STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295086	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Las Ventanas Retirement Comm Snf	10401 West Charleston Blvd Las Vegas, NV 89135

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33980 Based on interview, record review and document review, the facility failed to ensure the resident and/or resident's family were informed about the resident being placed on isolation (transmission-based precautions) upon admission for 1 of 15 sampled residents (Resident 46). The deficient practice had the potential for the facility not respecting the rights of the resident to be fully informed about their treatment. Findings include: Resident 46 (R46) R46 was admitted on [DATE], with diagnoses including epilepsy and abnormal findings of blood chemistry. On 07/09/2024 at 12:17 PM, R46's family member indicated nobody explained to the resident and resident's family about R46 being on isolation upon admission. The family member revealed nobody from the facility explained why the resident was on isolation. The family member confirmed R46 had tested negative for COVID-19. R46's Face Sheet (demographics) documented the family member was the resident's emergency contact and next of kin. R46's medical record lacked documented evidence the resident and/or resident's family was notified about the resident being placed on isolation upon admission. On 07/10/2024 at 12:56 PM, the Infection Preventionist (IP) Nurse confirmed the findings and revealed R46 was admitted on [DATE] at night and was placed on isolation upon admission due to loose stools. The IP Nurse indicated R46 had tested negative for COVID-19. The IP Nurse explained the nurses were expected to notify the resident or resident's family/responsible party (RP) if isolation was warranted. During admission, the charge nurse or admitting nurse was responsible to inform the resident or resident's family/RP in real time and document such notification in the progress notes. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The IP Nurse revealed R46 was placed on contact/droplet precautions (transmission-based precautions) upon admission on 06/17/2024 and the isolation was discontinued on 06/19/2024. The IP Nurse provided the line listing form (infection surveillance) which corroborated the interview. The IP Nurse confirmed the Progress Notes dated 06/19/2024 (when the isolation was discontinued), documented the Admission Nurse explained to R46 and resident's family member about the contact/droplet precautions. The IP Nurse acknowledged the notification should have been done on 06/17/2024 upon R46's admission and when the resident was placed on isolation. On 07/10/2024 at 2:31 PM, R46 was sitting in a wheelchair inside the resident's room. R46 indicated being placed on isolation upon admission but nobody explained the reason for the isolation. R46 revealed being scared when people were coming inside the room wearing a gown and with mask and gloves on. The resident was told there was an isolation sign by the door. R46 indicated coming from the hospital prior to admission and the resident was aware of having no infection and negative for COVID-19. On 07/10/2024 at 2:34 PM, the Admission Nurse indicated would have informed the resident or the resident's family within the shift when a resident was placed on isolation upon admission. The Admission Nurse explained the notification would have been documented in the progress notes. On 07/11/2024 at 8:02 AM, the Director of Nursing (DON) indicated the nurse who determined to put a resident on isolation should have informed the resident about the reason for the isolation and the necessary precautions to be taken. The notification should have been done in real time or when it was determined the resident needed to be on isolation. Either the admission nurse, charge nurse, medication nurse, or nursing management could have talked to the resident as long as they were the one who determined the resident should be placed on isolation. The facility's policy titled Resident Rights dated February 2021, documented the residents had the right to be notified of their medical condition and of any changes in their condition. The residents had the right be informed of and participate in their care planning and treatment.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40142 Based on interview, record review, and document review, the facility failed to follow the resident's choice for comfort-focused treatment for 1 of 3 sampled closed records (Resident 159). The failed practice resulted in a non-emergent hospital transfer which potentially caused the resident discomfort and distress. Findings include: Resident 159 (R159) R159 was admitted on [DATE], with diagnoses including malignant neoplasm of lungs and cachexia (wasting syndrome). A Provider Order for Life-Sustaining Treatment (POLST) dated 07/02/2024, documented in the event of a cardiopulmonary arrest, R159 elected not be resuscitated (DNR), allow natural death. The document revealed R159 desired comfort-focused treatment with a goal of maximizing comfort through symptom management. Transfer to hospital only if comfort needs cannot be met in current location. A physician's order (undated), documented do not transfer R159 to acute hospital per family member request. A nursing progress note dated 07/04/2023, revealed a certified nursing assistant (CNA) found R159 unresponsive at 7:00 PM and notified the nurse. The nurse assessed R159 who was found to have a blood pressure (BP) of 110 millimeters of mercury mmHg/52 mmHg, heart rate (HR) of 83, Oxygen saturation (O2Sat) of 94% on two liter of Oxygen via nasal cannula and temperature of 98.4 degrees Fahrenheit. Charge nurse was notified, 911 called. Paramedics arrived at 7:10 PM and left with R159 at 7:30 PM. Physician and family member made aware of the situation. A nursing progress note dated 07/04/2023, documented an emergency department nurse called to inform the facility R159 was going to be transported back to the facility. R159's family member arrived at the hospital, spoke with physician and no interventions were done due to R159's DNR status. A nursing progress note dated 07/04/2023, documented R159 arrived at facility at 10:46 PM with transport staff and a family member. Resident still unresponsive. A provider progress soap note dated 07/05/2024, revealed R159's family member was very upset due to the facility transferring R159 to the hospital on 07/04/2024 due to unresponsiveness. R159 was sent to the hospital where no interventions were done and was sent back to the facility. R159's family member emphasized to the nurse practitioner (NP) R159 was a DNR and wanted comfort measures only and no aggressive treatment. R159's family member agreed to a hospice evaluation. A hospice nurse came to evaluate R159 on 07/05/2023. A nursing progress note dated 07/05/2023, revealed R159 was pronounced at 8:29 PM. NP and family member notified. Coroner approved release of body to mortuary. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/10/2024 at 10:45 AM, the NP reviewed R159's POLST and indicated if R159 was found unresponsive, with stable vital signs and there were no signs and symptoms of discomfort or distress, the NP would have told the nurse to contact the family member who should make the decision on whether to transfer the resident to the hospital. The NP reviewed R159's medical record and indicated it appeared the Registered Nurse (RN) seemed to have called 911, transferred R159 to the hospital and notified the NP and the family member after the fact. The NP emphasized residents who elected DNR on their POLST may still be sent out to the hospital if they were in acute distress such as unrelieved pain, respiratory distress, or bleeding but if R159 was not showing signs of distress and was just unresponsive, the NP repeated the RN would have been instructed to ask the family member to decide as long as the RN notified the NP first. On 07/10/2024 at 2:27 PM, the RN who was assigned to R159 on the night of the incident recalled being notified by a CNA regarding R159 being found unresponsive. The RN went inside the room and assessed R159 who was found to be unresponsive with stable vital signs and no signs of discomfort. The RN indicated not checking R159's code status but assumed the charge nurse who was notified of the incident may have confirmed R159's code status. The RN indicated it was difficult to recall the sequence of events but based on the RN's documentation, the RN indicated being the one to call 911, and contacting the NP and R159's family member after the resident had already left. The RN recalled R159's family member was very upset upon learning R159 was transferred to the hospital and told the nurse R159 should not be sent to the hospital unless the resident was in actual distress. The RN emphasized R159 was not in any distress or discomfort during this time but was merely unresponsive. On 07/10/2024 at 2:52 PM, the charge RN who was on duty on the night of the incident indicated not being able to recall whether the RN notified the charge RN regarding R159's condition, or asked the charge RN to confirm R159's code status. The charge nurse indicated expecting the RN to assess the resident and when the resident was assessed to be unresponsive with stable vital signs and not in acute distress, the correct thing to do next would be for the RN to call the provider. The charge nurse indicated nurses can transfer residents to the hospital prior to physician notification only in emergent situations such as hypoxia, traumatic injury, bleeding episodes, etc. R159's situation was not considered emergent and so the physician should have been notified first before the transfer to the hospital. On 07/10/2024 at 2:55 PM, the Director of Nursing (DON) indicated when the RN assessed R159 to be unresponsive with stable vital signs, the RN should have confirmed the resident's code status and contact the physician once all pertinent information has been gathered. The DON indicated based on the RN's documentation, it appeared the RN called 911 and sent R159 to the hospital prior to notifying the physician. The DON stated because the RN did not notify the NP prior to R159's hospital transfer, there may have been missed opportunity in involving the resident's family member in the decision-making process to ensure the resident's treatment wishes were honored. The Change in Condition policy revised February 2021, documented the facility would promptly notify the resident, the attending physician, and the resident representative of changes in the resident's condition or status. Prior to notifying the physician, the nurse will make detailed observations and gather relevant and pertinent information for the provider including information prompted by the SBAR (situation, background, assessment, recommendation) communication form. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Advanced Directives policy revised September 2022, documented the physician order for life-sustaining treatment (POLST) recorded a resident's treatment wishes and were communicated to direct care staff and physician by placing the document in a prominent, accessible location. Facility staff were not required to provide care which conflicts with the resident's advanced directives. Complaint #NV00069770

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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** 33980 Based on observation, interview and record review, the facility failed to ensure a physician's order for an indwelling urinary catheter (Foley catheter) included the medical justification and the physician's orders were obtained to include all components of a Foley catheter care for 1 of 15 sampled residents (Resident 26). The deficient practice had the potential for the resident to acquire infection and unnecessary use of a Foley catheter. Findings include: Resident 26 (R26) R26 was admitted on [DATE], with diagnoses including aphasia following cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and functional quadriplegia. On 07/09/2024 at 9:25 AM, R26 was lying in bed and was observed to have an indwelling urinary catheter in place. The physician's orders dated 06/15/2024, included the following: - Urinary Catheter: 16 French (catheter size) 10 bulb indwelling catheter - Urinary Catheter Care: Cleanse with soap and water every shift. Empty Foley bag every shift for urinary retention. R26's medical record lacked documented evidence of a physician's order which included the medical justification for the use of the Foley catheter and physician's orders were obtained on when to change the Foley catheter and the urinary catheter bag. On 07/11/2024 at 2:22 PM, the Infection Preventionist (IP) Nurse explained the nurses were expected to obtain physician's orders for the Foley catheter use with a medical diagnosis (justification) to support the use of the Foley catheter, for monitoring the output, and for changing the Foley catheter as needed (PRN) or when clogged. The IP Nurse confirmed there was no medical diagnosis written in the physician's order for R26's Foley catheter. The IP Nurse indicated the need to check the order set for Foley catheter care and the facility's policy. On 07/11/2024 at 2:33 PM, a Registered Nurse (RN) revealed the nurses should have obtained the physician's orders for Foley catheter use which included the size of the Foley and the medical justification for the use of Foley such as urinary retention. The RN indicated the physician's orders for Foley catheter care should have been obtained which included to clean with soap and water every shift, empty Foley bag every shift, monitor and document output every shift, change the Foley bag every month and PRN, and change Foley catheter PRN. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/11/2024 at 2:43 PM, the IP Nurse explained the order set for Foley catheter care included to change the Foley catheter and the urinary drainage bag PRN. The IP Nurse indicated the physician's order should have included the medical diagnosis to support the use of the Foley catheter. The IP Nurse confirmed there were no physician's orders obtained to change the urinary drainage bag and the Foley catheter as needed for R26.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40142 Based on observation, interview, record review and document review, the facility failed to ensure a physician's order was obtained for an insertion of a peripheral intravenous (IV) access and care orders were entered and documented for the IV access for 1 of 15 sampled residents (Resident 161). The deficient practice placed the resident at risk for phlebitis (site infection). Findings include: Resident # 161 was admitted on [DATE], with diagnoses including right femur fracture with routine healing. On 07/09/2024 at 10:18 AM, R161 was seated in wheelchair watching television. A single lumen peripheral IV access was observed in R161's left forearm. The IV insertion site was covered with transparent dressing with white paper tape on each side. The dressing was not signed and dated and red drainage was observed around the insertion site. An IV pump was observed on the left side of the resident's bed. On 07/09/2024 at 10:20 AM, R161 indicated sustaining a fall-related fracture which required surgery and R161 was receiving antibiotics to prevent an infection since the surgical site still had drainage. R161 indicated the IV access was inserted at this facility a few days ago for IV antibiotic administration. A physician's order dated 07/03/2024, documented to give Cefepime hydrochloride IV solution two grams per 100 milliliter solution every 12 hours for right hip surgical drainage for seven days from 07/03/2024 until 07/10/2024. The medical record lacked documented evidence a physician's order to insert a peripheral IV access and care orders were entered and carried out for the IV access such as site monitoring and flushing. On 07/09/2024 at 10:29 AM, a Licensed Practical Nurse (LPN 1) confirmed by direct observation R161's IV access was unsigned, undated and had bloody drainage around the insertion site. The LPN indicated the facility policy was for peripheral lines to be replaced every 72 hours, so it was important to know when the peripheral line was inserted. On 07/11/2024 at 7:42 AM, LPN 2 indicated being assigned to R161 on 07/03/2024 but the LPN indicated not being the nurse who inserted R161's IV access and the line may have been inserted by night shift. LPN 2 explained a peripheral IV insertion required a physician's order and the nurse who inserted the IV access was responsible for entering care orders such as flushing and site monitoring every shift and replace every 72 hours or as needed when soiled, leaking and loose dressing. LPN 2 reviewed R161's medical record and confirmed there was no documentation a physician's order was obtained to insert an IV line and there were no care orders such as site monitoring and flushing every shift and remove and replace the IV access every 72 hours or as needed. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/11/2024 at 9:00 AM, the Director of Nursing (DON) indicated a physician's order was required for insertion of a peripheral line. According to the DON, the nurse who inserted the IV access was responsible for entering care orders such as site monitoring and flushing every shift. The DON stated the facility protocol was for nurses to sign and date all IV dressings so other nurses may know when the peripheral line was due to be replaced since peripheral IVs were meant for short term use and should be replaced every 72 hours. The DON reviewed R161's medical record and confirmed there were no orders to place R161's IV access and there were no care orders such as flushing, site assessment and replacing every 72 hours and as needed. The DON indicated consequences to not following the facility policy on IV site care was potential infection. The Peripheral IV Catheter Insertion policy revised February 2022, documented a physician's order was necessary for this procedure. Once inserted, label the dressing with date and initials.

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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** 46265 Based on observations, interviews, record review, and document review, the facility failed to ensure the medication error rate was below five (5) percent (%) when three errors were identified with 40 opportunities observed, calculating an error rate of 7.5 %. The deficient practice posed a potential risk of injury or harm to the resident. Findings include: The facility policy titled Administering Medications (2001) documented medications were administered in accordance with prescriber orders. The individual administering the medication would check the label three times to verify the right resident, right medication, right dosage, right time, and right method of administration before giving the medication. On 07/10/2024 in the morning, a medication administration pass observation was performed with 40 opportunities observed and revealed three errors. The medication error rate was 7.5%. Resident 46 (R46) R46 was admitted on [DATE] with diagnoses including epilepsy, hyperlipidemia, and osteoporosis. 1. On 07/10/2024 in the morning, during the medication administration pass observation, a Registered Nurse (RN1) administered medications to R46 including Psyllium Husk Powder (Metamucil). RN1 used small plastic teaspoon to scoop powder into a five-ounce cup and filled with water and mixed. 2. RN1 appeared to be ready to take medications to R46 and the surveyor questioned the amount of liquid mixed with the powder. RN1 revealed thinking the cup being used was eight ounces and transferred medication to larger cup and mixed in an additional three ounces of water. A physician order dated 06/26/2024 documented Psyllium Husk Powder give one tablespoon by mouth one time a day for bowel management. The product information label documented to mix powder with eight ounces of liquid. RN1 indicated all medications and supplements require a physician order and should be followed along with the product information label for powder mixtures. On 07/11/24 at 8:05 AM, the Director of Nursing (DON) indicated when administering medication or supplements which require mixing with water staff should follow the product guidelines unless a physician order specifies a different amount of water. Resident 4 (R4) R4 was admitted on [DATE] with diagnoses including legal blindness and hypertension. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 07/10/2024 in the morning, during medication administration pass observation, a Registered Nurse (RN2) administered R4's medication including PreserVision AREDS 2, giving R4 two capsules. A physician order dated 08/29/2023 documented PreserVision AREDS 2 oral capsule, give one capsule by mouth one time a day for eye supplement. On 07/10/2024 at 2:34 PM, RN2 revealed thinking RN2 only gave one pill however all medications should be given based on physician orders and would need to be clarified if given outside of the orders and any errors documented. On 07/11/2024 in the afternoon the Assistant Director of Nursing and Director of Staff Development indicated all medications should have a physician order and nursing staff were expected to follow order or clarify medication order as needed.

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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. 33980 Based on observation, interview and document review, the facility failed to maintain sanitary condition in the kitchen and failed to ensure 1 of 2 refrigerated juice dispensers was holding the juice cold in the storage chamber. The deficient practice could potentially result to cross-contamination in food preparation and posed a potential risk to safety and health standards. Findings include: Unsanitary condition in the kitchen On 07/09/2024 at 8:48 AM, the following were observed during the initial tour of the kitchen: - The cook's line ventilation hood filters were heavily soiled with gross build-up above the grill. - There was grease build-up on the underside of the griddle. - There was dust build-up in the crevices of the range (stove). The Director of Dining Services was present during the observations and acknowledged the surfaces and equipment in the kitchen should have been maintained in a sanitary condition. The Director of Dining Services explained the kitchen staff were responsible in cleaning the surfaces and equipment in the kitchen. The facility's policy titled Area and Equipment Cleaning revised in January 2023, documented the Maintenance Department was scheduled to clean equipment which required special training and equipment such as the ice maker, refrigeration coils and exhaust hood. Written procedures were available, detailing daily and weekly (as needed) cleaning for all areas and equipment in the department. Juice Dispenser On 07/09/2024 at 8:57 AM, the refrigerated juice dispenser (juice machine) in the second floor satellite kitchen, was not holding the juice cold in the storage chamber. Juice was dispensed at 69.2 degrees Fahrenheit. The Director of Dining Services confirmed the observation and acknowledged the temperature of the juice dispensed from the machine should have been in the 40's (degrees Fahrenheit). The Director of Dining Services explained the juice dispenser should have been repaired. On 07/11/2024 at 12:33 PM, the Director of Dining Services confirmed the best quality of the juice dispensed in the juice machine should have been at a temperature of 45 degrees Fahrenheit and below. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled Equipment Maintenance Program revised in January 2023, documented the Director of Food and Nutrition Services, jointly with the Maintenance Department, would plan in writing a program of preventive maintenance for all Food/Nutrition equipment requiring regular maintenance. The program included the regular inspection/maintenance by the Maintenance Department, and periodic servicing by service companies contracted through the Maintenance Department.