STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295073	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROYAL SPRINGS HEALTHCARE AND REHAB	8501 DEL WEBB BLVD LAS VEGAS, NV 89134

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and document review, the facility failed to ensure: - call lights were answered in a timely manner for 7 of 11 residents in Resident Council and 11 of 40 sampled residents (Residents #101, #381, #222, #30, #97, #116, #147, #113, #785, #192, #149); - incontinent care was provided in a timely manner for 1 of 11 residents in Resident Council and 4 of 40 sampled residents (Residents #30, #222, #101, and #207); - a resident did not have a cluttered room for 1 of 40 sampled residents (Residenr#118); - a resident was not pulled backward in a Geriatric (Geri) chair for 2 of 40 sampled residents (Residents #5 and #14); - residents were not spoken to in a rude manner for 3 of 10 residents in Resident Council and 1 of 40 sampled residents (Resident #208); - nail care was provided to 1 of 40 sampled residents (Resident #207); - Residents feeling hurried and missing items (Resident #41 and #73). Findings include: Call Lights Not Answered in a Timely Manner and Failure to Provide Incontinent Care in a Timely Manner Resident #101 (R101) was admitted on [DATE], and re-admitted on [DATE] with [DIAGNOSES REDACTED]. The Admission Minimum Data Set ((MDS) dated [DATE], documented a Brief Interview for Mental Status (BI[CONDITION]) score of 15, which indicated the resident was cognitively intact. R101 required extensive assistance of two staff with bed mobility, transfers, toilet use, and personal hygiene. The resident was impaired on both lower extremities and did not walk. On 0[DATE]20 at 7:56 AM, R101 reported a Certified Nursing Assistant (CNA) had been abrupt responding to the call light when the resident needed incontinence care. R101 indicated feeling disrespected by the CNA and felt like the CNA did not want to provide incontinence care. R101 was upset to the point of crying. R101 did not want to upset the staff due to fear of retaliation. On 0[DATE]20 at 8:18 AM, R101 activated the call light. A Restorative Nursing Assistant (RNA) entered R101's room and the resident requested care for urine incontinence. The RNA was heard telling R101 the RNA would go and tell R101's CNA. The RNA turned off the call light and left the room without providing incontinence care. On 0[DATE]20 at 8:25 AM, R101 activated the call light. The same RNA returned, turned off the call light and told the resident their CNA would return to provide care. The RNA left without providing incontinence care. A few minutes later the RNA reentered the room and told R101 their CNA was with another resident and would help the resident next. The RNA left the room without providing incontinence care. On 0[DATE]20 at 8:42 AM, R101 activated the call light. The Licensed Practical Nurse (LPN) responded and R101 requested care for incontinence. The LPN informed R101 the CNA would be coming soon, and left R101's room without providing incontinence care. On 0[DATE]20 at 8:48 AM, a CNA arrived to provide incontinent care. On 0[DATE]20 at 8:50 AM, the RNA was sitting at the nursing station where R101 resided. The RNA declined an interview with this inspector. The RNA reported to not work in this area of the facility and was to busy to be interviewed. On [DATE]20 at 8:26 AM, R101's call light was flashing above the door in the hallway, and the alarm was sounding. An LPN was at a medication cart near R101's room. The LPN entered R101's room and turned the call light off. The LPN returned to the medication cart. At 8:28 AM, R101's light was activated. The LPN remained at the medication cart and did not respond to R101's call light. There were no CNAs observed in the hallway. At 8:32 AM, five staff members walked by R101's room as the call light sounded. At 8:33 AM, the CNA entered the room and turned off the call light. R101 later confirmed the staff repeatedly turned off the call light and did not provide care. On 03/05/2020 at 9:26 AM, an LPN indicated if a resident needed incontinence care, the LPN would turn off the call light and get the resident's CNA. On 03/05/2020 at 10:08 AM, a Registered Nurse (RN) explained the LPN should not have left a resident to get the CNA. It was not acceptable to turn off a call light and tell the resident someone would return later to provide their care. On 03/04/2020 at 2:33 PM, the Director of Nursing (DON) indicated it was not acceptable to turn off the call light and leave the resident to get the CNA to provide care. The DON indicated staff were expected to answer resident call lights in a timely manner and provide the care a resident needed. On 03/11/20 at 11:57 AM, R101 reported feeling helpless when sitting for extended periods in a urine or stool soiled brief. R101 reported waiting for a call light response for incontinent care so long, the bed sheets became saturated with urine and / or stool. R101 indicated feeling upset when this happened and wished to get up to go to the toilet but was physically unable. R101 wanted to ask the facility staff how they would feel if they sat in a urine and stool-soaked brief in bed for over an hour. The Quality of Life Dignity policy (revised in August 2009) documented the staff would have maintained resident dignity by promptly responding to resident's request for toileting. Resident #381 (R381) was admitted on [DATE] with [DIAGNOSES REDACTED]. An Admission MDS, dated [DATE], documented a BI[CONDITION] score of 15, which indicated the resident was cognitively intact. R381 required a two-person assistance with bed mobility, transfers, toilet use and was dependent for bathing. R381 required a one person assist with wheelchair, dressing, eating and hygiene. On 02/25/2020 at 2:58 PM, R381 indicated the call light response time was very slow. R381 indicated feeling bad for having to wait over an hour to get assistance with incontinence care and brief change. The resident was previously in the 300 Hall and reported staffing was bad and the call light wait time was long on that floor also. The resident felt bad waiting for such a long time to get cleaned up and have their brief changed. Call Lights Answered in a Timely Manner On [DATE]20 at 11:02 AM, residents participating in the Resident Council Meeting expressed the following issues with call lights: Seven out of 11 resident expressed the CNAs do not always attend to a resident's request for care because the CNA would be asked to assist other staff and not respond to the original resident request in a timely manner. Six out of 11 residents indicated there were times the call light had been activated and no one responded. Staff could be seen walking by the room. This had occurred on all shifts. The residents indicated it could take up to one hour for the call light to be answered. Resident #30 (R30) was admitted on [DATE], with [DIAGNOSES REDACTED]. R30 was cognitively intact. R30 reported having to sit in wet briefs while waiting for assistance from a Certified Nursing Assistant (CNA). R30 explained at times the brief had been very soaked, to the point when the CNA arrived to provide incontinent care, the brief would be leaking. R30 verbalized it had been happening daily and was mentioned to staff every day. The facility Call Lights Answering policy dated August 2009, documented call lights would be answered promptly within an appropriate time frame. Staff would keep watch on all call lights. Staff would answer all lights promptly, regardless of whose resident it was. Staff would determine the nature of the resident's inquiry or request. Resident #113 (R113) was admitted on [DATE] with [DIAGNOSES REDACTED]. An MDS dated [DATE] documented a Brief Interview for Mental Status BI[CONDITION] score (BI[CONDITION]) score of 13, with a maximal assist on activities of daily living assistance. On 03/11/20 at 2:08 PM, a Licensed Practical Nurse acknowledged R113 was cognitively intact with no memory deficit. On 03/11/20 at 2:28 PM, R113 would use the call light to get a hold of the staff, and although R113 could hear

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F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) them outside the room, no one would acknowledge the call light was activated. R113 stated the lack of call light response would get so bad, the resident would have to use his personal phone to get a hold of a staff member to get assistance in changing a soiled brief. R113 would remain soiled for thirty to forty-five minutes until a staff member attended to his needs. R113 stated these occurrences made him feel less than human. On 03/11/20 the Unit Manager revealed the call light should be answered as quickly as possible and the needs of the residents attended to in a timely manner. Resident #118 (R118) was admitted on [DATE] with the [DIAGNOSES REDACTED]. A Minimum Data Set ((MDS) dated [DATE] revealed a Brief Interview for Mental Status (BI[CONDITION]) score of 14, wheelchair bound and a two persons assist with activity of daily living assistance. On 03/04/2020, the following observation was made in R118 room: on the left side of resident's bed against the wall, were three shelved boxes on the floor stacked on top of each other about 5 feet high. Next to the boxes were two 60-gallon garbage bags stacked on top of each other; there were clothing items and papers on the floor next to the garbage bags. All the following items were protruding into the walkway against resident's bed. Both bedside tables were filled with personal items, 2-3 inches off the table. On 03/04/2020, R118 stated residents called her belongings junk. R118's room environment did not feel home like. The resident would not keep her home in this current condition. The resident's clothing items were dumped on the floor when the resident moved rooms. On 03/04/2020, a Certified Nursing Assistant stated the room was cluttered and had been in its current condition since August of 2019. The CNA stated the room was a safety hazard, and there was not adequate room to safely use the Hoyer lift to get resident out of bed. On 03/04/2020, the Unit Manager, stated there was not enough space to comfortably move around room, and could potentially cause harm to the resident. On 03/04/2020, the Assistant Director of Environmental services, acknowledged the room was cluttered; had been in its current condition for about a year, and was a potential hazard to resident. On 03/05/2020 at 9:50 AM, the Social Worker was not aware of the conditions of the resident's room. The facility's Resident Belongings policy documented boxes or any items shall not be stored on the floor at any time. The facility's Job Description for Certified Nursing Assistants (undated) documents, one of their various duties was to maintain resident's environment in a safe, clean and orderly manner. Resident #785 (R785) was admitted on [DATE] with [DIAGNOSES REDACTED]. An MDS dated [DATE] documented a Brief Interview for Mental Status (BI[CONDITION]) score of 15, with a maximal assist on activities of daily living assistance. On 03/11/2020 at 2:55 PM, a Licensed Practical Nurse acknowledged R785 was cognitively intact with no memory deficit. On 03/11/2020 at 3:30 PM, R785 verbalized he/she would activate the call light and would have to wait in a soiled brief in excess of 45 minutes during the two to ten shift. The resident could hear people outside the door, no one would come in and attend to the residents needs. The resident would consequently start yelling nurse before a staff member would attend to the resident's requests. R785 felt frustrated, irritated and isolated when these occurrences took place. On 03/11/2020 the Unit Manager revealed the call light should be answered as quickly as possible and the needs of the residents attended to in a timely manner. Resident #192 (R192) was admitted on [DATE] with [DIAGNOSES REDACTED]. An MDS dated [DATE] documented a Brief Interview for Mental Status (BI[CONDITION]) score of 15, requiring maximal assistance on toilet transfer. On 03/11/2020 at 10:08 AM, a Licensed Practical Nurse acknowledged R192 was cognitively intact with no memory deficit. On 03/11/2020 at 10:40 AM, R192 stated the CNA's did not come at all when the F192 called them. The resident was awfully raw from wearing incontinent briefs all the time. No one from the facility had explained why the resident could not wear regular undergarments. The resident stated the staff told the resident it was too time consuming to sit the resident on the commode. The resident has sat in a soiled brief for an hour and a half before any came to change the brief. These occurrences made the resident feel like a waste of life and should not be in existance. On 03/11/20 the Unit Manager revealed the call light should be answered as quickly as possible and the needs of the residents attended to in a timely manner. Resident #149 (R149) was admitted on [DATE] with a [DIAGNOSES REDACTED]. R149 stated there was not enough staff for the number of residents on the floor. When the resident was on the 300 unit, the resident stated waiting 45 minutes for the call light to be answered especially during the two to ten shift. On 03/11/2020 at 12:28 PM, a Licensed Practical Nurse stated R149 was cognitively intact with no memory deficits exhibited. On 03/11/2020 the Unit Manager revealed the call light should be answered as quickly as possible and the needs of the residents attended to in a timely manner. Resident #5 (R5) was admitted on [DATE] with [DIAGNOSES REDACTED]. A Quarterly MDS dated [DATE], documented a BI[CONDITION] score of 3, which indicated the resident had severe cognitive impairment. R5 was dependent on one staff member for locomotion around the facility, dressing, eating, toileting and personal hygiene. R5 was dependent on two staff members for bed mobility and transfers. On 0[DATE]20 at 1:27 PM, R5 was up in a geriatric (Geri) chair (a recliner chair) in the common room near the television. On 0[DATE]20 at 1:48 PM, a CNA pulled R5 backward in the Geri chair. The CNA left R5 near the nursing station. On 0[DATE]20 at 1:49 PM, a different CNA was pushing a resident in a wheelchair while pulling R5 down the hallway at the same time. On 0[DATE]20 at 1:51 PM, the CNA confirmed residents should not have been pulled in any chair backward for safety and dignity concerns. On 0[DATE]20 at 1:56 PM, the second CNA confirmed pulling residents backward in their chairs was not an acceptable practice and was a dignity issue. Resident #14 (R14) was admitted on [DATE], with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE], documented R14 was absent of spoken words, rarely/never understood and with severe impairment to make decisions. On 03/11/2020 at 8:29 AM, RNA pulled R14 backwards in a Gerri Chair from the television room into the resident's room. On 03/11/2020, at 8:30 AM, the RNA acknowledged pulling R14 backwards in the Gerri Chair and indicated pulling the chair was not the correct way to transport a resident. The proper way to move a resident in a Gerri Chair was to push and direct the chair.
F 0561 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and clinical record review, the facility failed to get a resident out of bed per the resident's preference for 1 of 40 sampled residents (Resident #113). Findings include: Resident #113 (R113) was admitted on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status score of 13, indicating the resident was cognitively intact requiring maximum assistance with activities of daily living. On [DATE]20 at 9:00 AM, R113 verbalized a desire to get out of bed. R113 had not gotten out of bed in about a year. There were two wheelchairs covered in dust in the corner of R113's room with multiple items stored on top of them. There was a handwritten note indicating to get the resident out of bed into the wheelchair on Tuesday and Thursday. A Physician order [REDACTED]. The clinical record lacked documented evidence the resident was gotten out of bed daily. On 03/04/2020 at 11:00 AM, a Registered Nurse was unaware of the physician order [REDACTED]. On 03/04/2020 at 12:00 PM, a Certified Nursing Assistant was unaware of the physician order, hence the patient remained in bed. On 03/04/2200 at 12:07 PM, the Unit Manager acknowledged the residents request along with the physician's orders [REDACTED].
F 0568 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.** Based on interview and document review, the facility failed to ensure residents who had a resident trust account were provided with a quarterly statement. Findings include: On [DATE]20 at 10:38 AM, the Business Office Manager indicated being new in the position. The Business Office Manager was unable to provide documentation resident's with a trust fund account received a statement regarding the account. The facility Patient Trust Policy and Procedure, effective 08/01/2018, documented at least a quarterly a statement must be issued to all residents or responsible parties. This may be a copy of the resident ledger card and should show the beginning and current balance, total receipts and disbursements. A note should be made on the ledger card to show the statement was given out.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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**

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F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Based on observation, interview, clinical record review, and document review, the facility failed to ensure a clean comfortable homelike, sanitary environment was maintained and resident property was kept safe from loss or theft for 1 of 40 sampled residents (Resident #76). Findings include: On 0[DATE]20 at 8:15 AM, the following was observed during a tour of the 300 hall: -floor along the wall/base trim, corners, and at door jamb entry areas were caked with a brown/blackish color grime. -privacy curtain in room [ROOM NUMBER] between bed A and B bed was soiled with large brown splash and stains. -wall area below handrails had dried splash/drip marks, scuffs or other dried matter on the wall. -dining area cabinets had pieces of laminate missing, exposing the pressed board. Base trim had pulled away from the wall. -showers had broken tiles missing at the drain, tile/trim missing in shower stalls. Broken corner tiles where the floor and wall meet. On 03/04/2020 at 8:15 AM, a Licensed Practical Nurse (LPN) confirmed dry caked on matter on the handrail. The LPN attempted to clean the matter off the handrail and indicated the handrail should have been clean. On 03/04/2020 at 8:30 AM, a housekeeping staff member reported responsibilities included cleaning the resident rooms and nightshift cleaned the hallways. The staff member acknowledged the splatter marks on the walls and dirt/grime on the floors near room [ROOM NUMBER]. On 03/04/2020 at 8:45 AM, a housekeeping staff member reported responsibilities included cleaning resident rooms, bathrooms and the lobby. The evening and night crew cleaned the handrails, walls, as well as stripped, cleaned and waxed the floors. The staff member acknowledged the splash on the wall and indicated the walls and handrails should have been cleaned by housekeeping if they appeared dirty. On 03/05/2020 at 9:30 AM, the Maintenance Director reported knowledge of the lack of cleanliness and maintenance of the facility. The Maintenance Director indicated the facility had lost staff, and as a result, the workload had to be prioritize. On 03/05/2020 at 10:00 AM, the Assistant Maintenance Director reported Floor Technicians (Floor Techs) were responsible for cleaning the floors at night. Floor Techs were expected to clean the floors, wipe the walls and handrails. He indicated they are short staffed and not able to tend to extensive cleaning. He acknowledged the floor appearance was not acceptable. On 03/11/2020 at 10:07 AM, the Housekeeping Supervisor acknowledged the soiled handrails, walls and floor. The Housekeeping Supervisor indicted housekeeping were responsible for cleaning the rooms. If during their shift, the staff happen to see walls have spills, or handrails were soiled, the staff should clean the area. The evening shift buffs the floors, cleans the walls and handrails. The Housekeeping Supervisor had the responsibility to check the work has been completed. The privacy curtain in room [ROOM NUMBER] needed to be cleaned, this was confirmed by the Housekeeping Supervisor. The Housekeeping Supervisor indicated privacy curtains were rotated out daily per the cleaning schedule. If staff noticed a curtain was soiled, staff were to report it to the Housekeeping Supervisor for the curtain to be removed and cleaned. Resident #76 (R76) was readmitted on [DATE], discharged on [DATE] and readmitted on [DATE], with [DIAGNOSES REDACTED]. R76's Inventory of Personal Effects form dated 11/25/2019 and 0[DATE], documented one cellphone and one charger. A copy of a receipt for a cellphone dated 0[DATE]20 with a total amount of $216.13 was attached to the Inventory. The credit card used to pay the cellphone was under the name of R76's daughter. A Nurses Note dated 02/23/2020, documented the resident's cellphone could not have been located during the night shift. The resident's daughters were informed. On 0[DATE]20 at 9:52 AM, R76 indicated the cellphone was missing two or three days ago. R76 was upset because the cellphone was used to communicate with the resident's family. The resident used to keep the cellphone at bedside. On 0[DATE]20 at 1:10 PM, R76's daughter revealed on 02/23/2020 she got a phone call from a nurse about the resident's missing cellphone. The resident was upset and crying because the cellphone was missing. The resident had lost two cellphones at the facility. The first cellphone was missing on 01/09/2020. The cellphone was in the inventory and the facility did not replace the missing cellphone. The resident's daughter bought a new cellphone, included in the inventory, and went missing on 02/23/2020. R76's daughter explained the resident stayed in bed most of the time and did not go anywhere. The resident needed the cellphone to communicate with the family. On [DATE]20 at 11:11 AM, a Certified Nurse Assistant (CNA) revealed R76 kept the cellphone on the resident's chest all the time. Around two weeks ago, the CNA asked the resident where the cellphone was. The resident replied, I don't know. According to R76, the resident was being changed and the cellphone was probably got wrapped up in the linens. The CNA indicated R76 was bothered because the cellphone was missing. The resident usually stayed in bed, used the cellphone to play games and communicate with family. The CNA explained the inventory of belongings wound have been updated when a resident/family brought additional personal items to the facility. On [DATE]20 at 2:47 PM, a Unit Manager confirmed R76's cellphone was in the inventory dated 11/25/19 and 0[DATE] and should have been replaced. On 03/05/2020 at 9:59 AM, the Unit Manager explained the staff were expected to secure R76's cellphone during provision of care such as changing the linens and cleaning the resident. R76 stayed in bed most of the time. The resident had lost two cellphones. The staff should have checked regularly if the resident had the cellphone. On 03/05/2020 at 10:16 AM, the Administrator acknowledged the staff should have been more careful and monitored the resident's cellphone regularly when providing care. On 03/05/2020 at 12:37 PM, a Consulting Social Worker revealed a grievance for the first missing cellphone was resolved on 02/20/2020. Another grievance was filed on 02/25/2020 for the second missing cellphone and was pending investigation. On 03/05/2020 at 3:48 PM, the Director of Nursing (DON) indicated the staff were expected to respond immediately when the resident's cellphone went missing. The nursing management should have been informed as soon as possible so an investigation could have been initiated right away. The laundry department could have been checked if the cellphone was wrapped up in the linens. The DON explained the staff should have monitored regularly if the resident had the cellphone especially the first cellphone was already missing.
F 0604 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and clinical record review, the facility failed to ensure physical restraints were not used for 1 of 40 sampled residents (Resident #129) as evidenced by the resident's bed against the wall. Findings include: Resident #129 (R129) R129 was admitted on [DATE] with [DIAGNOSES REDACTED]. On [DATE]20 at 9:21 AM, R129 was observed lying in bed with the right side of the bed against the wall. On [DATE]20 at 3:36 PM, R129 was observed lying in bed with the right side of the bed against the wall. On [DATE]20 at 3:42 PM, a Certified Nursing Assistant (CNA) revealed the right side of the bed was against the wall to prevent R129 from climbing out of bed. The clinical record lacked documented evidence R129's bed being up against the wall was an intervention to prevent R129 from climbing out of bed. On 03/05/2020 at 3:50 PM the Director of Nursing confirmed R129's bed should not have been placed up against the wall, to prevent R129 from climbing out of bed.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** Based on interview, clinical record review and document review, the facility failed to ensure an allegation of sexual abuse was reported to law enforcement for 1 of 36 Facility Reported Incidents reviewed (Residents #10 and #13). Findings include: A Facility Reported Incident (FRI) dated 02/08/2020 documented a sexual allegation involving Resident #10 and #13. On 03/04/2020 at 1:58 PM, the Unit Manager indicated an investigation was initiated by the facility, but law enforcement was not informed. On 03/05/2020 at 4:20 PM, the Administrator confirmed law enforcement should have been informed. The facility Abuse Investigation and Reporting Policy revised July 2017 documented all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source, and misappropriation of the property would be reported by the Administrator or his/her designee, to the following agencies: state licensing agency, ombudsman, adult protective services, and law enforcement officials.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to maintain documentation an investigation into allegations of abuse was conducted for 1 of 36 Facility Reported Incidents reviewed (Resident #23). Findings include: Resident #23 (R23)

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) was admitted on [DATE] with [DIAGNOSES REDACTED]. A Nursing Progress Note dated 0[DATE] at 9:30 PM, documented the resident was awake, alert, nonverbal, tracheotomy/ventilator dependent, no signs or symptoms of pain, resident was a total assist with repositioning and total care with activities of daily living (ADLs), resident on skilled occupational and physical therapy services. On 0[DATE]20, a left hand x-ray revealed there was an acute [MEDICAL CONDITION] aspect of the head of the middle phalanx of digit 4 with associated hand swelling. A review of the Nursing, Respiratory, and physician progress notes [REDACTED]. A physician progress notes [REDACTED]. The physician documented the resident had an acute fracture on the lateral aspect of head, middle phalanx of 4th digit) splint on, orthopedic consult, currently non weight bearing. A physician progress notes [REDACTED]. Orthopedic consult for 01/22/2020. On 01/20/2020 at 6:31 PM, a late entry for 0[DATE]20 at 4:00 PM was documented. The late entry documented on 0[DATE], the resident went to a neurology consult. Upon returning to the facility, new orders were given by the neurologist for a x-ray of the left hand and ultrasonography of left forearm. The x-ray tech came on 0[DATE]20 at 9:00 AM, results were provided to the facility on [DATE] at 2:30 PM, which showed an acute fracture through the lateral aspect of the head of the middle phalanx of digit 4, left hand. The Physician Assistant ordered an orthopedic consult STAT (immediately) and for physical therapy to put a finger splint. Upon assessment, the resident denied any pain. History and interview with the resident and the resident's wife revealed both had no recollection as to how the resident sustained [REDACTED]. Orthopedic consult completed on 01/22/2020, documented left hand/wrist swelling. Mild diffuse swelling left hand/wrist, no [DIAGNOSES REDACTED], diffuse stiffness finger range of motion, no localized tenderness along entire left ring finger, no tenderness left wrist , range of motion stable, no pain with passive range of motion left hand/wrist. X-rays multiple views left hand and wrist do not show obvious fracture, anatomy intact. Resident has been care planned for high risk for falls and pain related to the fractured finger. The resident was unable to recall how the injury occurred. On 03/04/2020 in the afternoon, the Director of Nursing was not able to provide the final investigation report.
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** Based on interview, clinical record review and document review, the facility to assess, develop and implement a care plan for a resident who smoked for 1 of 40 sampled residents (Resident #36). Findings include: Resident #36 (R36) was admitted on [DATE] with [DIAGNOSES REDACTED]. An Admission Minimum Data Set ((MDS) dated [DATE], documented a Brief Interview for Mental Status (BI[CONDITION]) of 15, indicating the resident was cognitively intact. The MDS documented the resident was not a tobacco user. The clinical record lacked documented evidence a care plan related to smoking was developed for R36. On 0[DATE]20 at 8:55 AM, R36 was observed smoking in the smoking area. R36 reported to be a smoker on and off for many years. The resident claimed to have brought cigarettes into the facility at the time of admission. The resident did not recall participating in a discussion regarding smoking with any facility staff. On 03/05/2020 at 3:08 PM, the Registered Nurse (RN) MDS Director explained the nurse who performed the admission assessment identified whether the resident smoked. If the resident smoked, an assessment to determine if the resident was safe to smoke would be completed. At this point the resident would be coded in the MDS as a tobacco user. A smoking care plan would be initiated as a result of this process. The MDS Director indicated the activities staff and the nurses on the floor should enter the information into the computer to initiate a care plan for smoking. The MDS Director confirmed R36's clinical record did not identify the resident smoked on the admission nursing assessment dated [DATE]. The MDS Director was unable to locate a completed smoking assessment for R36. The MDS Director confirmed if a resident was not identified as a smoker, a smoking care plan would not be created. The MDS Director confirmed if R36 did smoke, there should be a safety assessment and care plan for smoking. On 03/05/2020 at 3:29 PM, a Licensed Practical Nurse (LPN) assigned to care for R36 explained if a resident smoked and staff observed the resident smoking, a smoking safety assessment and care plan should be completed. The LPN confirmed R36's clinical record did not contain a smoking safety assessment or care plan. The nurse confirmed the assessment was not done at admission. The LPN confirmed R36 smoked. The facility Smoking Policy Revised 02/15/2020 documented residents would be evaluated at admission to determine if they smoked and a Smoking assessment and Safety Evaluation would be completed.
F 0676 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and document review the facility failed to ensure the staff used a communication board prior to the provision of care for 1 of 40 sampled residents (Resident #76). Findings include: Resident #76 (R76) was readmitted on [DATE] discharged on [DATE] and readmitted on [DATE], with [DIAGNOSES REDACTED]. A Nursing Note dated 0[DATE]20, documented R76 had a hard time hearing. The Social Service Quarterly Note dated 03/02/2020, documented a late entry for [DATE]20. Social Service Assessment was conducted with R76 for an Assessment Reference Date of [DATE]20 (ARD/the date which signified the end of the look back period). R76's hearing was moderately impaired. The resident could have heard if other noises were removed. But due to the noises in R76's room such as the ventilator and Oxygen, it was necessary to write on the whiteboard to ensure the resident received messages appropriately. On 0[DATE]20 at 10:05 AM, R76 was lying in bed and had a whiteboard and markers on bedside. The resident was verbal and responded to questions if written on the whiteboard. On 0[DATE]20 at 12:53 PM, a Respiratory Therapist (RT) asked if the resident wanted to receive [MEDICAL CONDITION] care. The resident refused. The RT did not use the whiteboard in communicating with the resident. The RT confirmed the observation and acknowledged the staff should have used the whiteboard to communicate with the resident. On 0[DATE]20 at 1:10 PM, a family member revealed the resident had hearing problems since 2009. The resident's family brought the whiteboard and markers for the staff to use in communicating with the resident. The whiteboard was not always used by the staff. R76 could have done lip reading but not every time. The staff expected the resident could always do lip reading. A family member explained if the staff did not use the whiteboard and just talked, the resident could not have heard and understood what the staff were saying. As a result, the resident would have been upset and refused care like changing and cleaning the resident. On 0[DATE]20 at 2:03PM, the RT started to provide [MEDICAL CONDITION] care to R76. On 0[DATE]20 at 2:07 PM, a Registered Nurse (RN) entered the resident's room while the RT was providing the [MEDICAL CONDITION] care. The resident was leaning on the right side and paying attention with the RT while providing the [MEDICAL CONDITION] care. The RN touched the resident's left arm then applied the cream on the resident's left arm while the [MEDICAL CONDITION] care was still ongoing. The resident was startled. The RN did not use the whiteboard to communicate with the resident on what the RN would have done prior to applying the cream. On 0[DATE]20 at 12:55 PM, the RN confirmed the observation and indicated the resident was hard of hearing. The resident preferred the staff to use the whiteboard. The RN should have written in the whiteboard if it was okay with the resident to apply the cream while the [MEDICAL CONDITION] care was ongoing. The RN acknowledged the resident was startled when the RN touched the resident's left arm prior to applying the cream. On [DATE]20 at 11:11 AM, a Certified Nurse Assistant (CNA) revealed the resident was legally deaf. The staff should have used the whiteboard to communicate with the resident and prior to providing care. On [DATE]20 at 2:47 PM, the Unit Manager indicated the staff were expected to write in the whiteboard in communicating with the resident. On 03/05/2020 at 7:39 AM, the Director of Respiratory Department revealed the resident was hard of hearing. The RTs were expected to use the whiteboard to communicate with the resident. The facility Quality of Life - Accommodation of Needs policy revised in August 2009, documented in order to accommodate individual needs and preferences, staff attitudes and behaviors must have been directed towards assisting the residents in maintaining independence, dignity and well-being to the extent possible and in accordance with the resident's wishes. Staff should have interacted with the residents in a way which would have accommodated the physical or sensory limitations of the residents, promoted communication, and maintained dignity. Complaint #NV 068
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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	295073	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROYAL SPRINGS HEALTHCARE AND REHAB	8501 DEL WEBB BLVD LAS VEGAS, NV 89134

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) Based on interview, clinical record review, and document review the facility failed to ensure showers were provided as scheduled for 2 of 40 sampled residents (Resident #76 and #86). Findings include: Resident #76 (R76) was readmitted on [DATE], discharged on [DATE] and readmitted on [DATE], with [DIAGNOSES REDACTED]. R76's Plan of Care - Current form effective 12/02/2019, documented the resident required total dependence with one-person assist with bathing. The interventions included to set-up, assist, give shower, shave, oral, hair, nail care per schedule and as needed (PRN). Review of the Shower/Skin Assessment document from 12/01/2019 to 02/29/2020, revealed R76 missed showers on 12/13/19, 01/03/2020, 01/20/2020, 01/27/2020, 02/07/2020, and 0[DATE]20 as scheduled. On [DATE]20 at 12:58 PM, the Scheduler confirmed the findings and acknowledged there was no documented evidence to prove R76 received showers or a bed bath on the above-mentioned dates. The resident missed six shower days from 12/01/2019 to 02/29/2020. The Certified Nurse Assistants (CNA) were expected to complete the Shower/Skin Assessment document every time a resident received shower or bed bath. On [DATE]20 at 2:16 PM, the Unit Manager explained the CNAs were expected to provide a shower or bed bath to the residents as scheduled and complete the shower sheet every time a shower or bed bath was provided. On [DATE]20 at 3:18 PM, a CNA revealed each resident was scheduled to have a shower or bed bath twice a week. CNAs should have completed the Shower/Skin Assessment document every time a resident received a shower or bed bath. Resident #86 (R86) was readmitted on [DATE], with [DIAGNOSES REDACTED]. R86's Plan of Care - Current form effective [DATE]19, documented the resident required total dependence with two-person assist with bathing. The interventions included to set-up, assist, give shower, shave, oral, hair, nail care per schedule and PRN. Review of the Shower/Skin Assessment document from 01/01/2020 to 02/29/2020, revealed R86 missed shower on 01/24/2020, 01/28/2020, 02/04/2020, 02/07/2020, 02/20/2020, and 0[DATE]20 as scheduled. On [DATE]20 at 10:56 AM, a CNA indicated R86 was totally dependent on activities of daily living (ADLs) including shower. The resident should have received shower or bed bath twice a week. The resident's hair should have been washed with shampoo during scheduled shower days. On [DATE]20 at 12:52 PM, the Scheduler confirmed the findings and acknowledged there was no documented evidence to prove R86 received showers or bed bath on the above-mentioned dates. The resident missed six shower days from 01/01/2020 to 02/29/2020. The resident should have received shower twice a week. The Floor Shower Log ([LOC]) documented the shower schedule in the unit where R76 and R86 resided. The schedule indicated each resident was scheduled to have a shower twice per week. Complaint #NV 880 and #NV 988
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and document review, the facility failed to ensure medication was given per physician orders [REDACTED].#79, #129 and #137), a physician order [REDACTED].#166), and [MEDICAL CONDITION] precautions were followed per physician orders [REDACTED].#129). Findings include: Resident #79 (R79) was readmitted on [DATE] with [DIAGNOSES REDACTED]. A physician order [REDACTED]. The Medication Record for March 2020 documented the administration of Multivitamin was scheduled at 8:00 AM. On [DATE]20 at 7:26 AM, during the medication administration pass observation, a Registered Nurse (RN) prepared the following medications for R79 scheduled at 8:00 AM: - [MED] 25 milligram (mg) one tablet - [MED] 5 mg one tablet - [MEDICATION NAME] 0.1 mg one tablet - [MEDICATION NAME] XR 180 mg one tablet - [MEDICATION NAME] 40 mg one tablet - [MEDICATION NAME] 100 mg one tablet - [MEDICATION NAME] Sodium 100 mg one tablet - [MEDICATION NAME] 300 mg one tablet - [MEDICATION NAME] 100 my one tablet - [MEDICATION NAME] 325 mg one tablet - [MEDICATION NAME] 12 units solution On [DATE]20 at 7:37 AM, the RN administered ten tablets to R79 as listed above. The RN confirmed ten oral medications were given to the resident. On [DATE]20 at 9:29 AM, the RN confirmed Multivitamin was not given during the medication administration pass observation. The RN acknowledged the medication was not given as ordered. The physician's orders [REDACTED]. On [DATE]20 at 12:27 PM, the Director of Nursing (DON) explained the nurses were expected to access the electronic Medication Administration Record [REDACTED]. The facility's Administering Medications policy revised in December 2012, documented medications should have been administered as prescribed. Resident #129 (R129) was admitted to the facility on [DATE] with a primary [DIAGNOSES REDACTED]. On [DATE]20 at 9:21 AM, R129 was observed lying in bed with bilateral side rails raised on both the right and left side of the bed. A padded mat was attached to the outside of the left side rail. On [DATE]20 at 3:36 PM, a Licensed Practical Nurse (LPN) verbalized there should had been two padded mats, both placed on the inside of the left and right-side rails. On 03/04/2020 at 10:13 AM, R129 was observed lying in bed. One padded mat was observed on the outside of right bed rail, and no padded mat was observed on left bed rail. On 03/04/2020 at 10:45 AM, a Registered Nurse (RN) revealed the padded mats on the side rails were utilized for [MEDICAL CONDITION] precautions. The RN confirmed the two padded mats should had been placed on the inside of the left and right-side rails. A physician's orders [REDACTED]. A care plan dated 01/14/2019, documented resident required the use of padded side rails and was at risk for injury because of [MEDICAL CONDITION] disorder. Intervention included the use of padded side rails. On 03/05/2020 at 3:50 PM, the Director of Nursing (DON) confirmed the padded mats for R129's side rails were positioned inappropriately. A facility policy titled [MEDICAL CONDITION] Precautions (undated), documented [MEDICAL CONDITION] precautions will be initiated on residents with a history of [MEDICAL CONDITION] or a condition that may precipitate [MEDICAL CONDITION]. On 03/04/2020 at 10:17 AM, a Registered Nurse (RN) was observed administering R129's medications via gastrostomy tube ([DEVICE]). The RN prepared the medication by diluting the medication inside of a plastic cup. The RN filled a clean syringe with the diluted medication and proceeded to administer the medication to R129 through the [DEVICE]. After administering the medication, the RN flushed R129's [DEVICE], then disposed of the plastic cup, which contained residue of the medication. The RN did not flush R129's [DEVICE] prior to the administration of the medication. A physician's orders [REDACTED]. R129's care plan dated 04/22/2019, documented R129 was at risk for aspiration. Interventions included flush [DEVICE] with 50cc of water before and after medication administration. On 03/05/2020 at 12:39 PM, a RN explained when administering medications via [DEVICE], the [DEVICE] should had been flushed before administering medications. To prevent the tubing from becoming clogged. On 03/05/2020 at 3:56 PM, the DON confirmed the [DEVICE] should had been flushed before the administration of medications via [DEVICE] to prevent the tubing from becoming clogged. The facility policy titled Administering Medications through an Enteral Tube revised March 2015, documented steps in procedure include flush tubing with 15-30 mL warm sterile water or prescribed amount. Resident #137 (R137) was admitted to the facility on [DATE], with a primary [DIAGNOSES REDACTED]. The medication administration history documented [MEDICATION NAME] 1mg was given on the following dates: - 03/04/2020 at 2:54 AM - 03/05/2020 at 2:36 AM On 03/05/2020 at 12:13 PM, the Unit Manager (UM) verified the [MEDICATION NAME] 1mg was not given on time as ordered and verified R137's clinical record lacked documented evidence, why the medication was not given on time. The UM verbalized if medications were not administered on time as ordered, the staff should have documented the rationale within the clinical record. On 03/05/2020 at 4:04 PM, the Director of Nursing (DON) revealed the reason [MEDICATION NAME] 1mg was not given per order should have been documented in R137's clinical record and the physician should had been notified about the medication being given not on time as ordered. The facility policy titled Administering Medications revised December 2012, documented medications must be administered in accordance with the orders, including any required time frame, and medications must be administered within one hour of their prescribed time, unless otherwise specified. Resident #166 (R166) was admitted on [DATE] with [DIAGNOSES REDACTED]. A Situation Background Assessment Request (SBAR) and Progress Notes form dated 02/29/2020 documented R166's suprapubic catheter was dislodged. The form indicated the Licensed Practical Nurse (LPN) replaced a size 22 French (Fr) catheter. The form revealed the physician ordered for R166's to be transferred to the hospital for further evaluation. R166's medical record lacked documented evidence of a physician's orders [REDACTED]. On 03/04/2020 at 1:19 PM, the Director of Staff Development indicated licensed nurses would have ascertained a physician's orders [REDACTED]. The Suprapubic Catheter Replacement Policy revised October 2010 documented the licensed nurse would verify the physician's orders [REDACTED].

F 0685 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Assist a resident in gaining access to vision and hearing services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and document review, the facility failed to ensure a 1 of 40 sampled residents received proper treatment for [REDACTED].#97). Findings include: Resident #97 (R97) was admitted on [DATE] with [DIAGNOSES REDACTED]. On 0[DATE]20 at 3:16 PM, observed R97 laying in the bed in their room. The resident was

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F 0685 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) not wearing glasses. At times, questions to R97 had to be repeated so the resident could hear them. On 0[DATE]20 at 3:16 PM, R97 verbalized a wish to have eyeglasses and had an exam recently but did not get the glasses. R7 reported having trouble reading information on their wall. R97 wanted a hearing aid and explained having hearing in the left ear of 10%, in the right ear of 70% and no hearing aid. R7 explained they had been asking for glasses and a hearing aid since coming to the facility. A 0[DATE]19 physician order [REDACTED]. The 12/19/2019 Annual MDS Assessment Section B Vision, documented R97 saw large print but not regular print. For hearing, moderate difficulty was documented. The Nursing Notes dated 0[DATE]20, documented a request from R97 for hearing aids due to difficulty hearing. The physician was notified, and an audiology consultation was ordered. On 03/04/2020 at 1:43 PM, the Director of Social Services explained they often found out about needs for glasses from the MDS. If a family expressed a need or took concern, the Director of Nursing (DON) and Quality personnel would see how the facility could meet that need. The DON would speak with the Unit Manager. If there was a problem, the Director of Social Services would ask the DON what was happening. This would be documented in the Social Services Notes. There were also clinical rounds daily to discuss resident issues. The Director of Social Services was unaware of R97's vision and hearing needs and confirmed there was no documentation between December 2019 and February 2020 to address R97's requests. On 03/05/2020 at 4:45 PM, the Director of Social Services confirmed there was no documentation about R97's request for eyeglasses and a hearing aid. The Director explained the previous person in this position did not have a license in social work and was doing random, non-clinical actions with no documentation and was not allowed to go into resident's charts. The Director of Social Services verbalized the audiologist was in-house and came to the facility on ce a month to see residents. The facility Process for Hearing Aides - Audiologist, Dentist and Podiatry Appointments and Process of Optometry Appointments document (undated), documented the process of initiating an appointment/transportation request with the resident name and need. Nursing would schedule with the consultants who visit the facility on a monthly schedule. For optometry appointments the process was to initiate an appointment/transportation request with the patient name and need. Nursing would finalize the order and place the request in the Transportation folder for pickup every day. There was a form completed by the nursing staff for the appointment/transportation request.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review the facility failed to ensure a resident who was at risk for skin breakdown was repositioned every two hours as scheduled for 1 of 40 sampled residents (Resident #86). Findings include: Resident #86 (R86) was readmitted on [DATE] with [DIAGNOSES REDACTED]. R86's Plan of Care - Current form effective 07/17/2019, documented the resident was at risk for skin breakdown related to bowel and bladder incontinence, impaired bed mobility, history of pressure injury, and fragile skin. The interventions included to turn and reposition frequently. The physician's orders [REDACTED]. On [DATE]20 at 10:56 AM, a Certified Nurse Assistant (CNA) revealed the resident was totally dependent on activities of daily living (ADL) including repositioning. On 03/05/2020 at 7:24 AM, R86 was in bed and lying on her back. A Turning Schedule sign was posted on the wall inside the resident's room. The schedule documented repositioning in bed every two hours from 1:00 AM to 11:00 PM, facing door and window and laying on the back alternately. On 03/05/2020 at 7:26 AM, a CNA assigned to the resident confirmed the observation and revealed the CNA had not repositioned the resident since the start of shift at 6:00 AM. On 03/05/2020 at 8:51 AM, a Treatment Nurse explained R86 was at risk of developing pressure ulcers due to decreased mobility and poor circulation. The resident should have been repositioned every two hours to prevent skin breakdown and development of pressure ulcers. On 03/05/2020 at 9:17 AM, the resident was in bed and lying on her back. A Respiratory Therapist, (RT) was inside the resident's room. The RT indicated R86 was lying on her back when the RT checked on the resident at 7:00 AM and 9:00 AM today. The RT checked on the resident every two hours and found the resident on the same position in bed. The resident was lying on her back since 7:00 AM. On 03/05/2019 at 11:19 AM, the RT was inside the resident's room. The resident was lying on her back. The RT confirmed the resident had the same position as when the RT checked the resident at 7:00 AM and 9:00 AM. On 03/05/2019 at 11:27 AM, the Registered Nurse (RN) assigned to the resident revealed the work shift started at 6:00 AM. The RN saw the resident at 6:30 AM, 7:15 AM, and 11:15 AM. The resident was lying on her back during the said times when the RN checked on the resident. On 03/05/2019 at 11:30 AM, two CNAs pulled the resident up in bed. The resident was lying on her back. A CNA indicated it was the first time the CNA pulled the resident up in bed during the shift. On 03/05/2019 at 11:35 AM, the Unit Manager confirmed the turning schedule for R86 should have been followed. The nurse should have reminded the CNAs to follow the schedule. The CNAs were expected to reposition the resident per the turning schedule. The resident should have been repositioned every two hours to prevent skin breakdown. Complaint #NV 988
F 0687 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate foot care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review the facility failed to provide documented evidence of podiatry services for 1 of 40 sampled residents as scheduled (Resident #86). Findings include: Resident #86 (R86) was readmitted on [DATE] with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. A handwritten list of residents scheduled for podiatry services in January 2020 documented R86 was on a list for 01/14/2020. The list was contained in a binder maintained at [LOC] Nurse's Station. On [DATE]20 at 10:56 AM, a Certified Nurse Assistant (CNA) indicated resident toe nails were not cut by CNAs. CNAs would have to report to the nurses if a resident had long toenails. On [DATE]20 at 3:30 PM, the Unit Manager confirmed R86 was on the list for a podiatry consult on 01/14/2020. There was no documentation a podiatry consult was completed as scheduled. The Unit Manager was not sure if the resident was seen by the podiatrist in January 2020 or February 2020. On [DATE]20 at 3:38 PM, the Medical Records Director acknowledged there was no Interdisciplinary Progress Notes (IPN) of the podiatry visit in January 2020 for R86. The podiatrist was expected to complete the IPN every time podiatry services were provided. On 03/05/2020 at 8:59 AM, the Unit Manager indicated the nurses should have followed up with the podiatrist if R86 was not seen in January 2020. The nurses should have documented in the nurse's notes the follow-up made with the podiatrist. The Unit Manager acknowledged there was no documentation a follow-up was made for R86's podiatry services. On 03/05/2020 at 1:27 PM, the Director of Nursing (DON) explained the nurses were expected to include a resident in the list for podiatry services contained in the binder at the nurse's station, then call the podiatrist for the schedule. The podiatrist would have visited every month to see the residents in the list and provide podiatry care as requested and ordered. The podiatrist should have written a visit note then submitted the note to the medical records staff within 48 hours from the visit date. Medical records would have uploaded the visit note into the electronic health record upon receipt of the note. The DON indicated the nurses were expected to call and follow-up with the podiatrist if services were not provided as scheduled. The follow-up made and the podiatrist's response should have been documented in the Nurse's Notes. Complaint #NV 988
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and document review, the facility failed to ensure Restorative Nursing Aid(RNA) services were provided as ordered for 2 of 40 sampled residents (Resident #79 and #137). Findings include: Resident #79 (R79) was admitted to the facility on [DATE] with a primary [DIAGNOSES REDACTED]. On 02/25/2020 at 3:21 PM, R79 revealed not receiving any restorative services since being admitted to the facility. A History and Physical dated 0[DATE], documented R79 would be admitted to the skilled nursing home and would continue Physical Therapy (PT) and Occupational Therapy (OT) services. A communication form originated by the therapy department dated 0[DATE], documented Restorative Nursing Aide (RNA) to perform Range of Motion (ROM) on all joints and planes, three sets, 15 repetitions, once every six days, for 12 weeks to preserve joint integrity. A physician's orders [REDACTED]. The restorative minutes schedule revealed R79 had not received RNA services as ordered on the following dates: - 02/21/2020 - [DATE] - 02/23/2020 - 0[DATE]20 - 0[DATE]20 - 02/29/2020 - 03/01/2020 On 03/04/2020 at 2:50 PM, the RNA verified R79 had not received RNA services on those dates, as a result of the RNA staff being back logged. On 03/05/2020 at 4:06 PM, the Director of Nursing (DON) verbalized RNA services should have been able to carry out the workload and have provided services as ordered. Resident #137 (R137) was admitted to the facility on [DATE] with a primary [DIAGNOSES REDACTED]. On 02/25/2020 in the afternoon, R137 verbalized wanting more therapy services. A History and Physical dated 01/06/2020, documented R137 was admitted to the facility from an acute care hospital for a comprehensive rehabilitation program. A communication form

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F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 6) originated by the therapy department dated 02/11/2020, documented RNA to perform ROM on all joints and planes, three sets of 15 repetitions, six days per week, for 12 weeks. A physician's orders [REDACTED]. The restorative minutes schedule revealed R137 had not received RNA services as ordered on the following dates: - 02/12/20 - 02/13/20 - 02/15/20 - 02/16/20 - [DATE] - 02/20/20 - 02/23/20 - 0[DATE] - [DATE] On 03/04/2020 at 2:50 PM, an RNA verified R79 had not received RNA services on those dates, as a result of the RNA staff being back logged. On 03/05/2020 at 4:06 PM, the DON verbalized RNA services should had been able to carry out their workload and provide services as ordered. A facility policy titled Resident Mobility & Range of Motion revised July 2017, documented residents with limited mobility would receive appropriate services, equipment, and assistance to maintain or improve mobility unless reduction in mobility was unavoidable.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and clinical record review, the facility failed to ensure 1 of 40 sampled residents was properly transferred from the bed to a Geri-chair (Resident #147). Findings include: Resident #147 (R147) was admitted on [DATE] with [DIAGNOSES REDACTED]. On 02/25/2020 at 3:06 PM, R147 indicated was dropped by a Nurse a few days ago. The nurse was transfereing R147 from the bed to the chair when R147 was dropped on the floor, hitting their head and butt. The resident reported receiving an x-ray but did not go to the hospital. On 02/25/2020 at 3:06 PM, no hazards were observed, there were no obstructions between the resident and the Geri-chair against the wall. The bed was set in the low position. Resident was alert and oriented. The 08/01/2019 Plan of Care Summary and 0[DATE] Current Care Plan, documented R147's bed mobility and transfers as extensive, two-person assist. The plan also documented R147 was in bed to Geri-chair. A Falls Investigation Worksheet dated 0[DATE], documented a CNA was transferring R147 to the Geri-chair when the brake malfunctioned causing the Geri-chair to move back. The CNA was with the resident at the time of the fall. The CNA stated, I went to (R147) room, I got (R147) dressed and I looked for a sling but there wasn't one. I sat (R147) on the edge of the bed, but before that I positioned the Geri-chair and I locked it. I transferred (R147) and when (R147) sat down on the Geri-chair, the left wheel lock took off and the chair went back. I had (R147) in my grip so I gently assisted (R147) to the floor. No injury. Maintenance was immediately made aware of the malfunctioning brake. The facility safety policy was reviewed with the CNA. On 03/04/2020 at 9:39 AM, a Licensed Practical Nurse (LPN) explained the protocol for resident transfers was to use a sling and Hoyer lift to transfer the resident from the bed to the Geri-chair for all residents. The CNAs performed the task. If a resident could stand with an assist, the CNA did not use the Hoyer lift. On 03/04/2020 at 10:15 AM, another LPN explained the staff normally used a Hoyer lift for R147, most of the time. The LPN reported a CNA was transferring R147. There was no sling available. While transferring, the CNA lowered the resident down. The brake was on the chair, but the chair dislodged. The CNA was alone. The LPN verbalized the transfer should have been a two person assist. On 03/04/2020 at 10:34 AM, the CNA involved with the resident fall reported the transfer protocol was always two people. There was always a sling and Hoyer lift and two people were needed for that. This made it easier to change and move a resident. The Geri-chair had to be locked, then the resident was transferred. The CNA cleaned and dressed the resident and looked for a sling. There was no sling available because they were being washed. The CNA was busy and could not find help due to end of shift. The nurse was completing the med pass. The CNA locked the chair and began transferring the resident (without a sling or Hoyer lift). During the transfer, the CNA noticed the left brake on the chair had taken off, and heard the noise. As a result, the resident fell to the floor. On 03/05/2020 at 8:05 AM, the 200 Hall Unit Manager verbalized there were enough slings for the residents that needed them and R147 was a Hoyer lift resident. The Unit Manager verbalized in general, if a Hoyer lift was needed, it was always two staff, not one, even if the CNA thought they could do it alone. The CNA thought the resident could be transfered alone and without the Hoyer lift. On 03/05/2020 at 9:26 AM, the Director of Nursing (DON) reported there were two Hoyer lifts on each hall and 75 slings available. The CNA would retrieve the slings from the laundry, and the sling was used until soiled. Once soiled, the sling was sent back to the laundry to exchange for another one. On 03/05/2020 at 3:56 PM, an LPN reported the protocol for using a Hoyer lift was two staff at all times. The LPN explained all care staff received training on use once on the floor and it was documented in the employee's record.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and clinical record review, the facility failed to provide incontinence care in a timely manner which resulted in a moisture associated skin damage for 1 of 40 sampled residents (Resident #101), and failed to provide incontinent care to 6 of 40 sampled residents (Residents #30, #222, #192, #149, #785, and #113). Findings include: Resident #101 (R101) was admitted on [DATE] and re-admitted on [DATE], with [DIAGNOSES REDACTED]. On 0[DATE]20 at 7:56 AM, R101 reported a Certified Nursing Assistant (CNA) had been abrupt when responding to call light when the resident needed incontinence care. R101 indicated the CNA would enter the resident room to respond to a call light and when R101 requested care for a wet brief, the CNA would turn off the light and say they would return to provide care later. At times, the CNA's would return up to one and one-half hours later and the resident would be soaked with urine when the CNA returned. On 0[DATE]20 at 8:18 AM, R101 depressed the call light. A Restorative Nursing Assistant (RNA) was observed entering the resident room. The resident requested care for urine incontinence. The RNA was heard telling the resident the RNA would go and tell the resident's CNA. The RNA turned off the call light and left the room without providing incontinence care. On 0[DATE]20 at 8:25 AM, R101 activated the call light. The same RNA returned, turned off the call light and told the resident their CNA would return to provide care. The RNA left without providing incontinence care. A few minutes later the RNA reentered the room and told R101 their CNA was with another resident and would help the resident next. The RNA left the room without providing care. On 0[DATE]20 at 8:42 AM, R101 activated the call light. The Licensed Practical Nurse (LPN) responded. R101 requested care for incontinence. The LPN informed R101 the CNA would be coming soon. The LPN left without providing care. R101's medical record contained a Minimum Data Set ((MDS) dated [DATE], which documented a (Brief Interview for Mental Status) BI[CONDITION] of 15, indicating the resident was cognitively intact. R101 required extensive assistance of two staff with bed mobility, transfers, toilet use, and personal hygiene. The resident was impaired on both lower extremities and did not walk. The MDS dated [DATE], documented R101 was always incontinent of urine and frequently incontinent of bowel. Urinary incontinence and Activities of Daily Living (ADL) function were identified in the Care Area Assessment Summary (CAA). R101's medical record lacked documented evidence of a Care Plan specific to bowel and bladder incontinence. A Care Plan dated 06/29/2019 identified a stage 2 pressure ulcer in which the goal was to minimize further skin breakdown with interventions which included but were not limited to incontinence care as needed, turn and repositioning as tolerated. The Bed Mobility Care Plan dated 07/03/2019 documented the resident would be assisted with Activities of Daily Living (ADLs) and repositioned as tolerated. The CNA ADL report for July of 2019, documented R101 was dependent on staff for bed mobility, transfer, toileting, and personal hygiene. The CNA Flow Sheet for July and August lacked documented evidence R101 was provided care for bowel and bladder incontinence on the following dates for 3 dates for July 2019 and 9 dates for the month of August 2019. On 0[DATE]20 at 1:16 PM, R101 confirmed the wait times for incontinent care were much longer during mealtimes due to the CNA's being busy passing meal trays and helping other residents to eat. On 0[DATE]20 at 2:47 PM, a CNA indicated the CNA staff should assist a resident who has their call light on even if it was not their resident. It was not appropriate to turn off the call light and tell the resident they would get their CNA. On [DATE]20 at 8:26 AM, R101's call light was on. The LPN entered the room and turned the call light off. One minute later the call light was on. The LPN was standing outside of door at medication cart and did not respond. There were no CNAs observed on hallway. At 8:32 AM, five staff members walked by R101's room as the call light was flashing above the resident's door and the alarm was sounding at the nursing station. R101 later confirmed the staff had turned off the call light and did not provide incontinence care. On 03/05/2020 at 9:26 AM, the LPN indicated nursing should respond to call lights even during medication pass. Nursing should always check with resident to see what they need and take care of it if possible. If the nurse could not help them, the nurse should explain and would have to return to provide the care later. The LPN indicated if a resident needed incontinence care, the LPN would get the residents CNA and turn off the call light. On 03/05/2020 at

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	295073	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROYAL SPRINGS HEALTHCARE AND REHAB	8501 DEL WEBB BLVD LAS VEGAS, NV 89134

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F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 7) 10:08 AM, the Registered Nurse (RN) explained the LPN should not leave a resident to get the CNA. Is it not ok to turn off a call light and tell the resident someone would return later to provide their care. On 03/04/2020 at 2:33 PM, the Director of Nursing indicated it was not Ok to turn off the call light and leave the resident to get the CNA to provide care. On 0[DATE]20 at 1:55 PM, a CNA indicated an average of 13 to 14 of resident assigned to the CNA were dependent on the CNA for incontinence care. The CNA indicated incontinent residents were supposed to be checked and changed every 2 hours if needed. The CNA acknowledged residents did not consistently receive incontinent care promptly and at times the CNA was unable to ensure all assigned residents had their brief changed by shift change. When this occurred, the CNA would inform the oncoming CNA which residents needed to have their brief changed first. On 03/11/2020 at 12:09 PM, R101 reported in the past to have waited a long period of time for call light response for incontinent care that the bed sheets became saturated with urine and or stool. R101 indicated feeling upset when this happened and wished to get up to the toilet but was physically unable. R101 wanted to ask the facility staff how they would feel if they sat in a urine and stool soaked brief and bed for over an hour. Incontinent Care policy reviewed 2020, documented residents who were incontinent of bowel and bladder would be kept clean and dry. Incontinent rounds would be made every 2 hours as needed. The objective of the policy was to keep residents clean, dry, odor free and prevent skin breakdown. Resident #30 (R30) was admitted on [DATE] with [DIAGNOSES REDACTED]. R30 had a Brief Interview for Mental Status (BI[CONDITION]) score of 15 indicating the resident was cognitivelt intact. On [DATE]20 at 11:02 AM, the resident reported having to sit in wet briefs while waiting for assistance from the Certified Nursing Assistant (CNA). R30 explained at times their brief had been overloaded with urine, to the point that by the time the CNA came to clean and change the resident, the brief would be leaking. R30 verbalized it had been happening daily and was mentioned to staff every day. R30 explained the CNAs had limited help, therefore the residents received limited help. Resident #222 (R222) was admitted on [DATE], with [DIAGNOSES REDACTED]. R222 had a BI[CONDITION] score of 15. R222 reported there were times when the resident sat soiled with feces and would not get an answer to the call light for an hour. The resident verbalized it usually happened at night. It happened frequently in the past and twice in the last couple of months. The CNA would come into the room, knowing help was needed. R222 verbalized the assigned CNA would be on break and the CNA covering did not take care of the need. The CNA would turn off the light but would not provide toileting care or cleaning. R222 expressed they did not report the incidents to anyone, but had yelled and screamed at staff in response. On 03/05/2020 at 8:05 AM, the 200 Hall Unit Manager reported the expectation for call light response was that any staff should go into the resident's room and ask for what their needs were. In cases of bowel and/or bladder care, if the CNA was assigned somewhere else, the resident was told to wait until the CNA could come back. At that time the call light stayed on, even if the CNA had to come back for care. If a CNA became free, they would change the resident. The Unit Manager expressed that some residents understood, some did not. The average wait time depends. A reasonable time to wait for bowel/bladder care was 15 to 30 minutes. The Unit Manager reported the registered nurse cannot help with cleaning a resident. On 03/05/2020 at 9:26 AM, the Director of Nursing (DON) expressed the expectation for call light response was immediately, and 15 minutes would be acceptable. Bathroom calls were immediate, within five minutes. The CNA Job Description (undated), documented responsibilities to provide care in a manner which protected the dignity, respect, self-esteem and individuality of the resident. Responsibility of respect for the individual emotional, social, cultural and religious beliefs of the resident. Promptly answer resident call lights and respond appropriately to his or her needs. Responsibility to provide preventative skin care measures which included cleaning of the skin when necessary to maintain the skin clean, dry and free of urine or feces. Maintain resident's environment in a safe, clean and orderly manner. The Charge Nurse job description (undated), documented the Charge Nurse will direct and supervise duties performed by the nursing assistants under their charge. Direct and supervise care that meets the individual needs of each resident as assigned. The facility Quality of Life - Accommodation of Needs policy revised August 2009, documented the resident's individual needs shall be accommodated to the extent possible. Staff attitudes and behaviors must be directed towards assisting the residents in maintaining independence, dignity and well-being to the extent possible and in accordance with the resident's wishes. Resident #113 (R113) was admitted on [DATE], with [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status BI[CONDITION] score (BI[CONDITION]) score of 13 indicating the resident was cognitively intact, with a maximal assist on activities of daily living assistance. On 03/11/2020 at 2:08 PM, a Licensed Practical Nurse acknowledged R113 was cognitively intact with no memory deficit. On 03/11/2020 at 2:28 PM, R113 verbalized he would use the call light to get a hold of the staff, and although the resident could hear the staff outside the room, no one would acknowledge the call light was activated. R113 stated, the lack of call light response would get so bad, the resident would have to use a personal phone to get a hold of a staff member to get assistance in changing his soiled brief. R113 would remain soiled for thirty to forty-five minutes until a staff member attended to his needs; He stated these occurrences made him feel less than human. On 03/11/2020 the Unit Manager revealed the call light should be answered as quickly as possible and the needs of the residents attended to in a timely manner. Resident #785 (R785) was admitted on [DATE], with [DIAGNOSES REDACTED]. An MDS assessment dated [DATE], documented a Brief Interview for Mental Status (BI[CONDITION]) score of 15 indicating the residnet was cognitevly intact, with a maximal assist on activities of daily living assistance. On 03/11/2020 at 2:08 PM, an LPN acknowledged R785 was cognitively intact with no memory deficit. On 03/11/2020 at 2:44 PM, R785 verbalized how the call light was activated and would have to wait in a soiled brief in excess of 45 minutes during the two to ten shift. Although R785 could hear people outside the door, no one would come in and attend to R785's needs. R785 would consequently start yelling at nurse before a staff member would attend to the requests. R785 felt frustrated, irritated and isolated when these occurrences took place. On 03/11/2020 the Unit Manager revealed the call light should be answered as quickly as possible and the needs of the residents attended to in a timely manner. Resident #149 (R149) was admitted on [DATE] with a [DIAGNOSES REDACTED]. help for the number of residents on the floor. When R149 was on the 300 unit, the resident stated waiting 45 minutes for call lights to be answered with a soiled brief was the norm, especially during the two to ten shift. On 03/11/2020 at 12:28 PM, a Licensed Practical Nurse stated R149 was cognitively intact with no memory deficits exhibited. On 03/11/2020 the Unit Manager revealed the call light should be answered as quickly as possible and the needs of the residents attended to in a timely manner. Resident #192 (R192) was admitted on [DATE], with [DIAGNOSES REDACTED]. An MDS assessment dated [DATE], documented a Brief Interview for Mental Status (BI[CONDITION]) score of 15 indicating the resident was cognitively intact and requiring maximal assistance on toilet transfer. On 03/11/2020 at 2:08 PM, a Licensed Practical Nurse acknowledged R192 was cognitively intact with no memory deficit. On 03/11/2020 at 9:43 AM, R192 stated in reference to the nursing assistants, they don't come at all when I call them. The resident stated to have been awfully raw from wearing briefs all the time, and no one has explained why regular undergarments could not be worn. R192 indicated employees have told her it is too time consuming to sit her on the commode. When R192 has requested help, the resident has had to sit in a soiled brief for an hour and a half before any help comes. These occurrences have made the resident feel like they should not be in existence, and a are a waste of life. On 03/11/2020 the Unit Manager revealed the call light should be answered as quickly as possible and the needs of the residents attended to in a timely manner.
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** Based on observation, interview, record review, and document review the facility failed to ensure nutritional risks were identified and addressed for 1 of 40 sampled residents (Resident #166). Findings include: Resident #166 (R166) was admitted on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set assessment dated [DATE], documented a BI[CONDITION] (Brief Interview for Mental Status) score of 13 or cognitively intact. On 02/25/2020 and 0[DATE]20, in the morning and noon, R166 did not eat breakfast or lunch. On 02/26/3030, at 1:34 PM, R166 revealed refusing breakfast and lunch on 02/25/2020 and 0[DATE]20 due to decreased appetite. A Point of Care (POC) history report dated January 2020 to March 2020, documented R166 refused to eat at least one meal on, 11 days out of January 2020, 10 days out of February 2020 and 03/01/2020. The report indicated R166 refused breakfast, lunch, and dinner on 01/27/2020. A Dietary Quarterly Note dated 0[DATE] indicated R166's meal intake was 25% - 100% A Dietary Wound Note dated 0[DATE]20 documented R166's meal intake was 50-100% and liquid and oral supplements were required. On [DATE]20 at 2:52 PM, a Certified Nursing Assistant (CNA) indicated if a resident refused to eat breakfast, lunch, or dinner, an alternative would have been offered; and if the resident still refused the licensed nurse would have been informed. On [DATE]20 at 2:54 PM, a Licensed Practical Nurse (LPN) indicated if a resident refused a

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F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 8) meal, an alternative would have been offered. The LPN revealed if the resident still refused to eat, the physician and dietitian would have been informed. On [DATE]20 at 12:36 PM, the Dietary Manager confirmed the reason for refusal should have been identified and addressed. On [DATE]20 11:27 AM, the Registered Dietitian (RD) indicated the meal intake of a resident would have been included in the nutritional assessment, and any meal refusal would be addressed. The RD verified 166's refusal to eat should have been addressed and documented in the medical record. The medical record lacked documented evidence of staff addressing the meal refusal. The Refusal of Care, Treatment, and Procedures Policy revised August 2005, documented patterns of refusal or instances of refusal that directly threaten the health, safety, and well-being of the resident would require physician notification. The Nutritional Assessment Policy revised February 11, 2020, documented a nutritional assessment would be completed and would include the following component current weight and height, usual body weight, current clinical conditions, and meal intake. The Interdisciplinary team would identify risk factors such as inadequate calorie intake. The dietitian would make appropriate recommendations to meet estimated calorie intake. Sources of information for the nutritional assessment would include observations, interviews with the resident and staff, and the resident's medical record.
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, the facility failed to ensure tube feeding was administered per physician orders [REDACTED].#108 and #109) Findings include: Resident #108 (R108) was admitted to the facility on [DATE] with a primary [DIAGNOSES REDACTED]. On 02/25/2020 in the morning, R108's Tube Feeding (TF) machine was observed, running at 60cc (cubic centimeters) per hour. On [DATE]20 at 3:17 PM, R108 was observed lying in bed rubbing her stomach gesturing she was hungry. R108's TF was observed, running at 60cc per hour. On 03/04/2020 at 9:46 AM, R108 was observed lying in sleeping. R108's TF was observed, running at 60cc per hour. A physician's orders [REDACTED]. until dose limit met, 2100 Kilocalories (kcals) in 24 hours. A Registered Dietician (RD) recommendation note dated 11/29/2019, documented increase TF iso-source 1.5 1400cc dose at 70cc/hr. until dose limit via enteral pump reaches 2100 kcals, in 24 hours. On 03/04/2020 at 9:51 AM, a Registered Nurse (RN) verified R108's physician's orders [REDACTED]. until dose limit met, 2100 kcals in 24 hours. On 03/04/2020 at 9:56 AM, the RN confirmed R108's TF was set to 60cc/hr. and should have been set to 65cc/hr. The RN verbalized staff should have been checking the TF settings to ensure TF was being administered per physician's orders [REDACTED]. On 03/04/2020 at 11:14 AM, the Registered Dietician (RD) revealed based on R108 maintaining stable weight, R108 did not trigger to get reassessed. The RD confirmed R108's physician order [REDACTED]. instead of 60cc/hr. Resident #109 (R109) was admitted to the facility on [DATE] with a primary [DIAGNOSES REDACTED]. On 02/25/2020 in the morning, R109 was observed lying in bed the TF was set at 70cc/hr. On 03/04/2020 at 2:25 PM, R109's TF pump was observed set at 70cc/hr. A physician's orders [REDACTED]. until dose limit met, 1320 kcals in 24 hours. On 03/04/2020 at 2:25 PM, a RN verified R109's physician order [REDACTED]. instead of 70cc/hr., and the RN set R109's TF to 55cc/hr. On 03/05/2020 at 10:50 AM, the RN confirmed the TF settings for R108 and R109 were not set correctly per physicians orders, and verbalized it was not documented in R108 and R109's clinical record the TF was set incorrectly and the RN had changed the TF to the correct setting per physician's orders [REDACTED]. On 03/05/2020 at 12:28 PM, the Unit Manager (UM) confirmed the TF settings for R108 and R109 were set incorrectly, and the clinical record lacked documented evidence the RN had notified the physician and RD regarding the TF's being set incorrectly. The UM further explained, if a TF is running at an incorrect rate and the rate is changed. The physician and RD should be notified immediately. On 03/05/2020 at 4:09 PM, the Director of Nursing (DON) revealed the physician's orders [REDACTED]. Staff should have immediately notified the physician and RD. The facility policy titled Nutritional assessment dated [DATE], documented for residents receiving enteral nutrition support, the assessment shall include a gathering of information documenting appropriate recommendations as needed to meet calorie intake, standardized screening and assessments, and individualized care plans.
F 0694 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide for the safe, appropriate administration of IV fluids for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and document review, the facility failed to document attempts for intravenous insertions for 1 of 4 sampled residents (Resident #210). Findings include: Resident #210 (R210) was admitted on [DATE] with [DIAGNOSES REDACTED]. On 02/25/2020 in the afternoon, R210 reported currently receiving intravenous (IV) antibiotics for pneumonia. R210 explained the staff repeatedly had difficulty with IV insertions, which left a lot of bruises on the arms. On 02/25/2020 in the afternoon, R210's arms had multiple, scattered spots on both forearms, dark red to purple in color. There was a large oblong, dark red to purple spot on R210's inside right forearm. The spot was approximately 5.5 centimeters x 4.5 centimeters in size. R210 did not know where the large bruise came from, but was not in pain. The resident's clinical record documented R210 had a blood draw and IV stick for antibiotics on 02/25/2020 and was taking the blood thinner [MED], 20 milligrams daily for [MEDICAL CONDITION]. The resident's Situation, Background, Assessment, Recommendation (SBAR) and Progress Notes dated 02/10/2020, documented the resident was at risk for signs and symptoms of IV complications, such as infiltration (swelling), phlebitis (redness) and infection (swelling, redness). A 02/04/2020 physician order [REDACTED]. The nurses daily charting notes in the resident's clinical record lacked documented evidence of nursing attempts for IV insertions. On 03/04/2020 at 9:39 AM, a Licensed Practical Nurse (LPN) reported the protocol for a resident who was difficult stick was to attempt insertion two to three times in different spots and inform the Registered Nurse (RN). A nurse who may be an expert in IV sticks may have been used, to preserve the resident. If it doesn't work, the physician was called and a peripherally inserted central catheter (PICC) line was started. Documentation depended on the nurse and would be documented in IPN, the nurse notes or on the Medication Administration Record [REDACTED]. On 03/05/2020 at 8:05 AM, the 200 Hall Unit Manager explained the big bruise on R210's arm was reported to her yesterday. R210 reported it to a nurse. The protocol for a resident who was an IV hard stick, was to call the physician and request an order for [REDACTED]. The Unit Manager confirmed the IV insertion attempts were not documented in nurse notes or on the MAR. On 03/05/2020 at 9:26 AM, the DON reported the protocol for IV insertions was two attempts, in different places, then the physician would be notified to request a mid or PICC line. The request and documentation of the multiple IV insertion attempts should have been in the nurses notes. The DON confirmed there was no documentation of the IV insertion attempts in the nurses notes.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** Based on observation, interview and document review, the facility failed to ensure there was sufficient staff to meet the needs of the residents which resulted in emotional distress and skin break down for Residents #116, #149, #192, #222, #101, #381, #30, #113, and #147. Findings include: Resident #116 (R116): Indicated having to wait an hour and 30 minutes for someone to acknowledge their call light. Resident #149 (R149): On 03/11/2020 at 12:10 PM, R149 had gotten used to yelling instead of using the call light because when R149 used the call light, no one came. Resident #192 (R192): On 03/11/2020 at 10:40 AM, R192 stated has sat in a soiled brief for an hour and a half before anyone came to change the brief. These occurrences made the resident feel like a waste of life and should not be in existence. Resident #222 (R222): Sat soiled with feces and would not get an answer to the call light for an hour. The Certified Nursing Assistant (CNA) would turn off the light but would not provide toileting care or cleaning. Resident #101 (R101): On 0[DATE]20 at 7:56 AM, R101 indicated feeling helpless when sitting for extended periods of time in a urine or stool soiled brief for over an hour to an hour and a half. Resident #381 (R381): On 02/25/20 at 2:58 PM, R381 indicated there were not enough nursing staff and had to wait over an hour to get incontinent care. The resident felt bad waiting for such a long time to get cleaned up and have brief changed. Resident #30 (R30): Reported having to sit in wet briefs while waiting for assistance from the CNA. R30 explained at times their brief had been overloaded with urine, to the point the brief would be leaking. Resident #113 (R113): On 03/11/20 at 2:28 PM, R113 reported being soiled for thirty to forty-five minutes until a staff member attended to his needs. R113 stated these occurrences made him feel less than human. Resident #147 (R147): Reported they were transferred by one CNA and R147 fell to the floor. On 03/05/2020 in the morning, a CNA indicated staff should not walk past an active

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	295073	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROYAL SPRINGS HEALTHCARE AND REHAB	8501 DEL WEBB BLVD LAS VEGAS, NV 89134

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 9) call light. Staff should take care of residents and not pass the task on to another staff member. The CNA indicated residents who need incontinent care should be checked every two hours. The CNA indicated the facility was short staffed and at times would need to work overtime to get all the work done. On 0[DATE] at 1:32 PM, a CNA indicated the facility worked with insufficient number of CNAs and nurses. The CNA indicated a significant number of nursing staff did call in sick on the [LOC]. When that occurred, CNAs and other nurses were pulled from other units resulting in those areas of the facility being left without enough nursing staff. The CNA indicated staff were moved from their scheduled assignment to work in a different area to the facility because there were not enough CNAs or nurses. On 0[DATE] at 1:55 PM, a CNA reported to work the day shift but frequently filled in on the 2:00 PM to 10:00 PM shift due to not having enough CNAs. The CNA confirmed being sent to other areas of the facility was a frequent occurrence and this would consistently result in areas of the facility being short staffed. The CNA indicated being assigned to care for an average of 14 residents. CNA staff were expected to provide resident assistance with two meals during the day shift. Two of the assigned residents were expected to be showered during the shift, four to five residents were completely dependent for all care. Several residents required two staff members to perform Hoyer lift transfers. The CNA indicated at times it was hard to get nursing to help. The CNA was routinely assigned to 13 of 14 residents who required assistance with toileting or brief changes. The CNA claimed to have worked short many times and when staff called in sick, the facility did not usually replace the staff who had called in. The CNAs would work short staffed which resulted in a higher number of residents to care for. The CNA acknowledged resident care was not completed during the shifts when they worked short staffed. The CNA indicated residents were not receiving incontinence care or being repositioned every two hours On 03/11/10 in the morning, a Licensed Practical Nurse (LPN) indicated the facility did not have enough nursing staff. The LPN indicated the short staffing had resulted in residents being administered their medications late. On [DATE] at 2:45 PM, the Director of Nursing (DON) revealed four of eight residents indicated there were not enough nursing staff to provide care and 65-75 per cent of nursing staff interviewed indicated they were assigned too many residents to care for. The CNA explained there was not enough time to take care of the resident's needs. One example was there may not have been time for a resident needing Hoyer lift assistance to get up. See tags F 550 and F 686
F 0740 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure each resident must receive and the facility must provide necessary behavioral health care and services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review, the facility failed to ensure a psychiatric evaluation was coordinated following an altercation for 2 of 40 sampled residents (Resident #83 and #155) and 11 of 177 unsampled residents (Resident #42, #43, #181, #230, #70, #161, #232, #74, #228, #20, #175). Findings include: Resident #230 (R230) was admitted on [DATE] with diagnoses, including unspecified dementia and [MEDICAL CONDITION] disorder. Resident #161 (R161) was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #70 (R70) was admitted on [DATE] with [DIAGNOSES REDACTED]. A Facility-Reported Incident (FRI) documented on 12/17/19; a physical altercation occurred between R230 and R161. The report indicated R230 struck R161 in the neck. A Facility-Reported Incident (FRI) documented on 12/28/19; a physical altercation occurred between R230 and R70. The report indicated R230 struck R70 on the right cheek. R230's care plan dated 12/17/19 documented physically abusive related to [MEDICAL CONDITION] disorder as evidenced by hitting other residents at random times and listed psychiatric evaluation as needed as an intervention. R230's medical record documented a Physician Assistant (PA) progress noted dated 12/25/19 and [DATE] indicating Psychiatric Consult. R230's medical record lacked documented evidence of psychiatric consult in December 2019. R161's medical record lacked documented evidence of psychiatric evaluation in December 2019. R70's medical record lacked documented evidence of psychiatric evaluation in December 2019. On 03/04/2020 at 1:51 PM, the Director of Nursing (DON) indicated the PA's progress note indicating a psychiatric evaluation for R230 should have been clarified by the assigned nurse. The DON confirmed a psychiatric evaluation should have been coordinated within 24 hours following the physical altercation between R230 and R161 and R230 and R70 to help manage the residents' behaviors and prevent reoccurrence. Resident #181 (R181) was admitted on [DATE] with [DIAGNOSES REDACTED].#43 (R43) was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #83 (R83) was admitted on [DATE] with [DIAGNOSES REDACTED]. A Facility-Reported Incident (FRI) documented on 02/01/2020 a resident-to-resident physical altercation occurred. The report indicated R181 hit R43 with a cup. A Facility-Reported Incident (FRI) documented on 02/02/2020 a resident-to-resident altercation occurred. The report indicated R181 poured a glass of water on R83. R181's care plan dated [DATE] documented anxiety disorder as manifested by yelling out without provocation and listed psychiatric evaluation and follow up as indicated as an intervention. R181's medical record lacked documented evidence of psychiatric evaluation after the altercation on 02/02/2020. R43's medical record lacked documented evidence of psychiatric evaluation following the altercation with R181 on 02/01/2020. R43's medical record lacked documented evidence of psychiatric evaluation following the altercation with R181 on 02/02/2020. On 03/04/2020 at 1:51 PM, the DON confirmed a psychiatric evaluation should have been coordinated per R181's care plan. The DON confirmed a psychiatric evaluation should have been coordinated within 24 hours following the alleged altercation between R181 and R43 and R181 and R83 to help manage the residents' behaviors and prevent reoccurrence. Resident #20 (R20) was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #43 (R43) was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #155 (R155) was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #228 (R228) was admitted on [DATE] with [DIAGNOSES REDACTED]. A Facility-Reported Incident (FRI) documented on 01/04/2020 a verbal altercation occurred between R20 and R155. A Facility-Reported Incident (FRI) documented on 0[DATE]20 a verbal altercation occurred between R20 and R228. R20's care plan dated 11/20/19 documented Altered behavior as manifested by a verbal altercation with other residents and listed psychiatric evaluation as needed as an intervention. R43's behavioral care plan dated 11/08/19 indicated psychiatric evaluation as needed. R155's anxiety care plan dated 05/15/19 indicated psychiatric evaluation as needed. R20's medical record lacked documented evidence of a psychiatric consultation following the three separate incident altercations on 11/20/19, 01/04/2020, and 0[DATE]20. R43's medical record lacked documented evidence of psychiatric evaluation following the altercation with R20 on 11/20/19. R155's medical record lacked documented evidence of psychiatric evaluation following the altercation with R20 on 01/04/2020. R228's medical record lacked documented evidence of psychiatric evaluation following the altercation with R20 on 0[DATE]20. On 03/04/2020 at 11:50 AM, the DON confirmed a psychiatric evaluation should have been coordinated per R20, R43, and R155's behavioral care plan. The DON confirmed a psychiatric evaluation should have been coordinated within 24 hours following the alleged altercation between R20 and R43; R20 and R155; and R20 and R228 to help manage the residents' behaviors and prevent reoccurrence. Resident #232 (R232) was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #175 (R175) was admitted on [DATE] with [DIAGNOSES REDACTED].#74 (R74) was admitted on [DATE] with [DIAGNOSES REDACTED]. A Facility-Reported Incident (FRI) documented on 11/25/19; a verbal and physical altercation occurred among R175, R74, and R232. R232's medical record lacked documented evidence of a behavioral care plan addressing the altercation with R175 and R74. R74's medical record lacked documented evidence of a behavioral care plan addressing the altercation with R175 and R232. R175, R232, and R74's medical record lacked documented evidence of psychiatric evaluation following the incident on 11/25/19. On 03/04/2020 at 11:16 AM, the DON confirmed a psychiatric evaluation should have been coordinated within 24 hours following the alleged altercation which involved R175, R232, and R74 to help manage the residents' behaviors and prevent reoccurrence. Resident #42 (R42) was admitted on [DATE] with diagnoses, including dementia without behavioral disturbance. Resident #43 (R43) was admitted on [DATE] with [DIAGNOSES REDACTED]. A Facility-Reported Incident (FRI) documented on 11/08/19; a verbal and physical altercation occurred between R42 and R43. R43's behavioral care plan dated 11/08/19 indicated psychiatric evaluation as needed. R42's behavioral care plan dated 11/08/19 indicated psychiatric evaluation as needed. R42 and R43's medical record lacked documented evidence of a psychiatric consult following the incident on 11/08/19. On 03/04/2020 at 1:55 PM, the DON confirmed a psychiatric evaluation should have been coordinated within 24 hours following the alleged altercation to help manage the residents' behaviors and prevent reoccurrence. On 0[DATE]20 at 2:55 PM, a Licensed Practical Nurse (LPN) indicated if an altercation was witnessed, the attending physician would have been notified, and order for psychiatric evaluation would have been obtained. On [DATE]20 at 2:58 PM, an LPN indicated residents involved in an altercation should have been seen by a psychiatrist within 24 hours. On 03/04/2020 at 8:45 AM, the Unit Manager (UM) indicated the attending physician and psychiatrist would have been informed of a resident-to-resident altercation. The UM confirmed residents involved in an altercation should have been examined by a psychiatrist as part of the behavioral care plan intervention. On 03/04/2020 at 9:26 AM, the Director of Nursing (DON) indicated a resident's behavior and target

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F 0740 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 10) symptoms would have been assessed, and the intervention would have been evaluated on admission and as indicated. The DON explained if a resident, with pre-existing mental [DIAGNOSES REDACTED]. On 03/04/2020 at 10:11 AM, the DON confirmed the psychiatrist should have seen the involved residents within 24 hours from the time of the altercation. The DON verified a psychiatrist would have recommended adjustments to the [MEDICAL CONDITION] medication or determine a more appropriate facility placement. The DON acknowledged the psychiatric consult would have helped decrease the reoccurrence of an altercation. The Behavioral Assessment, Intervention, and Monitoring Policy revised December 2016 documented . Assessment 1. As part of the initial assessment, the nursing staff and attending physician would identify an individual with a history of impaired cognition, altered behavior, or mental illness such as [MEDICAL CONDITION] disorder or [MEDICAL CONDITION] . 2. The nursing staff would identify, document, and inform the physician about specific details regarding changes in an individual's mental status, behavior, and cognition such as onset, duration, intensity, and frequency of behavioral symptoms, and any precipitating or relevant factors or environmental triggers . 4. New onset or changes in behavior would be documented regardless of the degree of risk to the resident or others. The Behavioral Assessment, Intervention, and Monitoring Policy revised December 2016 documented . Cause Identification 1. The Interdisciplinary Team (IDT) would thoroughly evaluate new or changing behavioral symptoms in order to identify underlying causes and address any modifiable factors that may have contributed to the resident's change in condition, including physical changes, emotional and/or psychiatric stressor, and functional, social or environmental factors . The Behavioral Assessment, Intervention, and Monitoring Policy revised December 2016 documented . Management 2. The IDT would evaluate behavioral symptoms in residents to determine the degree of severity, distress, and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies would be implemented immediately if necessary to protect the resident and others from harm . Atypical behavior would be differentiated from behavior that was dangerous or problematic for other residents or staff, or behavior that signals underlying stress . 2. The care plan would incorporate findings from the comprehensive assessment and be consistent with current standards of practice . 8. Interventions and approaches would be based on a detailed assessment of physical, psychological, and behavioral symptoms and their underlying causes, as well as the potential situation, and environmental reasons for the behavior. The care plan would include frequency, intensity, duration, outcomes, location, environment, and precipitating factors or situations, target symptoms and interventions, the rationale for interventions, measurable goals, and how staff would monitor for effectiveness of interventions. The Dementia - Clinical Protocol Policy revised March 2015 documented . Treatment/Management . 8. The physician would order appropriate medications and other interventions to manage behavioral and psychiatric symptoms related to dementia based on pertinent clinical guidelines and regulatory expectations . 9. If a psychiatric consultant was called to help manage behavioral issues in the individual with dementia, the Interdisciplinary Team (IDT) would retain an active role by reviewing and implementing the psychiatrist' recommendations, addressing issues that affect mood, cognition, and function, monitoring for complications related to treatment, and evaluating progress.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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** Based on observation, interview and document review the facility failed to ensure a bubble pack of medication was secured; medications were secured in a resident room, and a medication cart and respiratory therapy cart were locked and secured. Findings include: On 02/25/2020 at 8:15 AM, the resident in room [ROOM NUMBER] stated he/she had a rash on their face. The resident had a tube of antifungal cream on the tray table. On [DATE]20 at 2:59 PM, in room [ROOM NUMBER] a tube of [MEDICATION NAME] 1% cream without a prescription label was noted on the residents tray table. The resident stated he/she applied the cream to the nose area and the cream was an over the counter medication. The resident explained the nurses were aware the had the [MEDICATION NAME] 1% cream. A Respiratory Therapist confirmed the resident had the [MEDICATION NAME] 1% cream. On [DATE]20 an Registered Nurse (RN) and Licensed Practical Nurse (LPN) indicated there was no current or discontinued physician's orders [REDACTED]. The RN confirmed the observation of the medication at bedside and stated there should be an physician's orders [REDACTED]. On 03/11/2020 at 11:17 AM, a Medication cart was outside 119 unlocked and unattended. There were no nurses observed in the hallway. On 03/11/2020 at 11:20 AM, an LPN exited a resident's room and towards the medication cart. The LPN confirmed the medication cart was unlocked. The LPN verbalized the medication cart was to be locked so no one got into the cart and got the medications. On 03/11/2020 at 2:00 PM, the on the 100 hallway an Respiratory Therapist (RT) cart was unlocked and unattended. Two staff members confirmed the observation and medications located in the RT cart. The RT stated she/he had forgotten to lock the cart. The RT explained the cart should have been locked because there were medications in the cart. On 0[DATE]20 7:29 AM, in the 200 Hall a full bubble pack of Potassium was on top of the medication cart. An LPN confirmed the observation. Facility Storage of Medications policy revised April 2007, documented the facility would store all drugs and biological's in a safe, secure and orderly manner. The nursing staff stall be responsible for maintaining medication storage.
F 0806 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and document review, the facility failed to ensure a resident's likes and dislikes were followed for 1 of 40 sampled residents (Resident #79). Findings include: Resident #79 (R79) was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 02/25/2020 in the morning, R79 revealed when staff delivered meal trays, it contained foods and beverages not of R79's preference. On 03/04/2020 at 12:57 PM, a Certified Nursing Assistant (CNA) delivered R79's lunch tray. When the tray was delivered, R79 verbalized not wanting milk served as a beverage with the meal. The CNA acknowledged R79 and removed the milk from the meal tray. R79's meal tray ticket, located on the meal tray documented under food/drink preferences the resident disliked milk. On 03/04/2020 at 1:04 PM, the CNA verbalized staff should read the meal tray ticket to ensure the meal tray match's what was on the meal tray ticket. On 03/05/2020 at 4:16 PM, the Director of Nursing (DON) confirmed staff should have reviewed the meal tray tickets before serving meal trays to ensure the meal ticket matched what was being served on the tray. The facility policy titled Nutritional assessment dated [DATE], documented the nutritional assessment shall identify food preferences and dislikes. Such interventions will be developed to include individualized care plans, and resident's personal preferences.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation and interview, the facility failed to ensure air conditioning vents over food preparation and equipment storage areas were free of dust and grime build up for 4 of 4 vents. Findings include: On 02/25/2020 at 8:53 AM, during the initial kitchen observation, four air-conditioning vents over food prep areas and in dishwashing room were observed to be soiled with significate buildup of dust and grime. During the tour, the Dietary Manager confirmed the observation.
F 0814 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Dispose of garbage and refuse properly.** Based on observation and interview, the facility failed to ensure garbage and medical waste was properly disposed of and the area surrounding the dumpster was clean. Findings include: On 02/25/2020 at 8:53 AM, during the initial kitchen observation, the outside dumpster and area surrounding the dumpster was observed to have medical waste including used latex gloves, a used catheter valve, broken glass, a pile of wood, bags of trash, rodent droppings, and a buildup of grime on the

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F 0814 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 11) cement. A foul odor was noted. The Dietary Manager confirmed the observation. On [DATE]20 at 9:33 AM, the Dietary Manager reported their department was not responsible for cleaning the area.
F 0838 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, facility failed to identify the changing resident population to considering their types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that were present within that population in the staffing component of their Facility Assessment. Findings include: The Facility Assessment documented the average stafffing of nurses would include a specific number of nurses and Certified Nursing Assistants. The document included a resident matrix list but did not identify the total number and varying care needs of each resident. The document did not identify a process to adjust the staffing levels in order to meet the changing needs of their residents. On 03/04/2020 at 2:33 PM, the Director of Nursing (DON), acknowledged not being familiar with the Facility Assessment and how to adapt nurse staffing levels based on the resident's changing needs, disabilities, [DIAGNOSES REDACTED].
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** Based on observation, interview, and document review, the facility failed to ensure hand hygiene was completed during wound care per facility protocol and failed to ensure infection control practices were followed. Findings include: Resident #194 (R194) was admitted on [DATE] with [DIAGNOSES REDACTED]. On [DATE]20 at 9:01 AM, the wound care nurse provided a dressing change to R194's pressure ulcer. The Licensed Practical Nurse (LPN) performed hand hygiene, donned gloves, removed the dressing and cleaned the wound per physician's orders [REDACTED]. With the soiled gloves, the LPN opened and dated a sterile border dressing touching the center of the sterile gauze with a contaminated right thumb, applied gel and covered the wound with the contaminated dressing. On [DATE]20 at 9:12 AM, the LPN described the dressing change process which included changing gloves after the wound had been cleaned. The LPN confirmed no hand hygiene or glove change was performed when transitioning from contaminated to clean process. The LPN confirmed the dressing should not have been touched, hand hygiene and gloves should have been changed during the procedure. The Handwashing/Hand Hygiene policy revised August 2015 documented staff were to perform hand hygiene after contact with used dressings, before moving from a contaminated body site to a clean body site during resident care. On 02/25/2020 in the morning, the medication cart on the [LOC] contained a small cup of M&M candies on top the medication cart. The candy belonged to a Licensed Practical Nurse (LPN), who indicated she/he should not eat at the medication cart for safety reasons. On 02/25/2020 at 12:09 PM, a linen cart outside of room [ROOM NUMBER], contained a cell phone on top of a box of examination gloves. A Respiratory Therapist (RT) indicated the cell phone should not be in the linen cart for infection control reasons.
F 0908 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep all essential equipment working safely.** Based on observation and interview, the facility failed to ensure 7 of 10 meal carts did not have missing doors. Findings include: On 02/25/2020 at 11:05 AM, on the [LOC]ways, the meal cart arrived at 11:40 AM. Both doors on the cart were missing. 03/05/2020 12:29 PM, the meal cart being delivered to the [LOC] was observed to be missing two doors. The Dietary Manager confirmed the observation. After lunch, in the dishwashing area, multiple food delivery carts were noted to be missing both doors. The carts missing doors included: The 200 and 300 Assistive Dining carts, the 300-hallway cart one, A and B carts, 100 Independent cart, and the 100 room carts. The Dietary Manager confirmed seven of ten food delivery carts were missing their doors, and the doors had been missing for two years. The Dietary manager indicated the missing doors could result in resident food getting cold.