

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  295095	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/09/2025
NAME OF PROVIDER OR SUPPLIER  Sandstone Spring Valley		STREET ADDRESS, CITY, STATE, ZIP CODE  5650 South Rainbow Blvd Las Vegas, NV 89118	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51395</b></p> <p>Based on observations and interview, the facility failed to ensure a resident was treated with dignity and respect by facility staff directing the resident to urinate in their incontinence brief for 1 of 16 sampled residents (Resident 3). The deficient practice had the potential to negatively impact the resident's well-being.</p> <p>Findings include:</p> <p>Resident 3 (R3)</p> <p>R3 was admitted on [DATE] with diagnoses including hypertension, end stage renal disease with hemodialysis, and congestive heart failure.</p> <p>On 01/07/2025 at 9:22 AM, a Certified Nursing Assistant (CNA) verbalized the staff are not supposed to tell incontinent residents to go to the bathroom in their briefs, however it does occur.</p> <p>On 01/07/2025 at 9:32 AM, Resident 5 (R5) verbalized having been told to urinate on themselves in the past. R5 verbalized feeling upset about it and has heard other residents have been told the same but cannot speak for them.</p> <p>On 01/07/2025 at 3:52 PM, R3 verbalized one CNA on the night shift told the resident if had to wait for the CNA, then just go in the brief, that is why briefs are worn. R3 verbalized this makes the resident want to cry at night and makes the stay at the facility difficult.</p> <p>On 01/07/2025 at 4:08 PM, the Director of Nursing (DON) verified it would not be appropriate for staff to direct a resident to urinate or defecate in their brief and staff would need to assist the resident to the bathroom as needed. The DON verbalized by directing a resident in this manner would result in dignity issues.</p> <p>Complaint #NV00073092</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51395</p> <p>Based on record review and interview, the facility failed to clarify discrepancies in the appeal decision resulting in a resident being discharged and lacked documented evidence of well-coordinated discharge planning for 1 of 16 sampled residents (Resident 4). The deficient practice had the potential for a resident not to receive the necessary skilled therapy to improve functional ability and provide the necessary provisions for continuation of care.</p> <p>Findings include:</p> <p>Resident 4 (R4)</p> <p>R4 was admitted on [DATE] and discharged on [DATE] with diagnoses including difficulty in walking, chronic osteomyelitis of right ankle and foot, contracture of muscle right lower leg, and limitations of activities due to disability.</p> <p>The Admission Minimum Data Set (MDS) dated [DATE] documented R4 had lower extremity (hip, knee, ankle, foot) functional limitations in range of motion with impairment on both sides.</p> <p>The Physical Therapy Evaluation and Plan of Treatment dated 08/23/2024 documented 100+ degrees flexion contracture (knee is bent at a fixed angle preventing it to be straightened fully) of right and left knees with right side greater than left.</p> <p>The Detailed Explanation of Non-coverage dated 11/09/2024 documented R4 was able to walk 100 feet without an assistive device, with one person watching the resident.</p> <p>A Beneficiary and Family Centered - Quality Improvement Organization (BFCC-QIO) Determination letter dated 11/09/2024 documented a review of the medical records showed the resident is walking 100 feet without an assistive device with supervision. The documentation does not support the need for daily skilled therapy services. Continued Skilled Nursing Facility coverage is not needed because the resident does not require daily skilled therapies.</p> <p>The Physician Discharge Summary dated 11/21/2024 documented gait (pattern of how a person walks) instability and continue physical therapy for gait training.</p> <p>The Interdisciplinary Team (IDT) Functional Abilities Discharge document dated 11/25/2024 documented R4's discharge performance for ability to walk ten feet: once standing, the ability to walk at least ten feet in a room, corridor, or similar space as not attempted due to medical condition or safety concerns.</p> <p>On 01/09/2025 at 9:24 AM, the Director of Rehabilitation (DOR) verbalized upon admission R4 was unable to walk due to bilateral lower extremity contractures, upon discharge R4 was still unable to walk. The DOR stated being unsure why the appeal decision would state R4 was able to walk 100 feet.</p> <p>On 01/09/2025 at 9:37 AM, the Case Manager stated the facility process when a resident makes an appeal to the discharge decision, was as follows:</p> <p>(continued on next page)</p>

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1) Submit the required records electronically to the insurance provider.</p> <p>2) When the insurance determination was received, staff would review the decision and provide the resident with the information.</p> <p>The Case Manager verified for R4 this review did not occur. The case manager verbalized providing R4 with the letter without reviewing the explanation for the decision.</p> <p>On 01/09/2025 at 9:58AM, the Case Manager recalled discussing discharge with R4 and their spouse stating the spouse was concerned due to not being able to provide care for R4 resulting in a decision for hospice services. The Case Manager acknowledged the discharge discussion was not documented, and care giver training did not occur.</p> <p>On 01/09/2025 at 12:00 PM, the Case Manager verbalized R4 was financially overqualified for Medicaid services and R4 declined additional placement options such as a group home. The Case Manager stated R4 was provided with care giver services information and agreed to discharge home with hospice services. The Case Manager acknowledged the medical record lacked documentation of the discussion.</p> <p>On 01/09/2025 at 12:15 PM, the DOR verbalized upon admission R4 stated their spouse was able to provide care. However, when therapy contacted the spouse, the spouse indicated were not able to provide care therefore caregiver training did not occur. The DOR acknowledged the medical record lacked documentation regarding the discussion.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51342</b></p> <p>Based on observation, interview, record review and document review, the facility failed to ensure showers were provided as scheduled for 1 of 16 sampled residents (Resident 14). The deficient practice had the potential to increase skin breakdown, infections, odor and bacteria buildup.</p> <p>Findings include:</p> <p>Resident 14 (R14)</p> <p>R14 was admitted on [DATE], with diagnoses of major vascular neurocognitive disorder- dementia.</p> <p>A Therapy to Nursing communication form dated 01/06/2024, documented the resident is front weight bearing with transfer and the resident had an assessed device of a rolling walker. The resident needed supervision for grooming, oral care, upper body dressing and footwear, moderate assistance with toileting, minimal assistance with showering and lower body dressing. The resident is independent with communication, vision and feeding.</p> <p>On 01/07/2025 at 4:50 PM, Director of Medical records provided two shower sheets which documented on 01/08/2024, the resident had a bed bath and on 01/16/2024 the resident had a shower.</p> <p>On 01/07/2025 at 2:38 PM, Employees 16 and Employee 17 (E16 and E 17) clarified if a resident would refuse a shower or bed bath, the CNAs would notify the nurse and document the event.</p> <p>E16 provided the shower schedule for R14's unit which documented showers are scheduled for morning and evening shift. E16 voiced resident showers are two days a week. E16 voiced if a resident had an accident after ADL care and the family requested for incontinent care the care would be completed immediately.</p> <p>On 01/09/2025 at 8:31 AM, an observation of the shower schedule on the unit where the resident was housed indicated showers are designated twice a week, which are on Mondays and Thursdays.</p> <p>On 01/09/2025 at 8:50 AM, review of January 2024 calendar revealed R14 did not receive a shower or bed bath on the scheduled shower days. R14 had missed scheduled showers for the week of 01/11/24 through 01/15/24, a shower for 01/18/2024 and 01/22/2024. The documents, which were provided by the Director of Medical Records, indicated the resident received a bed bath on 01/08/2024, a shower on 01/16/2024, and a skin assessment on 01/22/2024.</p> <p>On 01/09/2025 at 10:22 AM, Employee 18 (E18) clarified residents on the Mount [NAME] Unit receives showers twice a week. E18 stated the shower schedule is arranged between morning shift and evening shift. E18 expressed if a resident refused a shower or a bed bath the nurse would be notified and documentation on a shower sheet must be present, E18 expressed the resident would sign the shower sheet along with the CNA. E18 confirmed if the resident is unable to sign the shower sheet the assigned nurse would sign the shower sheet.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/09/2025 at 12:20 PM, the Director of Nursing (DON), stated the expectation for resident's personal hygiene and showers are important and has scheduled shower days. The DON confirmed the facility does expect the staff to accommodate the resident's preferences if requested for a later shower or bed bath. The DON voiced the staff can provide bed baths if the residents refuse a shower on the scheduled day.</p> <p>On 01/09/2025, facility policy titled Quality of life activities of daily living (ADL's) maintain abilities dated 11/2017, documented the facility provides the necessary care and services to support the resident's care needs. The policy clarified that residents are given the appropriate treatment and services to maintain the ability to carry out activities of daily living, including hygiene care of bathing, grooming, dressing and oral care. The policy also indicated if a resident is unable to carry out activities of daily living receives the necessary services to maintain good grooming, personal hygiene and oral hygiene.</p> <p>On 01/09/2025, facility policy titled Bed and Shower, adopted on 05/01/2024, documented the facility policy is to promote cleanliness, stimulate circulation and assist in relaxation.</p> <p>Complaint #NV00071075</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51342</p> <p>Based on observation, interview and document review, the facility failed to ensure two free standing portable oxygen cylinders were safely stored. The deficient practice had the potential to prevent avoidable accidents and increase concerns of potential harm to residents and the facility overall.</p> <p>Findings include:</p> <p>On 01/07/2025 at 8:42 AM in resident room [ROOM NUMBER], two free standing portable oxygen cylinders were left unattended.</p> <p>On 01/07/2025 at 8:45 AM, the resident stated was not sure why the oxygen cylinders are in the resident's room. One oxygen cylinder was empty, and the other cylinder was half full.</p> <p>On 01/07/2025 at 8:45 AM, a Certified Nursing Assistant (CNA) explained was not sure why the oxygen cylinders were inside the room. The CNA confirmed the oxygen cylinders were placed correctly but the oxygen cylinders should be placed in the closet with other oxygen cylinders. The CNA stated was not aware if the oxygen cylinders were empty.</p> <p>On 01/07/2025 at 8:48 AM, a Registered Nurse (RN) expressed the oxygen cylinders should be on a stand or Respiratory Therapy (RT) would take the tanks to be stored in the closet with empty oxygen cylinders.</p> <p>On 01/07/2025 at 9:00 AM, an RN explained oxygen cylinders are left in the oxygen storage room unless the resident is being transported. If the oxygen cylinder is kept in the resident's room for any reason the oxygen cylinder is placed on a stand for storage.</p> <p>On 01/07/2025 at 8:59 AM, in resident room [ROOM NUMBER] an oxygen cylinder was stored on a stand with wheels in the corner of the resident's room.</p> <p>On 01/07/2025 at 9:35 AM, in resident room [ROOM NUMBER] oxygen cylinders were not removed or stored in the oxygen storage room.</p> <p>On 01/09/2025 at 11:20 AM, facility policy titled Oxygen Handling and Storage last revised 05/01/2024, documented oxygen cylinders must be stored in a safe manner. The policy clarified oxygen cylinders must be secured to a wall with a chain or cable or is in a stationary rack specifically for holding oxygen cylinders.</p> <p>On 01/09/2025 at 12:20 PM, the Director of Nursing (DON), confirmed oxygen cylinders must be stored in a stationary rack, in an oxygen storage closet, or in a [NAME] with wheels. The DON stated that oxygen cylinders should never be left free standing inside a resident's room or hallway without the proper storage rack, contained rack or a [NAME]. The DON clarified if an oxygen tank must be stored in a resident's room it has to be on a [NAME].</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51341</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were secured for 1 of 6 sampled residents (Resident #19). This deficient practice had the potential to result in other residents having access to the medication.</p> <p>Findings include:</p> <p>Resident 19</p> <p>Resident 19 was admitted to the facility on [DATE], with diagnoses including type II diabetes mellitus with diabetic neuropathy, surgery on the digestive system, dehydration, elevated white blood count, hypertension, hyperlipidemia, unspecified, acute kidney failure unspecified, chronic kidney disease stage three unspecified, and acute cholecystitis.</p> <p>On 1/07/2025 at 9:00 AM, a white/pink cream in a medication cup was left on Resident 19's dresser, unattended.</p> <p>On 1/07/2025 at 9:03 AM, the Registered Nurse verbalized the medication cup with the cream medication, should not have been placed and left in the resident's room.</p> <p>On 1/09/2025 at 10:23 AM, the Registered Nurse verbalized Resident #19 had an order for Moisture Barrier cream with Zinc10%. The RN stated the Wound care nurse is the only staff member who would apply the Moisture Barrier Cream.</p> <p>On 1/09/2025 at 12:10 PM, the Wound Care Nurse verbalized Resident 19 had moisture barrier cream with Zinc. The Wound Care Nurse stated only the wound care nurse can apply the moisture barrier cream for Resident 19 and the cream cannot be left in Resident 19's room.</p> <p>Resident 19's treatment administration record revealed the Moisture barrier with Zinc 10% was applied on the coccyx after cleaning at 7:00am by the wound care nurse.</p>		