Sponge Bath, and TB - Tub Bath. The appropriate code was documented on the day ADL - Bathing was provided to a resident. RR was the code when resident refused. R213's ADL flowsheet for November 2023 and December 2023 lacked documented evidence the resident received either a shower or bath on the following dates: - 11/29/2023 (Wednesday) - 12/04/2023 (Monday) - 12/06/2023 (Wednesday) - 12/25/2023 (Monday) R213's medical record lacked documented evidence the resident refused shower or bath during the above-mentioned dates, and shower or bath were provided on other days to compensate for the missed shower or bath as scheduled. On 08/08/2024 at 12:41 PM, a Certified Nursing Assistant (CNA) explained the residents were scheduled to receive either a shower, bed bath, or sponge bath twice weekly. The CNA would have documented the type of bath provided in the ADL - Bathing flowsheet including resident's refusal. The CNA would have reported to the nurse if a resident refused bathing. The CNA indicated ADL documentation including bathing/shower were entered electronically. On 08/09/2024 at 7:35 AM the Director of Staff Development (DSD) revealed R213's shower schedule was every Monday and Wednesday. The resident would have received either a shower, bed bath, or sponge during those scheduled days and would have been documented in the ADL flowsheet under Bathing. The DSD confirmed R213 should have received shower or bath on the following days as scheduled: - 11/29/2023 (Wednesday) - 12/04/2023 (Monday) - 12/06/2023 (Wednesday) - 12/25/2023 (Monday) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DSD confirmed there was no documentation R213 received shower or bath during the above-mentioned dates, and no documentation in the nurse's progress notes of resident's refusal. The DSD explained the CNAs were expected to give shower or bath to the residents as scheduled and should have documented in the ADL - Bathing including refusal. The CNAs should have reported to the nurse if a resident refused. The nurse would have talked to the resident and explained the importance or taking a shower or bath. The nurse would have documented in the progress notes if the resident still refused despite the education provided. On 08/09/2024 at 9:10 AM, the Assistant Director of Nursing (ADON) confirmed there was no ADL flowsheet for bathing in November 2023 for R213. On 08/09/2024 at 11:53 AM, the Director of Nursing (DON) indicated the CNAs were expected to give a bath to the residents as scheduled. If a resident refused, the CNAs would have reported the refusal to the nurse. The nurse would have talked to the resident to provide education. If the resident still refused, the nurse should have documented the refusal in the nurse's progress notes. The facility's policy titled Activities of Daily Living (ADLs) dated 02/12/2024, documented the resident would receive assistance as needed to complete ADLs. A resident who was unable to carry out activities of daily living would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Complaint #NV00070454 Complaint #NV00070146

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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** 46265 Based on observation, interviews, record review, and document review, the facility failed to ensure a resident with a urinary catheter had appropriate diagnosis and a bladder training program was implemented for 1 of 24 sampled residents. The deficient practice had the potential for increased risk of infection. Findings include: Resident 203 (R203) R203 was admitted on [DATE] with diagnosis including benign prostatic hyperplasia (BPH) without lower urinary tract symptoms. On 08/06/2024 at 3:29 PM, R14 was sitting in room with catheter and verbalized being treated for wound on foot and was not able to explain why catheter was needed. An admission minimum data set (MDS) assessment dated [DATE], documented resident was admitted with indwelling catheter and was not participating in a bladder training program. On 08/09/2024 at 8:01 AM, the Director of Nursing (DON) indicated when resident was admitted with catheter, would ask for bladder training, urology consult. Diagnosis should be entered with the physician order for need of catheter. The DON verbalized for catheter placement, BPH alone was not sufficient for catheter and would need to be associated with urinary retention. The DON acknowledged the diagnosis does not meet criteria for catheter placement. The medical record lacked documented evidence of a bladder training program or justification for catheter use for R203. The facility policy titled Indwelling Urinary Catheter Management (revised 06/27/2023) documented the facility would ensure residents admitted with a urinary catheter would have a determined need and medical indication. The facility must ensure a resident who enters the facility with an indwelling catheter was assessed for removal of the catheter as soon as possible.

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F 0692

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide enough food/fluids to maintain a resident's health.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40131

Based on observation, interview, record review, and document review, the facility failed to ensure the ordered fluid restriction was followed for a dialysis dependent resident and the actual fluid intake or consumption was monitored for 1 of 24 sampled residents (Resident 14). The deficient practice could have the potential to result in adverse health outcomes, including fluid overload, increased blood pressure, and complications related to the resident's dialysis treatment.

Findings include:

Resident 14 (R14)

R14 was admitted on [DATE], with diagnoses including end-stage renal disease, dependence on renal dialysis, atrial fibrillation, mitral valve insufficiency, and the presence of a cardiac pacemaker.

A physician's order dated 08/01/2024, documented a fluid restriction of 1000 milliliter per day (ml/day). The distribution was as follows: 240 ml for breakfast, 240 ml for lunch, and 240 ml for dinner from Dietary; 140 ml for days and 140 ml for nights from Nursing, each shift, for managing R14's excessive fluid retention. The order also required documentation of the amount consumed.

On 08/06/2024 at 10:30 AM, R14 was out of the facility for a hemodialysis treatment. A pink water pitcher full of water was on R14's bedside table.

On 08/06/2024 at 3:20 PM, R14 was in bed with eyes closed. A pitcher of water, containing approximately 1000 ml, was at the bedside, along with 2 bottles of Glucerna (237 ml per carton) and a cup with approximately 240 ml of a colored drink.

On 08/06/2024 at 4:10 PM, R14 was observed in bed, eating a burger. There was an open soda with approximately 350 ml remaining from a 500 ml bottle, a pitcher of water with approximately 800 ml remaining from a 1000 ml pitcher, two cartons of Glucerna (237 ml per carton), and two extra-large smoothies at the bedside. Family members were present and reported R14 had a good appetite. A Licensed Practical Nurse (LPN) confirmed the presence of the water pitcher, soda, Glucerna, and smoothies at the bedside. The LPN explained R14 was on hemodialysis and had a fluid restriction but was unaware of who had provided the water and expressed concerns about the soda.

R14's facility Weight Summary documented an increasing weights weekly:

7/31/2024 152.0 Lbs.

7/24/2024 150.0 Lbs.

7/19/2024 148.8 lbs.

The Pre/Post Dialysis Communication form dated 07/30/2024, documented to limit R14's fluid intake, R14's predialysis weight was 141 lbs. and postdialysis weight was 136 lbs., which revealed five (5) lbs. of fluids were removed.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/08/2024 at 10:19 AM, a Registered Dietitian (RD) explained the nursing staff would obtain the fluid restriction order from the physician, as advised by the dialysis center. The RD indicated the order would specify the amounts of fluids to be provided on the meal tray, and nursing staff would monitor the resident's actual fluid intake. The RD had spoken with the dialysis center's RD, who confirmed R14's fluid restriction of 1000 ml per day was appropriate due to significant fluid retention. The RD indicated R14 was at risk for congestive heart failure and swelling or edema if retaining excessive fluid, which could compromise dialysis goals. The RD explained the staff were expected to restrict fluids as ordered, but only 8 ounces were provided by Dietary. The 1000 ml water pitcher should not have been given to R14 due to the fluid restriction. The RD confirmed no fluid monitoring was in place, despite its necessity. On 07/30/2024, the dialysis center removed 5 lbs. of fluid from R14, which was excessive compared to previous dialysis days, and advised limiting fluid intake to 1000 ml/day. The RD confirmed the fluid restriction was not followed and actual fluid intake was not monitored. On 08/08/2024 at 11:18 AM, a Certified Nursing Assistant (CNA) indicated was new to the facility. The CNA explained the water pitcher was passed at the beginning and end of shifts or as requested by residents and would need to check the resident's care plan for fluid restrictions. On 08/08/2024 at 11:24 AM, another CNA, who was caring for R14 confirmed awareness R14 was on hemodialysis. This CNA indicated the pink water pitcher, containing 1000 ml, was passed throughout the day. This CNA explained R14, who was not listed as on fluid restriction in the care plan, had not been communicated as having any fluid restrictions. On 08/08/2024 at 11:32 AM, a Licensed Practical Nurse (LPN) explained if a resident was on fluid restriction, it should have been documented in the care plan. The LPN indicated fluid intake should have been measured, limited as ordered, and monitored and documented throughout the day. On 08/09/2024 at 10:28 AM, a dialysis Registered Dietitian (RD) confirmed R14's fluid intake was advised to be limited to 1000 ml or 4 cups per day due to weight gain. The dialysis RD indicated not following the fluid restriction could have resulted in severe hypertension, fluid overload, and hospitalization . The RD verbalized R14's actual fluid intake should have been monitored to assess tolerance and avoid fluid overload. On 08/09/2024 at 12:06 PM, the Director of Rehabilitation Services (DORS) indicated R14 was functional in sitting up but did not ambulate. The DORS indicated R14's upper extremities had no limitations, and both arms were within functional limits, able to reach items freely. On 08/09/2024 at 3:17 PM, the Assistant Director of Nursing (ADON) indicated the staff were expected to follow the fluid restriction orders for a dialysis-dependent resident. On 08/09/2024 at 3:17 PM, the Director of Nursing (DON) indicated the resident's non-compliance with fluid restrictions should have been care planned and education provided to the family. The DON indicated the risk for non-compliance of the fluid restriction was fluid overload. A facility policy titled Physician Orders revised 03/10/2023, documented the facility was obligated to follow and carry out the orders of the prescriber in accordance with all applicable state and federal guidelines. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Hemodialysis Offsite dated 08/23/2023, documented to observe fluid restriction as ordered by the physician. Nutritional/Fluid management including documentation resident compliance with food/fluid restrictions and monitoring intake as ordered. Follow routine dialysis instructions on dialysis form.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33980 Based on interview, record review and document review, the facility failed to account for narcotics (opioid) signed out on the controlled drug record for one unsampled resident (R213). The deficient practice had the potential to delay a resident's pain management and increase the risk for physical and psychosocial harm. Findings include: Resident 213 (R213) R213 was admitted on [DATE] and discharged on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left-dominant side, difficulty in walking, and muscle weakness. The physician's order dated 11/28/2023, documented Hydrocodone-Acetaminophen (a controlled substance/opioid) Oral Tablet 5-325 milligram (mg) give one tablet by mouth every four hours as needed for pain level 4-6 (moderate). On 08/07/2024 at 3:20 PM, the Assistant Director of Nursing (ADON) indicated the Controlled or Antibiotic Drug Record (narcotic log) for R213's Hydrocodone-Acetaminophen 5-325 mg for November 2023, December 20, 2023 to December 31, 2023, and January 2024 could not be located. The ADON confirmed the facility only had a copy of the narcotic log for R213's Hydrocodone-Acetaminophen 5-325 mg from 12/01/2023 to 12/19/2023. R213's Medication Administration Record (MAR) for December 2023 and January 2024, documented the resident had received Hydrocodone-Acetaminophen 5-325 mg one tablet occasionally from 12/20/2023 to 01/24/2024. The narcotic log for R213's Hydrocodone-Acetaminophen 5-325 mg from 12/01/2023 to 12/19/2023, documented the medication was signed out to be administered on the following dates and times: - 12/01/2023 at 11:42 PM. - 12/03/2023 at 9:00 PM. - 12/09/2023 at 10:00 PM. - 12/19/2023 at 12:00 PM. R213's MAR for December 2023 lacked documented evidence Hydrocodone-Acetaminophen 5-325 mg one tablet was administered to the resident when the medication was signed out on the above-mentioned dates and times. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/08/2024 at 8:42 AM, a Licensed Practical Nurse (LPN) explained the narcotic log would have been filled out with the date, time, and signature of the nurse who pulled out the medication from the supply/stock. The MAR would have been signed every time the medication was administered to the resident to ensure the record between the narcotic log and MAR was reconciled. On 08/09/2024 at 12:04 PM, the Director of Nursing (DON) indicated the nurses were expected to document in the narcotic log every time they pulled out a narcotic medication from the stock. The nurses had to sign out in the narcotic log. The medication should have been administered to the resident, then the nurses should have documented in the MAR for the medication as given. If the resident refused the medication, the nurses should have documented the medication as wasted in the narcotic log and should have been witnessed by two nurses. The resident's refusal should have been documented in the MAR. The DON explained the copies of the narcotic log should have been submitted to the medical records. The facility's policy titled Management of Controlled Substances dated 08/29/2023, documented the facility would maintain a system to account for controlled medications' receipt and disposition in sufficient detail to enable an accurate reconciliation, and the facility would conduct a periodic reconciliation. The facility should routinely reconcile the number of doses remaining in the package to the number of doses recorded on the Shift Change Controlled Substance Inventory Count Sheet, to the medication administration record.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46265 Based on interviews, record review, and document review, the facility failed to ensure a physician order to discontinue medication was completed for 1 of 24 sampled residents. The deficient practice had the potential for adverse effects on the resident and unnecessary medications. Findings include: Resident 14 (R14) R14 was admitted on [DATE] with diagnoses including end stage renal disease, dependence on renal dialysis. A pharmacist consultation report documented R14 medication regimen was reviewed on 07/23/2024 with the recommendation to discontinue the medication Spironolactone as it was contraindicated for residents on dialysis. A physician response dated 07/29/2024 documented agreement with pharmacist recommendation and indicated the medication would be discontinued on 07/29/2024. The medication administration record indicated Spironolactone was a current and active medication with the most recent dose given on 08/08/2024. On 08/08/2024 in the afternoon, a Licensed Practical Nurse (LPN) indicated R14 was still receiving Spironolactone. On 08/09/24 at 7:49 AM, the Director of Nursing verbalized the process for pharmacist review and recommendation was to ensure resident was not receiving unnecessary medications. The pharmacist would complete a review monthly and provide any recommendations as needed. The information was sent by email to the Director of Nursing and Assistant Director of Nursing. If there was a recommendation it would be sent directly to the physician for review. The DON explained the Unit Manager was responsible to ensure the physician response was documented and if any changes were required it would be completed. The DON indicated the Spironolactone order was changed several times during R14's stay however the resident was still receiving the medication and it should have been discontinued based on recommendation and physician response. The facility policy titled Pharmacy Services and Medication Regimen Review (reviewed 08/28/2023) documented the pharmacist must report any irregularities to the attending physician, the facility medical director, and director of nursing and the reports must be acted upon.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295076	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/09/2024
NAME OF PROVIDER OR SUPPLIER Life Care Center of South Las Vegas		STREET ADDRESS, CITY, STATE, ZIP CODE 2325 E. Harmon Ave. Las Vegas, NV 89119	

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33980 Based on observation, interview, record review and document review, the facility failed to ensure it was free of a medication error rate of five percent (%) or greater for one unsampled resident (Resident 37). Failure to administer medications as prescribed could have delayed the therapeutic treatment for the resident. Findings include: On 08/08/2024 in the morning, a Medication Administration Pass observation was performed with 27 opportunities observed and revealed two errors. The medication error rate was 7.41%. Resident 37 (R37) Resident 37 was admitted on [DATE], with diagnoses including chronic kidney disease, acute kidney failure, and polyneuropathy. On 08/08/2024 at 8:00 AM, during the Medication Administration Pass observation, a Licensed Practical Nurse (LPN) prepared and administered the following medications to R37: - Heparin 5,000 units subcutaneous (SQ/injection) - Budesonide Suspension 0.5 milligram (mg)/2 milliliter (ml) inhale orally - Cholestyramine one packet 4 grams by mouth - Famotidine 20 mg one tablet by mouth - Ferrous Sulfate one tablet 325 mg by mouth - Fluticasone Propionate Nasal Spray 50 microgram one spray in both nostrils - Gabapentin 100 mg 1 capsule by mouth The LPN indicated there was a total of three tablets and capsule prepared and administered to Resident 37 during the Medication Administration Pass observation (Famotidine tablet, Ferrous Sulfate tablet, and Gabapentin capsule). The physician's order dated 07/16/2024, documented Gabapentin Oral Capsule 100 mg, give two capsules by mouth three times a day for neuropathy. The physician's order dated 07/31/2024, documented Oxybutynin Chloride Oral Tablet 5 mg, give one tablet by mouth every 12 hours for bladder spasm. The Medication Administration Record (MAR) for August 2024, indicated Oxybutynin Chloride Oral Tablet 5 mg scheduled at 8:00 AM was documented as administered to R37 on 08/08/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295076	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/09/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/08/2024 at 10:35 AM, the LPN confirmed one capsule of Gabapentin 100 mg was administered to R37 and Oxybutynin 5 mg was not given to the resident during the Medication Administration Pass observation. The LPN confirmed Oxybutynin 5 mg was signed in the MAR as given. The LPN acknowledged two capsules of Gabapentin 100 mg and Oxybutynin 5 mg should have been administered to the resident. On 08/09/2024 at 12:20 PM, the Director of Nursing (DON) indicated the nurses were expected to verify the five rights in medication administration including right dosage and right medication. The DON explained the nurses were expected to verify the orders and MAR before medication administration. The facility's policy titled Administration of Medications dated 08/24/2023, documented the facility would ensure medications were administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms. Staff who were responsible for medication administration would check the MAR and the doctor's order before medicating.

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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 - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50289 Based on observation, interview and document review, the facility failed to ensure stored foods were labeled and dated and food items were stored properly. This deficient practice posed a potential risk to safety and health standards which could lead to contamination, inadequate storage, and place residents at risk of foodborne illness. Findings include: On 08/06/2024 at 7:46 AM, open bags of green beans, asparagus, and peppers & onion mix were stored in the walk-in freezer without a date as to when the bag was opened. The Dietary Manager explained the open bagged items should have been dated as to when the bag was opened and then placed back in the freezer. On 08/06/2024 at 8:01 AM, a bottle of lemon juice, Jello packets, and canned pimentos were missing received on dates in the dry storage area. Also, silk, a milk substitute, was stored in the reach in cooler without a lid. The Dietary Manager explained the items in the dry storage area should have been dated as to when the items were received from the [NAME] and the silk should have been covered before placing back in the reach in cooler. On 08/07/2024 at 8:55 AM, a jug of pink liquid was in the reach-in cooler without a label as to what it was and no date as to when it was made/poured. There were also employee drinks (vitamin waters) stored in the reach-in cooler. The Dietary Manager explained the pink liquid should have been labeled and dated and the employee drinks should not have been stored in the reach-in cooler. On 08/07/2024 at 9:05 AM, cookie dough ice cream was found in a container of cookie dough in the ice cream shop's reach-in freezer. The Activity Director stated was not sure how or why the cookie dough ice cream got into the container of cookie dough. A document titled Food Safety, reviewed on 05/01/2024 revealed the following: -original food containers that are considered to be 'disposable' (e.g., cottage cheese containers) are not reused. -pre-packaged food is placed in leak-proof, pest-proof, non-absorbent, sanitary (NSF) container with a tight-fitting lid. The container is labeled with the name of the contents and date (when the item is transferred to the new container). 'Use by date' is noted on the label or product when applicable. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- associate food will not be stored with resident food. - food is labeled with the date received if not already indicated on the item. - leftovers are dated properly and discarded after 72 hours unless otherwise indicated.