STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1200	A. BUILDING _____ B. WING _____	02/21/2017

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NORTH LAS VEGAS CARE CENTER	3215 E CHEYENNE AVENUE, NORTH LAS VEGAS, NEVADA ,89030

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0000	Initial Comments - Inspector Comments: This Statement of Deficiencies was generated as a result of the Complaint Investigation survey conducted at your facility on 2/8/17 through 2/21/17, in accordance with 42 Code of Federal Regulations, Chapter IV, Part 483, Requirements for Long Term Care Facilities. The census at the beginning of the survey was 175. The sample size included 5 residents. There were seven complaints investigated. Complaint #NV00046207 with the following allegations could not be substantiated. Allegation #1 an untreated urinary tract infection and unresponsive staff contributed to a resident's death. Allegation #2 the facility never followed up with the results of a urine analysis and urine culture and sensitivity test and the never treated the resident for a urinary tract infection. Allegation #3 the family arrived at the facility to find the resident unresponsive, and the staff refused to give them any information about what was going on. The Director of Nursing was resistive to transfer the patient to an acute care hospital. Allegation #4 the sanitation at the facility is very poor, as there are no sinks in the halls and very few hand sanitizer dispensers available. The investigation into these allegations included: Observation of hand hygiene stations, nursing and housekeeping staff donning appropriate personal protective equipment and using appropriate hand hygiene procedures, the of cleaning of resident rooms and floors, a tour of the facility. Interviews were conducted with two housekeepers, three Licensed Nurses, the Director of Staff Development, the Director of Nursing, the Social Worker, and the Director of Maintenance. Clinical record review of 5 residents, including the resident of concern, and medical records from the acute care hospital. Review of the facility Housekeeping Task Sheets, Monthly cleaning schedules for resident rooms, Monthly Preventative Maintenance Logs, Housekeeping In-Service logs (5-Step Daily Patient Room Cleaning and 7-Step Daily Patient Washroom Cleaning) and Physician	0000		

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	Communication/Change in Condition. Complaint #NV00047307 was substantiated. The allegation when a resident was transferred to an acute care facility, the resident had heart congestion, kidney infection, bacteria in stools, and bedsores was substantiated and the resident was severely dehydrated was substantiated (See TAG Z121). The following allegations could not be substantiated. Allegation #1 a resident's family member called for a nurse to check on the resident and it took the nurse an hour and a half to come and check on the resident. The nurse never stated to the family member if the resident was okay or what was wrong. Allegation #2 a resident was transferred to an acute care hospital and the facility did not notify the family of what time the resident was sent to the hospital or why. Allegation #3 When the family arrived at the hospital they were told by a doctor the resident had heart congestion, kidney infection, bacteria in stool, bedsores and showed signs of not being groomed adequately upon arrival (fingernails not cut, hair not combed). The investigation into these allegations included: Observations of staff responding to call bells, residents' grooming and hygiene appearance, staff assisting residents with hygiene and grooming and nurses communicating with physicians regarding care and resident treatment plans. Interviews were conducted with three Licensed Nurses, two Certified Nursing Assistants, the Director of Nursing, the Director of Staff Development, the Social Worker and the Medical Director. Clinical record review of 5 residents, including the resident of concern and medical records from the acute care hospital. Review of the facility Patient's Rights & Responsibilities, Prevention and Management of Pressure Ulcers policy, Call Lights, Answering Of policy, Physician Communication/Change in Condition policy, Abuse, Neglect, and Misappropriation of Property policy, Patient/Resident Rights policy and Comprehensive Care Plan policy. Complaint #NV00047547 with the following allegation could not be substantiated: Allegation #1 a resident was found to have			

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	severe bruises on left breast/chest area. The investigation into this allegation included: Observations Certified Nursing Assistants (CNA's) and Licensed Nurses providing care and assistance to residents. Interviews were conducted with two Licensed Nurses, two CNA's, the Director of Nursing, the Director of Staff Development, and the Administrator. Clinical record review of 5 residents, including the resident of concern and medical records from the acute care hospital. Review of the facility self reports, Abuse, Neglect, and Misappropriation of Property policy. Complaint #NV00047329 with the following allegations could not be substantiated: Allegation #1 a letter mailed to a resident was not in the resident's room and later found in the Activity Room. The facility was negligent in the safekeeping of the resident's personal items. Allegation #2 the facility recommended a staff member as a Notary and they were unable to provide the notary service because the resident lived at the facility. Allegation #3 the Business Office Manager mishandled cash (confiscated on false pretense) cash belonging to the resident. Allegation #4 in the lobby restroom, the tall wastebasket that sits underneath the paper towel dispenser, causing the dispensed paper towels to touch upon the unsanitary wastebasket as a person presses the lever to receive the paper towels. Allegation #5 a small colorful poster in the lobby (a diagram of the building) was entirely incomprehensible and useless. Allegation #6 the resident's room door would often not stay open against the wall because the magnetic piece at the top of the door was broken. Allegation #7 after hours you have to exit into and walk a long dark driveway to reach the front parking lot, which is way too dark at night, and nobody is around. Allegation #8 a letter chart (communication board) went missing. Allegation #9 the Director of Nursing exhibited absolutely no interest in the family member's concerns, wrote nothing down, and asked no questions at the care plan meeting. Allegation #10 the family member never saw a doctor at the facility in three weeks and was told the doctor never meets with			

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	family members. Allegation #11 the facility actively failed to upkeep the resident's personal hygiene and appearance, resident's hair was straggly and matted, and way too long, resident was in need of a shave, fingernails were badly in need of clipping and there was dirt/debris beneath the fingernails, fingernails and toenails were never clipped in 21 days, staff did not help the resident with skin lotion, ears needed cleaning in general and from some scabbing debris and tongue was showing scabs. Allegation #12 a complete lack of social interaction with the resident, no effort to converse with him, no inquiry of how the resident felt about anything, or whether the resident had any questions. Allegation #13 a family member had a concern and wanted to know why the resident was unable to walk. The family suspected it was not due to medical issues, but rather due to neglect of nursing personnel. Allegation #14 there was an issue with the cleanliness of the resident's room. The resident dropped used tissues onto the floor and staff failed to pick them up. Allegation #15 a resident had to endure uncomfortable temperatures in the room. The investigation into these allegations included: Observations of staff responding to call bells and assisting residents with care and activities of daily living, inspection of the resident of concern's room, a tour of the facility including the interior and exterior. Interviews were conducted with the Director of Nursing, the Director of Social Services, a Social Worker the Director of Activities, the Director of Maintenance, two Licensed Nurses, the Director of Housekeeping, Business Office Manager, the Administrator, two Housekeepers, eight alert and oriented residents. Clinical record review of five residents, including the resident of concern. Review of the facility Patient Rights policy, Resident Council Meeting Minutes, Housekeeping Schedules, Cleaning Protocols, Preventative Maintenance Logs, Resident Trust Fund policy Patient/Resident, Impaired Communication policy, One on One Individual Activity/Recreation Programs policy, Complaint/Grievances Process policy, Mail Distribution policy, Abuse, Neglect, and			

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	Misappropriation of Property policy, Assisting Residents with Daily Care, per the Potter & Perry Fundamentals of Nursing, 8th Edition. Complaint #NV00047704 with the allegation an individual was bitten by bedbugs and there were crickets and cockroaches in the facility, and the facility refused to call an exterminator could not be substantiated. The investigation into the allegation included: Observations of the interior and exterior of the facility revealed there was no evidence of bedbugs, roaches, or crickets, and the demonstration of the step by step cleaning of a resident room and resident bathroom, including donning of appropriate personal protective equipment and thorough cleaning of rooms with isolation precautions by the Director of Housekeeping and two Housekeepers. Interviews were conducted with the Director of Maintenance, the Administrator, the Director of Housekeeping, two Certified Nursing Assistants, two Licensed Nurses and eight alert and oriented residents. Review of the facility Pest Control Invoices, Housekeeping Schedules, Preventative Maintenance Logs, and Cleaning Protocols (5-Step Resident Room and 7-Step Resident Washroom). Complaint #NV00048229 with the following allegations could not be substantiated: Allegation #1 a scabies outbreak. Allegation #2 bugs in the building. Allegation #3 the building is filthy. The investigation into these allegations included: Observations of the facility revealed no evidence of filth and bugs in the building, a demonstration of the step by step cleaning of a resident room and resident bathroom, including rooms with isolation precautions by two housekeepers, the two housekeepers and the Director of Housekeeping reviewed the processes of mopping the floors, cleaning all surfaces, storing and transporting linens in appropriate manners to the laundry, using appropriate disinfecting cleaners, and donning of personal protective equipment. Interviews were conducted with the Director of Nursing, the Medical, three Licensed Nurses, two Certified Nursing Assistants, the Infection Control Coordinator, and eight alert and oriented residents. Review of the facility Isolation Precautions and Scabies			

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	policy, Infection Control Protocols, Cleaning protocols, room cleaning schedules, Preventative Maintenance Logs, and Housekeeping Checklists. Complaint #NV00048199 with the following allegations could not be substantiated: Allegation #1 a resident's Power of Attorney found out there was a scabies outbreak in the facility, and residents and other nurses were affected. Allegation #2 a resident not been given a shower in a month, needs to see a Dermatologist to get rashes cleared. No blood work has been done. The investigation into these allegations included: Observation of two housekeepers demonstrate the step by step cleaning of a resident room and resident bathroom, including rooms with isolation precautions, the two housekeepers and the Director of Housekeeping reviewed the processes of mopping the floors, cleaning all surfaces, storing and transporting linens in appropriate manners to the laundry, using appropriate disinfecting cleaners, and donning of personal protective equipment. Interviews were conducted with the Medical Director, and the Director of Nursing. Clinical record review of five residents, including the resident of concern. Review of the facility Isolation Precautions and Scabies policy, Cleaning Protocols, Room Cleaning Schedules, Housekeeping Schedules, Preventative Maintenance Logs, and Housekeeping Checklists. 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 investigation, 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.			
121 SS= A	NAC 449.74441 - Maintenance - 2. A medical record must be: a) Complete; b) Accurate; c) Organized; and d) Readily accessible to those persons who are authorized to review the records Inspector Comments: Based on interview, record review, and document review, the facility failed to ensure the physician's discharge documentation in the clinical	121	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies: We have requested the physician complete the deficient discharge summary.	05/15/2017

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	record was accurate and complete regarding the transfer of a resident to an acute care facility upon a significant change of condition for 1 of 5 sampled residents (Resident #2). Findings include: Resident #2 was admitted to the facility on 6/20/16, with diagnoses including dysphagia, left above knee amputation, osteoporosis, protein calorie malnutrition, and deep vein thrombosis. The resident was transferred to an acute care hospital on 10/8/16 at approximately 3:00 PM. The acute care hospital's Emergency Department (ED) medical records dated 10/8/16 at 3:27 PM, documented the resident presented via ambulance for altered mental status. Per emergency medical services, the nursing home stated the resident was normally verbal, however this afternoon the resident had not spoken and had been almost unresponsive. The ED Physician's Examination revealed Resident #2 appeared ill and mildly distressed. Resident #2 responded to painful stimuli, oropharynx was clear and moist, no oropharyngeal exudate, heart rate was normal with regular rhythm, no respiratory distress, positive gastrostomy tube in place with abdomen soft, bowel sounds normal with no tenderness, no edema, positive above the left above the knee amputation, and unable to complete neurological exam due to altered mental status. Laboratory results were documented as follows: White Blood Cell - 11.20 Red Blood Cell - 3.25 Hemoglobin - 10.1 Hematocrit - 31.6 Sodium - 159 Blood Urea Nitrogen (BUN) - 57 Creatinine: 57.0 (high) Sodium: 159 (high). (Note: High levels of Creatinine and Sodium are indicators of dehydration. According to the Potter & Perry, 8th edition (Laboratory & Diagnostic Tests) the normal range of Creatinine is 0.6 mg/dl (milligrams/deciliter) - 1.2 ml / dl.) ED urinalysis revealed the clarity was turbid, with trace protein, positive for blood, nitrite, and leukocytes. The acute care hospital's medical records documented the following on 10/8/16 at 3:27 PM, in the emergency department: (...(Pt) Patient presents to the ED (Emergency Department) via EMS (Emergency Medical Services) for altered mental status. Per EMS, nursing home		2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur: A letter has been mailed to all physicians to remind them of the required components of a discharge summary. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Medical Records will conduct a monthly audit to verify compliance and follow up as necessary. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented: Medical Records Director 5) The date the corrective action will be completed: May 15, 2017	

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	stated the pt (patient) is normal verbal, however this afternoon she has not spoken and been almost unresponsive...ED Course: Critical care..." The ED Physician's Examination further indicated, Final diagnoses: Altered mental status, dehydration, urinary tract infection, sepsis, hypernatremia...Diagnosis management comments: afib (atrial fibrillation with RVR (rapid ventricular response) on Diltiazem Drip, pt has a UTI (urinary tract infection) and is severely dehydrated. Hypernatremia. NS (Normal Saline) given. Pt is altered..." The following laboratory results (Abnormal Complete Blood Count and abnormal Comprehensive Metabolic Panel) were completed on 10/8/16 at 4:04 PM: Creatinine: 57.0 (high) Sodium: 159 (high). The Physician's Discharge Summary, which was provided on 2/13/17, significantly lacked information: The documented diagnoses upon discharge were: 1. Altered mental status 2. Dysphagia and failure to thrive 3. Left above knee amputation 4. Diastolic congestive heart failure 5. Deep vein thrombosis 6 _____ (blank) 7. Protein-calorie malnutrition. 8. Osteoporosis and osteoarthritis. 9. _____ (blank). Brief Course of Stay: This is a 98 year old __ (blank) admitted to the ___ (blank) facility after a course of _____ (blank). During her stay in the facility the patient also ____ (blank) and followed medically. The Physical Examination portion of the Physician's Discharge Summary was completely blank regarding physical examination, vital signs, HEENT (head, eyes, ears, nose, throat), neck, CVS (central vascular system), abdomen, extremities, laboratory data, plan, transfer medications, blood work, code status, dietary, and problem list. The Current Plan of Care documented: "At this time, the patient will be continued on: 1. (blank). 2. (blank). 3. (blank). On 2/7/17 in the afternoon, the Director of Nursing (DON) indicated the facility's reference guide was Potter & Parry, 8th edition. On 2/7/17 in the afternoon, the DON indicated Resident #2 was frail, totally dependent on care, had dementia, and was on a gastrostomy tube (g-tube). On 2/21/17, the Director of Nursing indicated the physician's order for fluid			

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	intake was 1400 cc (cubic centimeters) of Tube Feed formula and 1950 cc of free water, for a total of 3,350 cc a day. On 2/16/17 via telephone, the Director of Nursing verified the Physician's Discharge Summary was incomplete and lacked complete information about the resident's medical condition at the time of discharge. The DON indicated, "It's not enough information. I don't know why the Physician Assistant didn't document a complete summary. That's a physician question." The DON verified the Physician's Discharge Summary was lacking information, and stated that she could not say that was unacceptable, just that it was a "Physician's issue and a question for the Physician". The facility's policy, "Documentation - Physician's Requirements", revised 7/1/16, indicated the physician records and signs the provision of and response to medical treatment and care in a discharge summary. Complaint #NV00047307 Severity: 1 Scope: 1			

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124 SS= E	NAC 449.74441 - Maintenance - 5. A facility for skilled nursing shall ensure that: a) Information contained in a medical record is not lost, destroyed or used in an unauthorized manner. b) No person willfully and knowingly falsifies or causes another person to falsify information contained in a medical record. Inspector Comments: Based on observation and interview, the facility failed to ensure personal health information was safeguarded and protected against unauthorized use. Findings include: On 2/9/17 at approximately 11:30 AM, 1 of 3 outdoor sheds was full of medical records labeled with residents' names. There was no lock on the door to the shed. The shed was accessible and open to the public way. On 2/9/17 at approximately 11:30 AM, the Director of Maintenance indicated he was not sure how long the medical records were stored there with an unlocked door, but as long as he can remember since his date of hire in June 2016. The Director of Maintenance had not communicated with the Administrator or the Director of Medical Records regarding the storage of the medical records in the shed. On 2/9/17 at approximately 12:00 PM, the Administrator verified the storage of the medical records in the shed. The Administrator was not sure why the medical records were stored in an unsecure manner. On 2/9/17 at 4:00 PM, the Director of Medical Records indicated she was not aware of any medical records stored in the shed. The Director of Medical Records further indicated all medical records for active residents were stored inside the facility in a locked area, and all medical records for previous residents should have been sent to the remote storage unit at Iron Mountain. Severity: 2 Scope: 3	124	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies: A lock was placed on the storage shed in question on 2-10-17. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur: Only Maintenance and Medical Records have a key to the shed in question. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Maintenance will check the shed weekly to ensure it is properly locked. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented: Maintenance Director 5) The date the corrective action will be completed: May 15, 2017	05/15/2017