Acceptable POC
Runaway 1/27/17

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295083	A. BUILDING _____ B. WING _____	C 12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEIGHTS OF SUMMERLIN, LLC	10550 PARK RUN DRIVE LAS VEGAS, NV 89144

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F 000	INITIAL COMMENTS \\\This Statement of Deficiencies was generated as a result of a complaint investigation completed in your facility on 12/6/16 through 12/14/16, in accordance with 42 Code of Federal Regulations (CFR), Chapter IV, Part 483 - Requirements for Long Term Care Facilities. The census at the beginning of the survey was 182. The sample size was six. There were five complaints investigated. Complaint #NV00047120 with the following allegations could not be substantiated. Allegation #1 a resident was given diabetes medication without first checking the sugar. Allegation #2 a resident's diaper was not changed. The investigation into the allegations included: Observation of residents receiving incontinent care, medication administration and a tour of the facility. Interviews were conducted with seven alert and oriented residents, two family members, two Certified Nursing Assistants (CNA's), three Licensed Practical Nurses (LPN's), the Director of Rehabilitation Therapy, and the Director of Nursing (DON). Review of six medical records including the resident of concern.	F 000		

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BUREAU OF HEALTHCARE QUALITY & COMPLIANCE LAS VEGAS, NV

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Administrator		1/27/2017

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 Complaint #NV00047484 with the following allegations could not be substantiated. Allegation #1 a resident was neglected. Allegation #2 a resident was overmedicated. Allegation #3 a resident did not receive diabetes medication. Allegation #4 a resident was completely dehydrated. The investigation into the allegations included: Observation of residents receiving incontinent care, medication administration, assistance during meals and a tour of the facility. Interviews were conducted with seven alert and oriented residents, two family members, two Certified Nursing Assistants, three Licensed Practical Nurses, the Director of Rehabilitation Therapy, and the Director of Nursing. Review of five medical records including the resident of concern. Documents reviewed included the policy "Fingerstick Glucose Measurement", revised 6/1/15. Complaint #NV00046879 with the following allegation was substantiated. Allegation: The resident's adjustable brace on the leg was not taken off for weeks, and when it was finally taken off there was a large lesion on the leg. See TAG F 309. The following allegations could not be	F 000		

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F 000	Continued From page 2 substantiated: Allegation #1: The doctor had no interaction with the resident. The CNA's would leave notes to the doctor but the doctor wouldn't address any of the complaints. Allegation #2: The resident has not had x-rays since being at the facility. Allegation #3: The resident would receive physical therapy and then be left in bed all day long. Allegation #4: The facility didn't pay attention to the dietary requests. Menus were sent out but what the resident ordered was not what was received. Allegation #5: The food was disgusting and they would not feed it to a dog. Allegation #6: The air filter was filthy and was like fur. The investigation into these allegations included: Walk through of the facility on 12/6/16 in the morning and afternoon. Observations of the air filters in the room in question and rooms on the first, second and third floor. Observation of the lunch meal on 12/6/16. Tray tickets and the food items served were checked. A sample test tray of the lunch meal and the alternative meal was tasted for palatability. Three activities were observed (Bingo and two musical activities). Observations of the CNA's on the units assisting residents with getting out of bed and activities of	F 000		

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F 000	Continued From page 3 daily living. Interviews were conducted with the Director of Nursing (DON), Wound Care Treatment Nurse, the Admission Nurse, two CNA's, the Dietary Manager, the Registered Dietitian, the Director of Rehabilitation, and the Physician Hospitalist. Eight alert and oriented residents were interviewed throughout the units. Ten alert and oriented residents were interviewed in the Dining Room. Clinical record review of six residents, including the resident of concern. Documents reviewed included facility menus, therapeutic diets, tray tickets, dietary preference slips, nurse staffing schedules, and activity calendars. Policies and Procedures reviewed included: -Assessment: Nursing, revised 11/28/16. -Nutrition Care Process, revised 11/28/16. -Food Preferences -Weights and Heights, revised 11/30/15. -Skin Integrity Management, revised 11/28/16. Complaint #NV00047344 with the following allegation could not be substantiated: Allegation: Every time the patient presses the call button, it takes a CNA about thirty minutes to show up. The investigation into the allegation included: Observations and walk through on the units on 12/6/16 and 12/14/16. Observations at the nursing stations of nurses answering call bells	F 000		

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F 000	Continued From page 4 timely. Interviews were conducted with the DON, two LPN's, two RN's, and the Nurse Educator. A Physician was interviewed via telephone. Interviews were conducted with eight alert and oriented residents and two family members on 12/8/16, and with four alert and oriented residents on 12/14/16. Clinical record review of six residents, including the resident of concern. Documents reviewed included nurse staffing schedules and the policy, "Call Lights", revised 3/2016. Complaint #NV00047781 with the following allegations was substantiated: Allegation: The facility missed a follow up appointment because it didn't have anyone to send with the resident. See TAG F 309. The following allegations could not be substantiated: Allegation #1: The resident was in excruciating pain at times, yet pain medications were not given in a timely manner. Allegation #2: The call bell does not get answered and the family member has had to call the nurse's station for the resident. The investigation into these allegations included:	F 000		

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F 000	Continued From page 5 Observations on the 100 West Unit on 12/14/16. Interviews were conducted with the DON, 100 West Nurse Manager, the Nurse Educator, and two Licensed Practical Nurses (LPN's). Interviews were also conducted with the Transportation Coordinator, Case Manager, and the Licensed Social Worker. Clinical record review of six residents, including the resident of concern. Document review included the Transportation Log. 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.	F 000		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.	F 309	483.24 483.25 PROVDE CARE/ SERVICES FOR HIGHEST WELL BEING What Corrective Actions Will be accomplished for those residents found to have been affected by this deficient practice Resident #6 will be transported with needed assistance to all her scheduled appointments	

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F 309	Continued From page 6 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and document review, the facility failed to: 1) ensure a follow up medical appointment was completed for 1 of 6 sampled residents (Resident #6); and 2) complete an accurate nursing assessment of the condition of a patient's fractured leg for 1 of 6 sampled residents (Resident #2). Findings include: Resident #6 Resident #6 was discharged from the acute care facility and admitted to the facility on 11/19/16 with diagnoses including fracture of lumbosacral spine and pelvis, displaced fracture of second cervical vertebra, weakness, and fracture of one rib - left side. The Acute Care Facility's Discharge Summary indicated to follow up with (Physician #3) and (Physician #4) in 2 weeks.	F 309	How will you identify other residents having the potential to be affected by the same practice All residents have the potential to be affected by the practice What measures will be put in place to ensure the deficient practice does not recur NPE/desingee will re educate staff on transporting residents safely with residents families/ or staff How will the facility monitor its corrective actions to ensure that deficient practice is being corrected Nurse manager/designee will conduct audits to ensure this practice does not recur Audits will be completed weekly for 4 weeks and monthly for 3 months. Date of Completion 1/29/2017	

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F 309	Continued From page 7 The Progress Notes dated 12/12/16 indicated, "Ortho apt (Orthopaedic appointment) rescheduled with husband informed." The Physician's Consult indicated Resident #6 was seen by the Orthopaedic Specialist for the pelvic fractures on 12/12/16. The Transportation Log indicated the following: "Wednesday 12/7/16: 11:45 AM: (Resident #6): *Rescheduled to 12/29/16 due to CNA (Certified Nursing Assistant) unavailable to accommodate pt (patient). MD (Medical Doctor) Ofc (Office) called with earlier appointment on 12/12." On 12/14/16 at 11:00 AM, the Transportation Coordinator indicated the appointment with the Orthopedic Specialist for Resident #6's pelvic fracture follow up was delayed from 12/7/16 to 12/12/16 due to a CNA not being available to go to the appointment. The Transportation Coordinator indicated she realized the assigned CNA was not going to be able to go with the patient the day prior to the appointment, and left a voice mail message stating Resident #6 spouse needed to go with the resident. On 12/14/16 at 11:30 AM, the DON indicated the Transportation Coordinator should have called her and the DON would have found a CNA to go with the patient, so that the patient would not have had to miss the 12/7/16 appointment. On 12/14/16, the resident indicated she was scheduled to see the doctor for an appointment on 12/7/16. The nurse and the Transportation Coordinator told her the night before her husband had to go with her because there was no CNA available. The resident indicated she was told by	F 309		

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F 309	Continued From page 8 the nurse that, if her husband was not able to go to the appointment with her, she would have to wheel herself from the parking lot to the doctor's office, which made her feel very upset and worried. Complaint #NV00047781 Resident #2 Resident #2 was admitted on 7/5/16 from an acute care facility with diagnoses including status post motor vehicle accident, fractured clavicle, fractured fibula left leg, muscle weakness, iron deficiency anemia, acute post-hemorrhagic anemia, nontraumatic subarachnoid hemorrhage, and chronic kidney disease stage 4. The Acute Care Facility's electronic record indicated Resident #2 was at another Acute Care Facility's Emergency Department on 6/24/16 for a syncopal episode status post motor vehicle accident, left Against Medical Advice, but returned with shortness of breath, left chest pain, and transferred to the Acute Care Facility. The Acute Care Facility's admitting diagnosis indicated Resident #2 had oxygen at 3 liters continuous and a knee immobilizer. Knee Immobilizer Assessment: The Acute Care Facility's Discharge Statement documented Resident #2 had a fracture of the left fibula, left leg traumatic hematoma, and had a knee immobilizer. The Physical Therapy and Occupational Therapy Notes documented Resident #2 had a fracture of	F 309	NV00047781 What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice Resident # 2 has been discharged from this facility How will you identify other residents having the potential to be affected by the same practice All residents have the potential to be affected by the same practice What measures will be put in place to ensure the deficient practice does not recur NPE/designee will re educate staff on resident body assessment and thorough documentation upon admission and as needed during the residents stay at the	

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F 309	Continued From page 9 the shaft of the fibula and was wearing a left knee immobilizer. The Skin Integrity Report only documented a coccyx wound on 7/26/16. There was no documentation of the left lower extremity condition of the skin. Resident #2 was discharged on 7/27/16. (Patient #2 went to his physician's appointment on 7/27/16, who then sent him to the acute care facility emergency department.) Resident #2 arrived via ambulance on 7/27/16 at 10:13 AM. The acute care facility's Emergency Documentation indicated, "...Pt (patient) was at VA (Veteran's Administration) for check up and found to be lethargic, hypotensive and tachycardic. Brought in by ambulance..." The Photographic Wound Documentation documented Resident #2 had an abrasion present on admission, left medial leg: 1.5 cm width x 1 cm length; and left posterior thigh 1cm x1cm. On 12/6/16 at 12:30 PM, the LPN (Licensed Practical Nurse) Unit Manager indicated Resident #2 did have a knee immobilizer on throughout the stay from 7/5/16 through 7/27/16. The knee immobilizer covered the left leg from the top of the knee to the mid-calf. The LPN Unit Manager further indicated the condition of the resident's leg should have been assessed and documented on the Initial Nursing Assessment and the Wound Care Progress Notes by the nurses. On 12/6/16 at 12:40 PM, the Wound Care Nurse indicated when she completed her assessment	F 309	center. NPE/designee will do re education on removing any immobilizers,splints, etc with a doctors order to properly assess and thoroughly document the resident skin upon admission and when needed during the residents stay at the center.Education will include notifying the doctor of the assessment results How will the facility monitor its corrective actions to ensure that deficient practice is being corrected Nurse managers/designee will conduct audits on body assessments and removal of immobilizers/splints etc to assess residents skin weekly for 4 weeks and monthly for 3 months. Date of Completion 1/29/2017	

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F 309	Continued From page 10 on 7/8/16, Resident #2 would not allow her to take off the knee immobilizer. The Wound Care Nurse verified she did not document the knee immobilizer on her assessment, did not notify the physician about the resident's refusal, and did not re-attempt to assess the left leg without the immobilizer on. The Wound Care Nurse further indicated she treated the resident's coccyx wound, but did not look at the leg underneath the brace. The Wound Care Nurse indicated it was her standard of practice that, upon the initial assessment, the body skin check is completed and thoroughly documented. If the resident has any loss of skin integrity, the results are then to be documented on the Weekly Summary body diagram. On 12/6/16 at 1:00 PM, the Director of Rehabilitation indicated Resident #2 was always wearing the (adjustable, with velcro attachments) knee immobilizer from the time of the initial Physical Therapy Assessment from 7/6/16 throughout the stay until 7/27/16. The Director of Rehabilitation indicated Resident #2 appeared reluctant to bear weight on the left leg. There was no assessment whether there was friction of the knee immobilizer against the skin. The Director of Rehabilitation verified the therapists did not remove the knee immobilizer and look at the leg. On 12/6/16 at 1:15 PM, the RN Nurse Educator indicated she did not remember the resident specifically; However, it was the standard of practice for nurses to do a skin assessment, and, if there's a dressing or a brace, they have to look underneath. The RN Nurse Educator verified there was no documentation of the knee	F 309		

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F 309	Continued From page 11 immobilizer or the skin integrity and it was not acceptable for a resident to go 23 days wearing a knee immobilizer without an assessment of the condition of the skin underneath. On 12/6/16 at 3:30 PM, the LPN who conducted the Initial Nursing Assessment on 7/5/16 indicated it was the protocol to do a complete assessment upon admission and document appropriately, including what the skin looks like. If a patient has an immobilizer, it's important to look at the leg. If the patient residents, the nurse should tell the house nurse and call the doctor. The LPN verified the Initial Nursing Assessment and the clinical record did not document the knee immobilizer and the condition of the skin underneath. On 12/6/16 at 3:45 PM, the physician (Physician #1) indicated via telephone interview that he did not get a chance to look at the leg without the knee immobilizer from 7/6/16 through 7/27/16. The physician indicated it's the nurses' job to take off the knee immobilizer and look at the condition of the skin underneath, and stated, "I depend on the nurses to look at it." The physician further indicated Resident #2 had some issues of noncompliance but was generally compliant with care. He was aware that Resident #2 had varicose veins by history, but was not notified by the nurses that Resident #2 refused to allow the nurses to take off the knee immobilizer. The policy, "Skin Integrity Management", indicated Practice Standards: Review pre-admission information to plan for patient's needs prior to admission. Complete a comprehensive evaluation of the patient upon admission. Identify the patient's skin integrity	F 309		

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F 309	Continued From page 12 status and need for prevention intervention or treatment modalities through review of all appropriate assessment information. Perform a skin inspection on admission and weekly. Document. Perform wound observations and measurements and complete 'Skin Integrity Report' upon initial identification of altered skin integrity, weekly, and with anticipated decline of wound. Perform daily monitoring of wounds or dressings and document. The policy, "Assessment: Nursing", indicated the facility will conduct initially and periodically a comprehensive and accurate assessment of each patient's functional capacity, and notify the physician of the assessment results. Complaint #NV00046879	F 309		