STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295040	A. BUILDING _____ B. WING _____	C 04/25/2018

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ST JOSEPH TRANSITIONAL REHABILITATION CENTER	2035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a complaint investigation initiated in your facility on April 19, 2018 and completed on April 25, 2018, in accordance with 42 Code of Federal Regulations (CFR), Chapter IV, Part 483 - Requirements for Long Term Care Facilities. The census at the time of the survey was 81. The sample size was five. There were five complaints investigated. Complaint #NV00050069 with the following allegations could not be substantiated. Allegation #1 a family member reported a Respiratory Coordinator found a resident unresponsive, holding ventilator tubing in the resident's hand, this caused the resident to be transferred to the hospital, and the facility was untruthful about the incident. Allegation #2 a family member thinks there was a cover up about something that happened to the resident the night before the resident was found unresponsive on 08/03/17, and the facility refused to give the family member information about the incident. The investigation included: Observation of residents on ventilators. Interviews were conducted with the Respiratory Therapy Manager of the Ventilator Program, two Respiratory Therapists, the Director of Nursing	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 5/25/18

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

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F 000	Continued From page 1 and the Administrator. Review of five medical records including the resident of concern. Complaint #NV00051954 with the following allegation could not be substantiated. Allegation #1 the facility failed to provide copies of discharge documentation to Aging and Disability Services Division as required of skilled nursing facilities. The investigation into the allegation included: Interview conducted with the Administrator. Review of the facility Discharge and Transfer policy dated 03/21/18. Complaint #NV00051380 with the following allegations could not be substantiated. Allegation #1 a family member removed a resident from the facility because the facility was giving the resident too much fluid. Allegation #2 the resident's dry weight should have been between 125-130 pounds, but due to the facility giving the resident so much fluid the resident's dry weight was 145 pounds. Allegation #3 the facility gave the resident 1000 ml of fluid a day and was giving additional water to the resident with medications and flushes. The investigation included: Observation of residents on fluid restrictions Interviews were conducted with a Certified	F 000		

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F 000	Continued From page 2 Nursing Assistant, a Licensed Practical Nurse and the Director of Nursing. Review of five medical records including the resident of concern. Review of the facility Fluid Balance Policy and Hemodialysis Communication and Documentation Policy. Complaint #NV00051077 was substantiated. The allegation the resident was discharged home alone, and it was an unsafe discharge was substantiated (See Tag 660). Complaint #NV00052510 was substantiated. The allegation the facility did not address the resident's needs for cleaning and the resident was left in feces was substantiated (See Tag 550). The following allegations could not be substantiated. Allegation #1 call lights were left unanswered for long periods. Allegation #2 resident was kept from calling nurse's station to request care. Allegation #3 staff were not trained to communicate with residents who were hearing impaired. Allegation 4# the facility had issues with providing wound care. The investigations into the allegations included : Observation of call lights in the 100-hall and	F 000		

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F 000	Continued From page 3 300-hall, call light placement in the rooms of three sampled residents and one unsampled resident, wound care for one sampled resident, and a tour of the facility. Interviews were conducted with two sampled residents, family of one unsampled resident, one CNA, one Licensed Practical Nurse, one wound care nurse, two Social Workers, the Director of Nursing and the Administrator. Review of three medical records including the resident of concern. Review of staff assignment for 04/19/18, wound care progress notes for one sampled resident, the facility's policies on Call Lights and Skin Integrity Management. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, St. Joseph Transitional Rehabilitation Center does not admit that the deficiency listed on this form exists, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and /or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550	F550 ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** Resident #2 was provided the care as requested by the Certified Nursing Assistant on 4/25/2018. Resident #6 care was completed as requested by the Certified Nursing Assistant on 4/25/2018.	

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F 550	Continued From page 4 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to treat each resident with respect and dignity by not responding to the resident's request for assistance with toileting needs in a timely manner and discussed	F 550	***How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken:*** The facility residents have the potential to be affected by the deficient practice. The facility Center Nurse Executive and or designee will conduct resident interviews on/or before 6/1/2018 to identify any other residents that could be affected by the deficient practice. ***What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:*** The facility Center Nurse Executive and/or designee will in service the facility Nursing staff on or before 6/8/2018 on the facility policy for Resident Rights and on Dignity of a Resident. ***How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:*** The facility Center Nurse Executive and/or designee will conduct a minimum of five observation audits per day five days a week for two weeks, a minimum of five observation audits per day three days a week for two weeks, a minimum of five observation audits per day weekly for four weeks, then a minimum of five observation audits monthly until compliance is achieved and maintained. Results of the audit will be reported to the facility Quality Assurance meeting monthly and as directed by the committee. **Date of Completion:** 6/8/2018	

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F 550	Continued From page 5 resident's care with other residents and/or resident's family for 2 of 5 sampled residents and one unsampled resident (Residents #2 and Resident #6). Findings include : On 04/19/18 at 10:10 AM, Resident #2 was turned to the side facing the door. The resident indicated pressing the call light at approximately 9:30 AM due to a bowel movement. The resident indicated a Licensed Practical Nurse (LPN) already informed the assigned Certified Nursing Assistant (CNA) of the resident's cleaning needs. An offensive odor was evident in the room. Resident #2 verbalized frequently waiting one to two hours to get cleaned. The resident recounted staff gave the excuse another resident required several staff and time for care. On 04/19/18 at 10:12 AM, CNA #1 knocked on the door of Resident #2's room. The CNA was standing by the door and asked the resident what was needed. The resident verbalized needing to be cleaned. The CNA told the resident the assigned CNA (CNA #2) would be made aware. CNA #1 walked away. On 04/19/18 at 10:15 AM, CNA #2 entered the room and pulled the privacy curtain to provide care to Resident #2. On 04/19/18 at 10:20 AM, an unsampled resident was unconscious, ventilator-dependent, and unable to express needs. The family member of the unsampled resident expressed displeasure over the interruption of the care being provided to the resident.	F 550		

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F 550	Continued From page 6 The family member indicated CNA #2 was assisting with toileting care for the resident when CNA #1 entered the room. In the presence of the resident and family member, CNA #1 informed CNA #2 that Resident #2 had a bowel movement and needed to be cleaned. The family member described CNA #2 left the room before the resident's care was completed. CNA #1 acknowledged informing CNA #2 of Resident #2's request in the presence of the unsampled resident and family member indicating CNA #2 was busy providing care on the unsampled resident at the time. On 04/19/18 at 01:30 PM, the Director of Nursing (DON) verbalized nurses should be able to help if the CNA's were busy and the CNA's should be able to care for residents not assigned to them if they were available. The DON confirmed staff should not discuss care needs in the presence of other residents and/or resident's family. The DON acknowledged it was a dignity and privacy issue. Complaint #NV00052510	F 550		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge	F 660	F660 ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** Resident #4 discharged from the facility on 10/26/2017. ***How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken:*** Residents discharging from the facility have the potential to be affected by the deficient practice. The facility Administrator and/or designee will review 30 days of discharges to identify any other	

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F 660	Continued From page 7 rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.	F 660	residents affected by the deficient practice on or before 6/1/2018. ***What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:*** The facility Administrator and/or designee will provide inservicing to the facility staff in regards to the facility Discharge Policy and Procedure with emphasis on safe discharging on or before 6/8/2018. ***How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:*** The facility Administrator and/or designee will conduct audits on discharges five times a week for two weeks, three times a week for two weeks weekly for four weeks, then monthly until compliance is achieved and maintained. Results of the audit will be reported to the facility Quality Assurance meeting monthly and as directed by the committee. **Date of Completion:** 6/8/2018	

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F 660	Continued From page 8 (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on interview, record review and document review the facility failed to ensure a resident who required assistance with activities of daily living had a family member or other caregiver at home at time of discharge for 1 of 5 sampled resident (Resident # 4). Findings Include: Resident #4 was admitted on 09/15/17 with diagnoses including difficulty walking, muscle weakness, dependence on renal dialysis, type 2 diabetes and repeated falls.	F 660		

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F 660	Continued From page 9 The initial Occupational Therapy (OT) evaluation dated 09/18/17, indicated the resident required OT to maximize independence with activities of daily living (ADLs) and return to prior level of functional abilities. The OT evaluation documented the resident was a poor historian and unable to clearly state prior level of functioning. The Physical Therapy Discharge Summary dated 10/26/17, documented the resident had a Physical Performance and Mobility Examination score of 2 out of 12 and the resident required supervision with ambulation. The Occupational Therapy Discharge Summary dated 10/25/17, documented the resident required set-up assistance with feeding, set-up assistance with dressing, set-up assistance with hygiene and grooming, contact guard with toileting, and supervision with bed mobility and transfers. The Discharge/Transition plan dated 10/25/17, documented the resident needed assistance with personal care, transfers from bed/chair, and walking. On 04/19/18 in the afternoon, the Director of Social Services explained the resident was discharged to home because the resident said someone was home to help care for the resident. The Director explained that a phone call was sometimes made to the home to verify there was someone to care for a person being discharged. The Director explained a phone call was not made in this instance because the resident was alert and oriented and said there was someone at	F 660		

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F 660	Continued From page 10 home who could help with activities of daily living. On 04/19/18 at 4:10 PM, the Director of Rehab explained Resident #4 had received rehab at the facility while the resident's spouse was receiving care at another facility. Once the spouse was home the resident was discharged to home. The Director of Rehab explained the resident was not able care for self at the time of discharge and needed someone else to be at the home. The Rehab Director confirmed the resident was not able to care for self with just Home Health services. The Director of Rehab was not sure if anyone had spoken with the spouse on the phone to confirm the spouse was at home. The Discharge Planning Process policy, revised on 03/01/18, indicated the interdisciplinary team should consider whether a caregiver or support person was available and could provide care as needed as part of discharge needs. Complaint #NV00051077	F 660		