STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295095	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandstone Spring Valley	5650 South Rainbow Blvd Las Vegas, NV 89118

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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 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give residents a notice of rights, rules, services and charges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50210 Based on observation, interview, clinical record review, and document review, the facility failed to ensure residents were informed both orally and in writing prior to or upon admission of the rules related to leaving on pass. This deficient practice had the potential to affect the entire facility population of 129 residents. Findings include: Resident # 347 Resident #347 was admitted to the facility on [DATE], with a primary diagnosis of encounter for surgical aftercare following surgery on the skin and subcutaneous tissue. On 09/23/2024 at 3:09 PM, Resident #347 verbalized the resident was unable to leave the premises. In the past, when Resident #347 wanted to go across the street for food or to the grocery store, Resident #347 was told by facility staff if the resident left, the facility would kick the resident out. Resident #347 verbalized being in the facility felt like being in a prison. On 09/24/2024 at 2:34 PM, during a resident council interview, 5 of 5 residents reported wanting to leave the premises of the facility but all were told if they left, the residents would be considered against medical advice (AMA) and discharged . The residents verbalized to leave the property on pass, the physician would need to give the residents permission. On 09/26/2024 at 9:27 AM, a Certified Nursing Assistant (CNA) verbalized residents who wanted to leave the facility property would need to reach out to a nurse and the nurse would get the residents a pass as residents were not allowed to walk out and go. If residents were to leave, residents would be considered AMA. The CNA verbalized residents complain all the time about wanting to leave the facility premises. On 09/26/2024 at 10:06 AM, a Licensed Practical Nurse (LPN) verbalized residents who wanted to go out on pass would need to talk with the nurse and the nurse would talk with the physician to get permission. The LPN explained whether a resident was granted pass depended on a history of drug abuse, whether the resident came back to the facility within the required timeframe the last time, and some were just not allowed to leave. (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

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The LPN verbalized residents used to want to leave on pass all the time, but recently the physicians stopped allowing residents to go. If a resident still wanted to leave without the Physician order, the physician would inform the resident it was considered AMA, and the resident would not be allowed to return to the facility. On 09/26/2024 at 10:32 AM, the Director of Nursing (DON) explained if residents wanted to leave the facility on pass, the residents would need to get a physician order. The DON explained if a resident still wanted to leave the facility, or if the resident did not return within the timeframe, the resident may be considered AMA and not allowed to return to the facility. The DON verbalized many residents requested to go out on pass, but the order was not granted often. The DON explained disqualifying factors included a medically unstable resident, a resident not alert and oriented, a resident with an intravenous port, and a resident with a history of drug abuse. On 09/27/2024 at 9:18 AM, the DON verbalized the decision to consider a resident AMA was left to the physician. The DON confirmed the policy documented both the physician and the interdisciplinary team determined whether a resident was fit to go out on pass and confirmed the facility was not following the policy for both the physician and the interdisciplinary team to be involved. The DON verbalized residents should be informed by the physician at the first doctor appointment of the facility rules and policies related to going out on pass. The DON confirmed the facility did not have any documentation residents were informed of facility rules or processes related to going out on pass prior to or upon admission, including the risk of discharge if the resident did not return within the allotted timeframe. The DON confirmed the facility should inform residents in writing of the rules related to going out on pass. The facility's admission packet lacked documented evidence residents were informed in writing of the facility rules and processes regarding going out on pass. The facility policy titled Continuum of Care: Leave of Absence, dated 05/01/2024, documented nursing would obtain a physician's order for the resident to go out on pass. The decision of appropriateness of a leave was made by the Physician in conjunction with the interdisciplinary team. If a resident leaves on a leave of absence and does not return or contact the facility, the facility reserved the right to attempt to locate the resident, including calling the police.

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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** 31739 Based on clinical record review, document review and interview, the facility failed to ensure a resident or resident representative was provided information about the right to formulate an advanced directive for 1 of 29 sampled residents (Resident #84). The deficient practice has the potential to deprive residents of their right for self-determination. Findings Include: Resident #84 Resident #84 was admitted to the facility on [DATE], with diagnoses including anoxic brain damage, acute respiratory failure with hypoxia, and severe persistent asthma with acute exacerbation. Resident #84's clinical record lacked documented evidence of an advance directive or information provided to the resident or the resident's representative about the right to formulate an advanced directive. On 09/26/2024 at 7:28 AM, the Director of Nursing confirmed the facility had not determined if Resident #84 had an advanced directive or if the resident or the resident's representative was provided information to formulate one. The facility policy titled, Care and Treatment, Advance Directives, adopted 05/01/2024, documented upon admission, the resident and/or representative would be informed of advance directive options and documentation in the resident's record the information was provided would be completed.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30748 Based on observation, interview and document review, the facility failed to ensure 4 of 4 dining rooms maintained a comfortable home-like environment by storing medical equipment in the dining areas. The deficient practice had the potential to affect all residents who wish to eat in the dining areas. Findings include: On 09/24/2024 at 7:54 AM, in the Lake [NAME] dining room, the following medical equipment was being stored: -One hoyer lift, -One vitals sign monitor, and; -One wheelchair scale. On 09/24/2024 at 8:06 AM, there was a resident eating breakfast in the Lake [NAME] dining room. The resident explained the medical equipment was always in the dining area, however, did not know how long the equipment had been there. On 09/24/2024 at 8:11 AM, a Certified Nursing Assistant (CNA) explained the medical equipment was supposed to be put away in the cubbies, located in each hallway, however staff would put the equipment in the dining area after use. The CNA confirmed the medical equipment was stored in the dining room and verbalized the dining room was not a comfortable homelike environment for the residents who wished to eat in the dining room. On 09/24/2024 at 9:15 AM, in the Red Rock dining room, the following medical equipment was being stored: -One geri chair, -One IV drip post, -Three vital sign monitors, -One IV hanger; and, -One wheelchair scale. On 09/24/2024 at 9:19 AM, a Registered Nurse (RN) explained the medical equipment was always stored in the dining room and the equipment should be stored somewhere other than the dining room. The RN verbalized there were residents who ate in the dining room with each meal and one resident who had family visit at every meal. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/24/2024 at 9:21 AM, the Respiratory Therapist confirmed the dining room was being used to store medical equipment and explained there was an area available to store the equipment. The room was located next to the dining room and was large enough to accommodate all medical equipment stored in the dining room. The Respiratory Therapist confirmed the Red Rock dining room was being used to store the medical equipment and verbalized the dining room was not a comfortable, homelike environment. On 09/25/2024 at 7:33 AM, in the Valley of Fire dining room, the following medical equipment was being stored: -One wheelchair scale, -One oxygen concentrator, -One sliding weight scale, -One shower chair, -Two hoyer lifts, -One vitals sign monitor; and, _One three foot tall fan. On 09/25/2024 at 7:42 AM, a CNA confirmed the Valley of Fire dining room was being used to store medical equipment and verbalized the dining room was not a safe, comfortable homelike environment for residents. The CNA explained working at the facility for the last three years and the medical equipment had always been stored in the dining room and staff was using the dining room to store the medical equipment for staff convenience. On 09/25/2024 at 7:46 AM, located in the Mount [NAME] dining room, the following medical equipment was being stored: -Two food carts, -One wheelchair scale, -One hoyer lift, -One sliding weight scale; and, -Three vital sign monitors, On 09/25/2024 at 7:50 AM, the Director of Nursing (DON) confirmed the Mount [NAME] dining room was being used to store medical equipment and verbalized the dining room was not a comfortable homelike environment for residents wishing to eat in the dining room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON explained there were various other areas to store the equipment, such as the nurses' stations and verbalized the dining room was for resident use and residents were not to be staring a medical equipment while eating a meal. On 09/25/2024 at 8:39 AM, the Administrator explained storing of medical equipment in each dining room was a common practice for the facility and there were cubbies in each hallway designed to store medical equipment. The Administrator admitted not thinking anything about storing the medical equipment in dining areas was not conducive to a homelike environment for the residents. The facility policy titled Resident Rights, adopted 05/01/2024, documented residents had the right to an environment that maintained and enhanced each resident's dignity and respect. The facility policy titled Physical Environment: Space and Equipment, dated 07/2018, documented the facility would provide sufficient space and equipment in dining areas and storage of supplies elsewhere. The dining space would not restrict a resident's functional movement. The facility policy titled Physical Environment: Dining and Resident Activity Rooms, dated 07/2018, documented the facility would provide comfortable areas for residents to engage in dining activities.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30748 Based on interview, clinical record review and document review, the facility failed to ensure a care plan was developed for 1) a resident receiving hospice services (Resident #57), 2) a resident dependent on a respirator (Resident #69), and 3) a resident with anxiety (Resident #15) for 3 of 29 sampled residents. This deficient practice has the potential to deprive residents of receiving appropriate care. Findings include: Resident #57 Resident #57 was admitted to the facility on [DATE], with diagnoses including psychotic disorder with hallucinations due to a known physiological condition, cognitive communication deficit and depression, unspecified. On 09/24/2024 at 7:57 AM, Resident #57 verbalized being confused as to what care was being provided in the facility and could not verbalize if the resident was receiving hospice services. A physician's order dated 09/18/2024, documented admit to hospice on 09/18/2024. Resident #57's clinical record lacked documented evidence of a care plan for hospice. On 09/26/2024 at 8:38 AM, the Director of Nursing (DON) verbalized all staff referred to resident care plans to determine care needs of each resident and to determine how to properly provide care and monitor a resident's care. Care Plans were developed and revised when care needs had changed for the resident, such as being put on hospice to receive end of life care. The DON confirmed Resident #57 lacked a care plan for hospice care and verbalized the lack of a care plan could have health consequences for the resident. 50210 Resident #15 Resident #15 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of anxiety disorder unspecified. An active physician's order dated 08/13/2024, documented Hydroxyzine Pamoate capsule 25 milligrams(mg). Give one tablet via gastronomy tube every 12 hours as needed for anxiety. A consent for psychotropic medication dated 08/13/2024, documented Hydroxyzine 25 mg with an expected duration of 14 days. Resident #15's comprehensive care plan lacked a care plan for anxiety or Hydroxyzine Pamoate anxiety medication. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/26/2024 at 11:34 AM, a Certified Nursing Assistant (CNA) verbalized the CNA knew to monitor residents with anxiety through verbal discussions with nurses and by looking at the resident's care plan. The CNA verbalized not monitoring for Resident #15's anxiety. On 09/26/2024 at 4:35 PM, a Licensed Practical Nurse (LPN) verbalized Resident #15 had anxiety exhibited by staying up all night. The LPN confirmed Resident #15 took Hydroxyzine Pamoate to manage anxiety. The LPN verbalized care plans were sometimes used and the LPN would expect anxiety to be on a resident's care plan and confirmed anxiety was not on Resident #15's care plan. On 09/26/2024 at 5:06 PM, the Director of Nursing (DON) verbalized psychotropics should be included in a care plan, and if not the psychotropic, a baseline care plan for the diagnosis and relating interventions should be on a care plan. The DON verbalized the resident had a care plan related to hoarding and disorganized thinking but was unable to provide a care plan for the Hydroxyzine Pamoate or anxiety diagnosis. 31739 Resident #69 Resident #69 was admitted to the facility on [DATE], with diagnoses including acute respiratory failure, unspecified whether with hypoxia or hypercapnia, pneumonia due to pseudomonas, and dependence on respirator (ventilator) status. Resident #69's care plan last updated on 09/08/2024, lacked documented evidence the resident's respiratory failure and dependence on a respirator (ventilator), was developed and documented objectives, goals and interventions. On 09/26/2024 at 4:02 PM, the DON confirmed a care plan for Resident #69's respiratory failure and respirator dependence had not been developed. The DON verbalized staff would not have been able to implement the care or services the resident required if a care plan was not developed. The facility policy titled, Care and Treatment, Care Planning, adopted 05/01/2024, documented the interdisciplinary team would develop a comprehensive care plan for each resident, and would review and revise the plan as the resident's care needs changed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on observation, interview, and document review the facility failed to meet professional standards of medication administration and ensure medications were not left, unsecured, at a resident's bedside for 1 of 4 residents observed for medication administration (Resident #82). The deficient practice placed the patient at risk for not receiving needed medication. Findings include: Resident #82 Resident #82 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including other acute osteomyelitis, left ankle and foot and chronic obstructive pulmonary disease, unspecified. On 09/26/2024 at 9:04 AM, a Licensed Practical Nurse (LPN) began preparing medications for Resident #82. Included in the prepared medications was ClearLax 17 grams (gm), mixed in water, in a clear plastic cup. On 09/24/2024 at 9:17 AM, the LPN entered Resident #82's room and placed the resident's medications on the bedside table. The LPN stood at the resident's bedside while the resident took the oral tablet medications. The LPN then explained the indication for ClearLax to Resident #82. On 09/26/2024 at 9:19 AM, the LPN exited Resident #82's room. The ClearLax remained on the bedside table. On 09/26/2024 at 9:21 AM, the LPN confirmed the ClearLax was left on Resident #82's bedside table when the LPN exited the resident's room. The LPN explained all medications should be taken/swallowed by the resident prior to the LPN leaving the resident's room. On 09/27/2024 at 7:32 AM, the Director of Nursing (DON) explained it was the DON's expectation of nursing staff to remain with the resident until all medications were taken/swallowed by the resident. The DON explained if medications were left in a resident's room staff would not know if the resident took the medication and residents may not receive the therapeutic benefits the medication was prescribed for if the medication was not taken. The facility policy titled Medication Access and Storage, adopted 05/01/2024, documented medication supply was to only be accessible to staff lawfully authorized to administer medications. All drugs and biologicals were to be stored in locked compartments under proper temperature controls.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30748 Based on interview, clinical record review and document review, the facility failed to ensure a code status of do not resuscitate (DNR) was not documented as full code in the electronic health record for 4 of 29 sampled residents (Resident #57, #75, #40, and #347). This deficient practice had the potential to result in a resident with DNR status being given life-saving measures during an emergent event. Findings include: Resident #57 Resident #57 was admitted to the facility on [DATE], with diagnoses including psychotic disorder with hallucinations due to a known physiological condition, cognitive communication deficit and depression, unspecified. Resident #57's electronic chart documented the resident was a full code and was to receive cardio pulmonary resuscitation (CPR) in an emergent event. Resident #57's Provider Order for Life-Sustaining Treatment (POLST) dated [DATE], documented the resident was on comfort-focused treatment and was a DNR. Resident #75 Resident #75 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including anoxic brain damage, not elsewhere classified, tracheostomy status, gastrostomy status, and dependence on respirator (ventilator) status. Resident #75's electronic chart documented the resident was a full code and was to receive CPR in an emergent event. Resident #75's POLST dated [DATE], documented the resident was a DNR. On [DATE] at 8:38 AM, the Director of Nursing (DON) explained a POLST documented what treatment wishes a resident may have. The wishes included CPR, which indicated a resident would like to receive CPR in the event CPR was needed and the other wish was to be a DNR. A DNR meant no life saving measures would be taken in the event a resident stopped breathing. The DON verbalized staff referred to a resident's electronic chart for code status. The DON verbalized if a resident was to receive CPR and was a DNR status, that would be a violation of a resident right and go against the resident's right to choose. If a resident was DNR and received CPR, it would cause psychological harm to the resident. The DON confirmed Resident's #57 and #75 were both DNR status, however the electronic chart documented both residents were full code 50210 (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #40 Resident #40 was admitted to the facility on [DATE], and readmitted [DATE], with a primary diagnosis of other cerebrovascular disease. Resident #40's electronic chart documented the resident was a full code and was to receive CPR in an emergent event. Resident #40's POLST, dated [DATE], documented the resident was a DNR to be on comfort-focused treatment without artificial nutrition or feeding tube. A DNR Order for Resident #40 dated [DATE], documented no CPR would be undertaken, only palliative care to maintain comfort, full code for now was written underneath, and the document was unsigned. Resident #347 Resident #347 was admitted to the facility on [DATE], with a primary diagnosis of encounter for surgical aftercare following surgery on the skin and subcutaneous tissue. Resident #347's electronic chart documented the resident was a full code and was to receive CPR in an emergent event. Resident #347's POLST, dated [DATE], documented the resident was a DNR. On [DATE] at 2:10 PM, a Licensed Practical Nurse (LPN) verbalized POLSTs inform nurses what type of life sustaining treatment a resident wanted. The LPN explained in an emergent event, the LPN would look at what was documented in the resident's electronic health record to determine the resident's code status. On [DATE] at 2:30 PM, the DON explained POLSTs helped the facility determine code status for residents. The DON confirmed resident POLSTs and what was documented on the electronic health record should match. The DON explained in an emergent event, staff should refer first to the signed document. The DON confirmed Resident #347 was DNR status, however the electronic chart documented the resident was full code. The DON explained when Resident #40 began hospice, the resident's brother gave verbal confirmation Resident #40 was a full code. The DON confirmed Resident #40 was their own medical representative and the document was not signed and should have been. The DON confirmed Residents #40 and #347 were both DNR status per their POLSTs, however the electronic chart documented the residents were full code. The facility policy titled Advance Directive, adopted [DATE], documented a resident's choice about advance directives would be respected and once a resident chose to be full code or DNR a discussion would be had, a physician signature obtained for a POLST and documented accurately in the resident's clinical record.

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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** 50210 Based on observation, interview, clinical record review, and document review, the facility failed to ensure an ordered therapeutic diet was on the resident meal card and provided to 1 of 29 sampled residents (Resident #89). This deficient practice placed the resident at risk for not receiving an appropriate diet to maintain nutritional needs. Findings include: Resident #89 Resident #89 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of type two diabetes mellitus without complications. A physician order dated 08/06/2024, documented heart healthy consistent carbohydrate (CCHO) diet regular texture regular consistency. Resident #89's care plan included an intervention revised 08/18/2024, documenting prescribed diet was heart healthy CCHO diet. On 09/24/2024 at 10:19 AM, Resident #89 verbalized Resident #89 was diabetic. The facility served a lot of carbohydrates that did not taste very good, so Resident #89's family often brought meals Resident #89 liked better. The Week At a Glance regular diet menu documented breakfast would include assorted juice, choice of hot or cold cereal, pancakes, sausage, fresh fruit cup, margarin or syrup, and milk or another beverage. The Week At a Glance CCHO diet menu documented breakfast would include assorted juice, choice of hot or cold cereal unsweetened, a pancake, sausage, fresh fruit cup, margarin or diet syrup, and milk or another beverage. On 09/26/2024 at 9:29 AM, Resident #89's breakfast plate included two pancakes, a sausage patty, oatmeal, and a banana. On 09/26/2024 at 9:29 AM, a Certified Nursing Assistant (CNA) confirmed Resident #89's breakfast included two pancakes, a sausage patty, oatmeal, and a banana. Resident #89's meal card for 09/26/2024, documented a regular diet regular texture. On 09/26/2024 at 1:55 PM, the Dietary Manager (DM) explained resident diets were transferred to meal cards through an automated process between the electronic health record (EHR) and the kitchen's electronic system. Meal cards were updated as the diet order in the EHR was updated. The DM verbalized Resident #89 was on a regular diet and confirmed the meal card documented a regular diet regular texture. The DM confirmed Resident #89's diet order dated 08/06/2024, documented heart healthy CCHO diet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295095	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandstone Spring Valley	5650 South Rainbow Blvd Las Vegas, NV 89118

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DM verbalized the kitchen's electronic system had an update approximately one month prior and the system did not update with diet orders. The kitchen staff manually entered diets into the kitchen's electronic system and Resident #89's therapeutic diet must have been missed on Resident #89's meal card. The DM was unsure how long Resident #89 was served a regular diet. On 09/26/2024 at 2:28 PM, the Dietician verbalized it was important to ensure CCHO therapeutic diets were served to residents who needed them because it helped to stabilize sugar levels. The Dietician explained ordered diets were documented in the EHR and automatically changed in the kitchen's electronic system to be printed on cards. The Dietician verbalized Resident #89 should be on a Heart Healthy CCHO diet. The facility policy titled Meal Identification, Resident Meal Card, undated, documented all residents should have a tray card on file indicating diet orders and would be used by dining services staff to identify and provide accurate meal service for the individual while honoring their dining needs. To ensure meal cards were kept accurate, the Dining Services Manager (Dietary Manager) would compare the meal card to the written physician diet order in the medical record on a regular basis, including verification of accurate diet order. The facility policy titled Honoring Resident Choice and Self-Directed Living at Meals, undated, documented residents would be offered meals that provide nutritional adequacy and are consistent with their plan of care.

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	295095	A. Building B. Wing	09/27/2024

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30748 Based on interview, clinical record review and document review, the facility failed to obtain Dialysis Communications forms for a resident receiving hemodialysis for 1 of 29 sampled residents (Resident #198). This deficient practice potentially places residents at risk for not receiving continuity of care. Findings include: Resident #198 Resident #198 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including end stage renal disease, other specified abnormal findings of blood chemistry, and heart failure, unspecified. A physician's order dated 09/22/2024, documented hemodialysis every Tuesday, Thursday, and Saturday. Resident #198's Care Plan initiated on 09/24/2024, documented the resident required renal dialysis related to renal failure and was to receive dialysis every Tuesday, Thursday and Saturday. Resident #198's clinical record lacked documented evidence dialysis communication forms were being sent with the resident to dialysis and obtained in the medical record. On 09/25/2024 at 1:20 PM, the Director of Nursing (DON) explained the facility could not locate any dialysis communication forms for Resident #198 and the resident was sent out for dialysis with the dialysis binder, to include the communication forms, and did not return with the binder. A phone call was placed to the dialysis clinic, in an attempt to locate the communications forms, however, the dialysis clinic verbalized the resident did not bring a binder to dialysis and the binder could not be located. A nursing progress note dated 09/25/2024, documented the resident was sent to dialysis with the resident's dialysis book and the resident did not return with the book. The resident was unable to verbalize to the nurse being sent with the dialysis book so a call was placed to the dialysis clinic. The dialysis clinic informed the nurse, the resident did not bring the dialysis book to the appointment on 09/24/2024. On 09/25/2024 at 2:58 PM, the DON verbalized dialysis communication sheets were required to be sent with the resident to dialysis and sent back to the facility with the resident upon return from dialysis. The dialysis communications sheets would inform staff if there were any complications during the dialysis appointment needing to be monitored. The DON verbalized if the sheets were not returned with the resident, the health of the resident could be at risk because staff would not be aware of health concerns to monitor for the resident. The DON confirmed there were no dialysis communication sheets for the resident. (continued on next page)

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	295095	A. Building B. Wing	09/27/2024

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Sandstone Spring Valley	5650 South Rainbow Blvd Las Vegas, NV 89118

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Dialysis, adopted 05/01/2024, documented the facility staff would coordinate with the dialysis center for individual care and would obtain copies of communication sheets from the dialysis center after each appointment.

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	295095	A. Building B. Wing	09/27/2024

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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** 49557 Based on interview, clinical record review, and document review the facility failed to discontinue a medication after receiving an order to discontinue the medication for 1 of 29 sampled residents (Resident #4). This deficient practice resulted in the resident receiving an unnecessary medication. Findings include: Resident #4 Resident #4 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including osteomyelitis of vertebra, sacral and sacrococcygeal region and neuromuscular dysfunction of bladder, unspecified. An Order Summary Report for Resident #4, dated 09/26/2024, documented the following: -Oxybutynin Chloride oral tablet, give one tablet by mouth BID for overactive bladder. The order date was 09/17/2024, with a start date of 09/18/2024. -Tolterodine Tartrate (Detrol) two mg tablets, give one tablet by mouth BID for urinary frequency, urgency, and incontinence. The order date was 09/17/2024, the start date was 09/18/2024. The September 2024 Medication Administration Record (MAR) for Resident #4 documented the following: -Oxybutynin Chloride, give one tablet by mouth two times a day for overactive bladder. The start date was 09/18/2024. The medication was administered to the resident one to two times daily from 09/18/2024 through 09/25/2024. -Tolterodine Tartrate two mg tablets, give one tablet by mouth two times a day for urinary frequency, urgency, and incontinence. The start date was 09/18/2024. The medication was administered to the resident two times per day from 09/18/2024 through 09/25/2024. On 09/26/2024 at 11:57 AM, a Licensed Practical Nurse (LPN) verbalized the LPN was not sure why Resident #4 was prescribed two drugs from the same drug class, to treat the same diagnosis. The LPN explained when a resident was prescribed two drugs from the same class the nurse would hold the medications and contact the physician for clarification of which medication to continue. The LPN retrieved the unit's mobile phone to contact Resident #4's physician. The LPN verbalized a previous message was in the phone indicating staff had contacted the physician on 08/29/2024, via the phone's text messaging function, regarding the two medications. The physician's response included instruction to discontinue Tolterodine and continue Oxybutynin. The LPN explained this was an order and the order should have been entered in the resident's record in addition to a progress note to detail the information. The LPN reviewed Resident #4's record and confirmed the record lacked a progress note related to the medications or an order to discontinue Tolertodine. The Tolterodine and Oxybutynin remained active on the resident's MAR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295095	A. Building B. Wing	09/27/2024

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/26/2024 at 12:04 PM, the LPN called Resident #4's physician to report the incident. A Progress Note dated 09/26/2024 at 12:26 PM, documented the LPN clarified with the physician to discontinue Tolterodine and continue Oxybutynin. On 09/26/2024 at 4:19 PM, the DON explained staff could communicate with the physician via the unit's mobile phone and confirmed staff could receive orders via the unit phone's text messaging function. The DON explained the DON's expectation of staff when staff received an order from the physician was to enter the order in the resident's clinical record and carry out the order. The DON confirmed if staff continued to administer a medication to a resident after staff received an order from the physician to discontinue it, this would be considered an unnecessary medication and would not be following physician's orders. The facility policy titled Administration of Drugs, adopted 05/01/2024, documented medications were to be administered as prescribed by the physician.

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	295095	A. Building B. Wing	09/27/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50210 Based on interview, clinical record review, and document review, the facility failed to ensure a psychotropic medication's side effects were monitored, a psychotropic medication's related behaviors were monitored, and an as needed psychotropic medication was limited to 14 days for 1 of 29 sampled residents (Resident #15). This deficient practice placed residents at risk for not receiving appropriate medications for their overall health status. Findings include: Resident #15 Resident #15 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of anxiety disorder unspecified. A consent for psychotropic medication dated 08/13/2024, documented Hydroxyzine 25 mg with an expected duration of 14 days. An active physician's order dated 08/13/2024, documented Hydroxyzine Pamoate capsule 25 milligrams(mg). Give one tablet via gastronomy tube every 12 hours as needed for anxiety. Resident #15's physician orders lacked evidence of side effect monitoring or behavior monitoring for Hydroxyzine Pamoate. Resident #15's comprehensive care plan lacked a care plan for anxiety, Hydroxyzine Pamoate anxiety medication, side effect monitoring or behavior monitoring. Resident #15's August and September 2024 Medication Administration Records documented the following: -Hydroxyzine Pamoate was administered from 08/14/2024 through 09/15/2024, 20 days after the 14-day period, and the order continued to be active through 09/25/2024. -No side effect monitoring for anxiety or Hydroxyzine Pamoate. -No behavior monitoring for anxiety or Hydroxyzine Pamoate. Resident #15's Progress Notes lacked documented evidence of Hydroxyzine Pamoate 25 mg side effect or behavior monitoring. On 09/26/2024 at 11:34 AM, a Certified Nursing Assistant (CNA) verbalized the CNA knew to monitor residents with anxiety through verbal discussions with nurses and by looking at the resident's care plan. The CNA verbalized not looking out for Resident #15's anxiety. (continued on next page)

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	295095	A. Building B. Wing	09/27/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/26/2024 at 4:35 PM, a Licensed Practical Nurse (LPN) verbalized residents on psychotropic medications should have behavior monitoring, side effect monitoring, and a care plan related to the psychotropic. The LPN confirmed Resident #15's as needed Hydroxyzine Pamoate 25 mg order was used to treat Resident #15's anxiety and was an active order from 08/13/2024 through 09/26/2024. The LPN confirmed Resident #15 was last administered the Hydroxyzine Pamoate approximately one week prior. The LPN confirmed there was no order to monitor side effects or behaviors, nor a care plan related to Hydroxyzine Pamoate or anxiety. On 09/26/2024 at 5:06 PM the Director of Nursing (DON) verbalized as needed psychotropic medications should have side effect monitoring, behavioral monitoring, a care plan for either the psychotropic or the diagnosis, and a 14-day active period. The Director of nursing confirmed Resident #15's Hydroxyzine Pamoate order was active from 08/13/2024 to 09/26/2024, and was last administered on 09/15/2024, 20 days after the end of the 14-day period. The DON verbalized believing the 14-day requirement for as needed psychotropic medications did not apply to long-term residents. The DON confirmed Resident #15's clinical record lacked documented evidence of side effect and behavior monitoring related to the Hydroxyzine Pamoate for anxiety. The facility policy titled Psychoactive Drug Use, dated 05/01/2024, documented as needed psychotropic medication orders were limited to 14 days, results of behavior monitoring, and interventions would be included in assessments, and adverse reactions would be monitored according to the resident plan of care.

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	295095	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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** 49557 Based on observation, interview, clinical record review, and document review the facility failed to ensure medications were administered with an error rate of less than 5 percent (%). There were 31 opportunities and 6 medication errors. The medication error rate was 19.35%. Findings include: Resident #48 Resident #48 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including acute respiratory failure with hypoxia and other seizures. On 09/25/2024 at 7:47 AM, a Licensed Practical Nurse (LPN) explained medications were required to be administered within one hour before and one hour after the scheduled administration time on the Medication Administration Record (MAR). On 09/25/2024 at 10:13 AM, a Registered Nurse (RN) began preparing to administer medications to Resident #48. Among the medications prepared were the following: -Cholecalciferol D3 1000 units, two tablets were placed in a medication cup. -Docusate Sodium 100 milligrams (mg), one tablet was placed in a medication cup. -Enoxaparin Sodium 40 mg, one prefilled syringe. -Keppra Levetiracetam 100 mg/milliliter (ml), 15 ml were placed in a medication cup. -Valproic Acid 250 mg/ five ml, ten ml were placed in a medication cup. -Metoprolol 25 mg, one half tablet was placed in a medication cup. On 09/25/2024 at 11:04 AM, the RN administered the prepared medications to Resident #48, one at a time, through the resident's feeding tube. The September 2024 MAR and an Order Summary Report for Resident #48 documented the following: -Cholecalciferol tablet 1000 units, give two tablets enterally one time a day for supplement. The scheduled administration time was 9:00 AM. -Docusate Sodium oral tablet 100 mg, give one tablet via G-Tube two times a day for constipation. The scheduled administration time was 9:00 AM. -Enoxaparin Sodium injection solution prefilled syringe 40 mg/ 0.4 ml, inject 40 mg subcutaneously one time a day for anticoagulant. The scheduled administration time was 9:00 AM. (continued on next page)

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	295095	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandstone Spring Valley	5650 South Rainbow Blvd Las Vegas, NV 89118

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Keppra solution 100 mg/ml, give 15 ml via G-Tube two times a day for seizure prevention. The scheduled administration time was 9:00 AM. -Valproic Acid oral solution 250 mg/ five ml, give ten ml via G-Tube two times a day for seizures. The scheduled administration time was 9:00 AM. -Metoprolol Tartrate, give 12.5 mg by mouth two times a day for hypertension. The scheduled administration time was 9:00 AM. On 09/26/2024 at 4:16 PM, the Director of Nursing (DON) explained medications were to be administered within one hour before or one hour after the scheduled administration time. The DON confirmed medications administered after 11:00 AM, with a scheduled administration time of 9:00 AM, would be considered late. The facility policy titled Administration of Drugs, adopted 05/01/2024, documented medications were to be administered in accordance with the written orders of the ordering/prescribing physician. Medications were to be administered within one hour before or after the prescribed time. Unless otherwise specified by the ordering/prescribing physician, routine medications were to be administered as scheduled.

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	295095	A. Building B. Wing	09/27/2024

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Sandstone Spring Valley	5650 South Rainbow Blvd Las Vegas, NV 89118

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on observation, interview, clinical record review and document review, the facility failed to ensure 1) expired medications were removed from 1 of 5 inspected medication carts and 1 of 2 inspected medication storage rooms, 2) an unsealed medication was removed from 1 of 5 inspected medication carts, and 3) discontinued medications were removed from 1 of 5 inspected medication carts. This deficient practice has the potential to place residents at risk of receiving medications that were no longer at a safe level of efficacy. Findings include: Expired Medication On 09/24/2024 at 2:35 PM, during an inspection of the medication room on the Valley of Fire unit in the presence of Licensed Practical Nurse (LPN)1, the following items were found: -Three intravenous (IV) solution bags containing Pantoprazole 40 milligrams (mg) in 100 milliliters (ml) of Normal Saline (NS). The use by date on the three IV solution bags was 09/06/2024. The IV solution bags were hanging on the wall of the medication room, with current IV medications for residents. -One vial of Humalog Lispro. The expiration date printed on the vial was 05/2022. The vial was stored in the refrigerator in the medication room. LPN1 confirmed the three IV solution bags of Pantoprazole and the vial of Humalog Lispro were past the best by and expiration dates printed on the medications. LPN1 explained when medications were expired or past the use by date, the medications should be placed in a box in the medication room. The box was intended to temporarily store expired or discontinued medications until the medications could be destroyed. LPN1 then moved the Pantoprazole and Humalog Lispro to the bin designated for expired or discontinued medications. On 09/24/2024 at 3:17 PM, during an inspection of a medication cart on the Lake [NAME] unit in the presence of a Registered Nurse (RN), a bottle of Geri-Lanta, regular strength with an expiration date of 05/2024 printed on the bottle, was found. The RN confirmed the bottle of Geri-Lanta had expired and should have been removed from the medication cart prior to the expiration date. On 09/25/2024 at 4:15 PM, during an inspection of a medication cart on the Valley of Fire unit in the presence of LPN2, a bottle of Sodium Bicarbonate ten grams with an expiration date of 05/2024 printed on the bottle was found. (continued on next page)

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	295095	A. Building B. Wing	09/27/2024

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Sandstone Spring Valley	5650 South Rainbow Blvd Las Vegas, NV 89118

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The LPN2 confirmed the bottle of Sodium Bicarbonate had expired and should have been removed from the medication cart prior to the expiration date. LPN2 explained it was important to remove expired medications from the cart as administering an expired medication to a resident could result in an adverse reaction for the resident. Open Medication Package On 09/25/2024 at 4:59 PM, during an inspection of a medication cart on the Mount [NAME] unit in the presence of LPN1, a syringe of Lovenox 40 mg/0.4 ml was found. The seal on the syringe's package was broken. Store in original carton or packaging until ready to use was printed on the container. LPN1 confirmed the package was no longer sealed and explained the medication should have been discarded. Discontinued Medication Resident #103 Resident #103 was admitted to the facility on [DATE], with diagnoses including displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing and difficulty in walking, not elsewhere classified. Resident #103 was discharged from the facility on 09/13/2024. On 09/24/2024 at 3:17 PM, during an inspection of a medication cart on the Lake [NAME] unit in the presence of a Registered Nurse (RN), the following items were found stored in the medication cart: -Four doses of Morphine four mg/ml. The label attached to the Morphine indicated the medication belonged to Resident #103. A log to track dispensed doses was attached the package of Morphine with a rubber band. The log indicated the last dose was administered on 08/11/2024. The RN explained the Morphine was discontinued and was being stored in the medication cart until it could be given to a unit manager to dispose of it. The RN denied a specific timeframe for when a discontinued medication should have been given to the unit manager and explained it was whenever the unit manager was not busy. A physician's order dated 08/05/2024, documented Morphine Sulfate injection solution, four mg/ml. Use one ml IV every 24 hours as needed prior to wound care or dressing changes. The discontinue date was 08/13/2024. On 09/26/2024 at 4:06 PM, the Director of Nursing (DON) explained it was the DON's expectation medication would be stored according to manufacturer guidelines. The DON verbalized an open package of Lovenox would not be appropriate to store in the medication cart and the medication should have been discarded as staff would no longer know if the medication was safe or had been contaminated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295095	A. Building B. Wing	09/27/2024

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Sandstone Spring Valley	5650 South Rainbow Blvd Las Vegas, NV 89118

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON explained it was the facility's process to discard outdated, expired, or discontinued medications. Medications, including controlled substances, belonging to residents who were discharged from the facility should have been removed from the medication cart and discarded. The DON denied it would be appropriate for medication which had been discontinued the month prior to remain in the medication cart. The facility policy titled Medication Access and Storage, adopted 05/01/2024, documented outdated, contaminated, or deteriorated medications and those in containers which were cracked, soiled, or without secure closures were immediately removed from stock, disposed of according to procedures for medication destruction and reordered from the pharmacy, if a current order existed. The facility policy titled Discarding and Destroying Medications, adopted 05/01/2024, documented it was the policy of the facility for medications not able to be returned the dispensing pharmacy (controlled substances, non-unit-dose medications, medications refused by the resident, and/or medications left by residents upon discharge) should be destroyed. CPT #NV00071985

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295095	A. Building B. Wing	09/27/2024

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Sandstone Spring Valley	5650 South Rainbow Blvd Las Vegas, NV 89118

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 50210 Based on observation, interview, and document review, the facility failed to ensure the menu was followed for a breakfast service. This deficient practice had the potential to affect all residents in the facility. Findings include: On 09/26/2024 at 8:31 PM, breakfast was delivered to residents in the Valley of Fire Unit to include cereal, fruit, pancakes and sausage. The Week At a Glance menu documented breakfast for Thursday would include assorted juice, choice of hot or cold cereal, cheesy eggs, hashbrowns, banana, toast, margarine or jelly, and milk or another beverage. The breakfast for Friday would include assorted juice, choice of hot or cold cereal, pancakes, sausage, fresh fruit cup, margarin or syrup, and milk or another beverage. On 09/26/2024 at 2:18 PM, the Dietary Manager (DM) verbalized breakfast on Thursday 09/26/2024 was swapped with the breakfast for Friday 09/27/2024 because the cook looked at the wrong day on the menu and began preparing for the breakfast for Friday instead of the breakfast for Thursday. The DM verbalized residents would be notified of this change by changing the menus in each unit hallway. The facility policy titled Honoring Resident Choice and Self-Directed Living at Meals, undated, documented residents would be offered all food and beverage components planned in the approved menu.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295095	A. Building B. Wing	09/27/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 30748 Based on observation, interview, and document review, the facility failed to ensure 1) a dietary aide's purse was not being stored with resident food in the dry storage area of the kitchen, 2) a hairnet was donned prior to entering the kitchen, 3) hand washing was performed when entering the kitchen or prior to donning gloves, 4) beverages were covered when traveling down hallways, 5) food was stored at safe temperatures, and 6) thermometers were properly sanitized between foods during the taking of temperatures. This deficient practice placed residents at risk for food-borne infectious illnesses. Findings include: 1. Storage of personal items: On 09/23/2024 at 12:56 PM, located on a shelf containing food for residents, was a staff members purse. On 09/23/2024 at 1:00 PM, the Dietary Aid confirmed the purse belonged to them and verbalized the Dietary Manager had previously spoke to the Dietary Aid on a few occasions about leaving the Dietary Aid's purse next to resident food. The Dietary Aid explained the purse was not to be stored with resident food because the food can get contaminants causing illnesses. On 09/24/2024 at 10:38 AM, the Dietary Manager explained the Dietary Manager had previously warned the Dietary Aid about storing the purse with resident food and the Dietary Aid continued to place the purse with resident food. The Dietary Manager verbalized personal items were not to be stored with resident food because it could cause a bacteria outbreak should the residents consume the food. On 09/25/2024 at 8:39 AM, the Administrator verbalized personal items were not to be stored with resident food to protect the resident's health and safety. The Administrator explained there were personal lockers available to the dietary staff to store the personal belongings. The Administrator verbalized the facility did not have a policy regarding the storage of personal items in the kitchen and the facility followed best practices. The facility policy titled Food Receiving and Storage, adopted 05/01/2024, documented the facility would store food in a manner that complied with safe food handling practices. The facility policy titled Preventing Foodborne Illness-Food Handling, adopted 05/01/2024, documented food would be stored in a way to prevent the risk of foodborne illnesses and staff would handle food with practices of safe food handling to prevent foodborne illnesses. 49557 2. Hair covering: (continued on next page)

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	295095	A. Building B. Wing	09/27/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/25/2024 at 12:38 PM, during an observation of the satellite kitchen on the Mount [NAME] unit, a Licensed Practical Nurse (LPN) entered the satellite kitchen. The LPN opened the refrigerator, removed a tray of desserts, set the tray aside and retrieved a yogurt. The LPN was not wearing a hairnet and did not perform hand washing upon entering the kitchen. On 09/25/2024 at 12:40 PM, the LPN confirmed the LPN was not wearing a hairnet and did not perform hand washing upon entering the kitchen. The LPN confirmed staff were required to don a hairnet and hands were to be washed when entering the kitchen. The facility policy titled Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices, adopted 05/01/2024, documented employees must wash their hands whenever entering or re-entering the kitchen. Hair nets or caps must be worn to keep hair from contacting exposed food, clean equipment, utensils, and linens. 50210 3. Hand Hygiene On 09/25/2024 at 12:57 PM, the Dietary Aide entered the kitchen and donned gloves. The Dietary Aide did not wash hands prior to donning the gloves. On 09/25/2024 at 12:57 PM, the Dietary Aide confirmed the Dietary Aide did not wash hands upon entering the kitchen and prior to donning gloves. On 09/25/2024 at 12:59 PM, the DM confirmed the Dietary Aide did not was hands prior to donning gloves and should have. 4. Uncovered Beverages On 09/24/2024 at 8:02 AM during a dining observation of meal service, the following occurred: -Beverages were poured in the dining area, outside the satellite kitchen in the Valley of Fire Unit. -Beverages were set on meal trays on an open meal cart. -Four trays were transported down the hall and delivered to resident bedrooms. -Process was repeated three times for the 1100 hallway with 18 uncovered beverages, and twice in the 1200 hallway with 13 uncovered beverages. On 09/24/2024 at 8:40 AM, a Certified Nursing Assistant (CNA) confirmed the beverages were uncovered while being transported down the hallways. The CNA confirmed the open beverages risked the spread of bacteria between residents and staff. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/24/2024 at 10:38 AM, the Dietary Manager (DM) verbalized food and beverages should be covered in the hallways because it presented a sanitation issue with people coughing in the hallways and bacteria being spread. The DM confirmed beverages were being served uncovered in the Vally of Fire Unit and should not have been. 5. Food Storage On 09/25/2024 at 12:05 PM, the Dietary Aide entered the satellite kitchen in the Valley of Fire Unit and transferred beverages, pudding, and vanilla shakes into the refrigerator. The refrigerator's built-in thermometer was flashing between C46 and 88.8. On 09/25/2024 at 12:21 PM, the Dietary Aide verbalized the Dietary Aide observed the refrigerator's temperature every shift and after each meal. The Dietary Aide confirmed the refrigerator's built-in thermometer was flashing and verbalized being unsure why but may be due to the refrigerator door being open. The Dietary Aide removed beverage pitchers from the refrigerator and put them in the dining room to be served to residents. After closing the door, the Dietary Aide confirmed the built-in thermometer was still flashing and verbalized the built-in thermometer may be flashing because the refrigerator was on defrost mode. The Dietary Aide verbalized there was a thermometer inside the refrigerator reading at 55 degrees Fahrenheit (F). The Dietary Aide verbalized food should be stored at 40 F. On 09/25/2024 at 12:40 PM, the DM verbalized food should be stored at or below 41 F. The DM confirmed the refrigerator stored milk, cottage cheese, chocolate pudding, individual size yogurts, vanilla shakes, oatmeal, salads, and resident items to include tortillas, cheese slices, cooked ravioli, ham, smoothies, grapes, jelly jars, Greek yogurt and whipped cream. On 09/25/2024 at 12:40 PM, the following items were assessed to be above 41 F and confirmed by the DM: -Milk at 47.6 F. -Cottage cheese at 50 F. -Chocolate pudding at 50.1 F. -Yogurt at 41.6 F. -Vanilla pudding desserts at 54.5 F. The facility policy titled Serving Temperatures for Hot and Cold Foods, undated, documented foods would be served to ensure a safe and appetizing dining experience at 41 F or below for cold beverages, fruits, desserts, salads, and dairy products. 6.Thermometer Sanitation (continued on next page)

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	295095	A. Building B. Wing	09/27/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/25/2024 at 12:51 PM, during lunch tray line observation, the Dietary Aide took the temperature of the chopped pork, wiped the thermometer with an alcohol swab, then wiped the thermometer with a stained, dirty appearing rag. The Dietary Aide used the same thermometer to take the temperature of the minced and moist pork, wiped the thermometer with a new alcohol swab, then wiped the thermometer with the stained, dirty appearing rag. The Dietary Aide took the same thermometer and took the temperature of the chopped pork, wiped the thermometer with an alcohol swab, and wiped the thermometer with the stained rag. On 09/25/2024 at 12:59 PM, the DM confirmed the Dietary Aide used the rag to wipe the thermometer before taking the temperature of the other foods. The DM verbalized the Dietary Aide should have use the alcohol swab and let the thermometer air dry without using the rag because it contaminated the other foods the thermometer was placed in. The DM asked if the DM could reheat the food to kill bacteria or if the DM would need to serve all new food to the residents. The facility policy titled Monitoring Food Temperatures for Meal Service, undated, documented alcohol swabs may be used to sanitize between uses while taking temperatures or if contamination of the thermometer occurs. If applicable, the manufacturer's recommendations for cleaning and sanitizing thermometers may be followed. The facility policy titled Preventing Foodborne Illness-Food Handling, adopted 05/01/2024, documented food would be stored in a way to prevent the risk of foodborne illnesses and staff would handle food with practices of safe food handling to prevent foodborne illnesses. CPT #NV00070408

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295095	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30748 Based on interview, clinical record review and document review, the facility failed to ensure resident records were complete and accurate for 1 of 29 sampled residents (Resident #80). The deficient practice had the potential for the resident not receiving appropriate care and/or medications. Findings include: Resident #80 Resident #80 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic kidney disease, unspecified, unspecified severe protein-calorie malnutrition, and muscle wasting and atrophy, not elsewhere classified, multiple sites. Resident #80's weight record documented the following: -04/01/2024: used a sitting scale -04/08/2024: used a sitting scale -04/16/2024: used a sitting scale -04/23/2024: used a sitting scale -04/29/2024: used a sitting scale -05/06/2024: used a sitting scale -06/04/2024: used a sitting scale -07/03/2024: used a sitting scale -07/10/2024: used a sitting scale -07/12/2024: used weights taken during dialysis -07/18/2024: used weights taken during dialysis -07/20/2024: used weights taken during dialysis -07/23/2024: used weights taken during dialysis -07/24/2024: used weights taken during dialysis -08/06/2024: used a sitting scale (continued on next page)

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	295095	A. Building B. Wing	09/27/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-08/08/2024: used weights taken during dialysis -08/10/2024: used weights taken during dialysis -09/03/2024: used a sitting scale -09/23/2024: used a wheelchair scale Resident #80's Care Plan initiated on 04/07/2024, and revised 09/25/2024, documented: -On 04/29/2024, the resident had a significant weight gain x one week -On 05/06/2024, the resident had a significant weight gain x 30 days -On 07/03/2024, the resident had significant weight loss x 30 days -On 08/10/2024, the resident had significant weight gain x one week -On 09/03/2024, the resident had significant weight gain x 30 and 90 days. The resident was to be weight monthly, On 09/26/2024 at 1:03 PM, the Registered Dietician explained there was one Certified Nursing Assistant (CNA) in the facility designated to take resident weights. The method used to weigh each resident needed to be consistent by using the same method each time the resident was weighed. The consistent method used to weigh each resident would determine if a resident was experiencing a significant weight loss or weight gain and if the same method was not used each time, the weights of each resident would not be accurate. The staff would not be able to honestly determine if a resident was experiencing significant weight loss or weight gain. The Registered Dietician confirmed Resident #80 was not weighed using a consistent method and the facility could not determine an accurate weight gain or weight loss for the resident. On 09/26/2024 at 2:19 PM, the CNA designated to take resident weights could not be located in the facility. The facility policy titled Nutrition Monitoring & Management Program, adopted 05/01/2024, documented the purpose of weighing residents was to ensure and maintain acceptable parameters of nutritional status, such as body weight and protein levels. Weights would be obtained using the same device on each weigh date. 31739 The facility policy titled, Documentation, Charting and Documentation, adopted 05/01/2024, documented all services and care shall be documented in the resident's record and documentation must be complete and accurate.

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	295095	A. Building B. Wing	09/27/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on observation, interview, clinical record review, and document review the facility failed to ensure Enhanced Barrier Precautions (EBP) were in place for a resident with chronic wounds for 1 of 29 sampled residents (Resident #292) and hand hygiene was performed during medication administration for 1 of 4 residents observed during medication administration (Resident #82). The deficient practice had the potential for spreading infectious illnesses to all residents. Findings include: Resident #292 Resident #292 was admitted to the facility on [DATE], with diagnoses including localized swelling, mass and lump, lower limb, bilateral and chronic venous hypertension (idiopathic) with ulcer. On 09/23/2024 at 2:00 PM, Resident #292 was lying in bed with bilateral lower legs wrapped with elastic bandages. The resident explained the resident was admitted to the facility for care of a wound on the resident's leg. The resident recalled the wound was present for approximately four to five months. Resident #292's room lacked EBP signage and a personal protective equipment (PPE) cart. A progress note dated 09/21/2024, documented bilateral lower extremity venous stasis ulcers. A physician's order dated 09/23/2024, with a start date of 09/25/2024, documented cleanse left leg with normal saline (ns), pat dry, apply honey gel, cover with wrap every day shift Monday, Wednesday, and Friday for 30 days. A physician's order dated 09/23/2024, with a start date of 09/25/2024, documented cleanse right leg with ns, pat dry, apply honey gel, then abdominal (abd) pad, wrap with kerlix, every day shift Monday, Wednesday, Friday for 30 days. On 09/26/2024 at 12:17 PM, a Licensed Practical Nurse (LPN) explained EBP was required when providing care to residents with chronic wounds. The LPN explained residents were evaluated for the need for EBP upon admission and an order was entered to implement EBP if the resident had a catheter or a chronic wound. EBP was intended to limit the spread of infections around the facility. The LPN confirmed Resident #292 had wounds on the resident's right and left lower leg, the wounds were venous ulcers. The LPN explained Resident #292's record documented the wounds as most likely chronic. The LPN verbalized Resident #292 would require the implementation of EBP and confirmed EBP was not in place. On 09/26/2024 at 4:24 PM, the Director of Nursing (DON) explained EBP was used for residents with indwelling medical devices and chronic wounds. The intent of EBP was to protect residents from infection. (continued on next page)

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	295095	A. Building B. Wing	09/27/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON confirmed Resident #292 had chronic wounds and should have had EBP put in place upon admission. The DON reviewed the resident's record and confirmed EBP was not implemented upon admission to the facility. The facility policy titled Enhanced Barrier Precautions, adopted 05/01/2024, documented residents with wounds and indwelling devices were at especially high risk of acquisition of and colonization with multi-drug resistant organisms (MDROs). Wounds generally included chronic wounds, example: venous stasis ulcers. Procedure included: 1) identifying residents requiring EBP, including residents with wounds that required dressings, 2) posting clear signage on the door/wall outside the resident room indicating the type of precaution and personal protective equipment required, and 3) placing a PPE cart immediately inside the resident's room. Resident #82 Resident #82 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including other acute osteomyelitis, left ankle and foot and chronic obstructive pulmonary disease, unspecified. On 09/26/2024 at 9:01 AM, LPN2 entered Resident #82's room and checked the resident's blood pressure. On 09/26/2024 at 9:04 AM, LPN2 exited Resident #82's room, donned a pair of gloves, cleansed the blood pressure cuff with an antimicrobial wipe, doffed the pair of gloves and began preparing medications for Resident #82. LPN2 did not perform hand hygiene upon exiting the resident's room or after doffing gloves. On 09/26/2024 at 9:17 AM, LPN2 entered Resident #82's room and administered medications to the resident. On 09/26/2024 at 9:21 AM, LPN2 explained hand hygiene was required in between medications passes, when entering and exiting a resident's room, before donning gloves, and after doffing gloves. LPN2 confirmed the LPN2 did not perform hand hygiene upon exiting Resident #82's room, prior to donning gloves, or after doffing gloves. On 09/26/2024 at 4:16 PM, the DON explained hand hygiene was required to be performed when hands were soiled and before and after nursing interventions. The DON confirmed hand hygiene was required to be performed after removing gloves. The facility policy titled Hand Hygiene, adopted 05/01/2024, documented healthcare personnel were to use an alcohol-based hand rub or wash with soap and water for the following clinical indications: between all services to residents, after touching the resident's immediate environment, and immediately after glove removal. The facility policy titled Standard Precautions, adopted 05/01/2024, documented standard precautions included washing hands after removing gloves. Gloves were to be removed promptly after use, before touching non-contaminated surfaces and items, before going to another resident, and hands were to be washed immediately to avoid transfer of microorganisms to other residents or environments. (continued on next page)

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	295095	A. Building B. Wing	09/27/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CPT #NV00070408

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295095	A. Building B. Wing	09/27/2024

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 31739 Based on employee record review, document review and interview, the facility failed to ensure an employee completed training on preventing, identifying, and reporting abuse, neglect, misappropriation of property, and exploitation (abuse training) for 1 of 35 sampled employees (Employee #8). The deficient practice had the potential to place residents at risk for abuse and neglect. Findings Include: Employee #8 Employee #8 with a title of Certified Nursing Assistant and a hire date of 10/17/2023. Employee #8's record lacked documented evidence abuse training had been completed. On 09/25/2024 at 1:19 PM, the Director of Human Resources confirmed Employee #8 was hired on 10/17/2023 and had not completed abuse training since hire. The facility policy titled, Freedom from Abuse, Neglect, and Exploitation, Preventing and Prohibiting Abuse, revised 09/13/2022, documented staff would receive training related to the prohibition and prevention, identifying and recognizing, and reporting of resident abuse, neglect, misappropriation of property, and exploitation.