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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 295094 | A. BUILDING _____ B. WING _____ | 07/29/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SPANISH HILLS WELLNESS SUITES | 5351 MONTESSOURI STREET, LAS VEGAS, NEVADA ,89113 |

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| 0000 | Initial Comments -<br><br>Inspector Comments: This Statement of Deficiencies was generated as a result of a State Licensure Complaint Investigation conducted in your facility on 07/29/2020, in accordance with Nevada Administrative Code (NAC) 449. The census at the time of the inspection was 132. The sample size was six. There were six complaints investigated. Complaint #NV00061285 with the following allegations was substantiated. Allegation #1: A resident was discharged home without oxygen. The allegation was substantiated (See Tag Z 064). Allegation #2: A resident who was independent with transfers needed maximum assistance. The allegation could not be substantiated. Physical therapy treatment records indicated the resident required maximum assistance with all activities of daily living upon admission. The Physical Therapy Discharge summary indicated improvement with multiple activities of daily living. This was confirmed by the Director of Nursing (DON). Allegation #3: A home caregiver was not provided any notification of the resident's care needs upon discharge. The allegation could not be substantiated. Interviews with a Licensed Practical Nurse (LPN) and a Registered Nurse (RN) verified the medical record contained documented evidence the home caregiver had been provided information. Review of Discharge policy confirmed the LPN and RN had provided education per the facility's policy. Complaint #NV00061282 with the following allegations could not be substantiated. Allegation #1: The facility would not allow a resident to be discharged. The allegation could not be substantiated. The resident's medical record contained documented evidence the facility had provided ongoing discharge planning and had attempted to discharge the resident. Interviews with two Social Workers, an LPN, two RNs and the RN Case Manager revealed the facility had made multiple attempts to safely transfer or | 0000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: TANELLA VALENZUELA | Title: Administrator | Date: 09/01/2020

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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| | discharge the resident per the resident's request. Allegation #2: A resident was over medicated and became confused. This allegation could not be substantiated. Interviews with two Social Workers, an LPN and two RNs indicated the resident was alert and oriented. The medical record documented the resident had multiple co-morbidities including diabetes and high blood pressure. The resident's medical record documented medications were provided as ordered by the physician. Monthly pharmacy medication reviews from 04/01/2020 through 07/01/2020 did not identify medications that would cause confusion or other interactions. Complaint #NV00060891 with the following allegations were substantiated without regulatory deficiencies. Allegation #1: The facility would not re-admit a resident was substantiated without regulatory deficiencies. Interviews with an LPN, an RN and a Social Worker indicated the resident was not readmitted due to safety concerns and the resident's need for a higher level of supervision. The facility was not able to provide the level of supervision needed to keep the resident safe. Review of the facility's Discharge and Transfer policy dated 10/23/2019 indicated facility staff members followed policy. Allegation #2: A resident's guardian was not notified of a change in condition, discharge and the facility did not return the guardian's calls. The allegation could not be substantiated. Interviews with the Social Worker indicated multiple ongoing attempts to contact the resident's guardian had been made. The medical record contained documented evidence multiple attempts had been made including calls and voice mail messages. The medical record contained documented evidence contact had been made with the on-call guardian. Complaint #NV00060798 with the following allegations could not be substantiated. Allegation #1: The facility did not have a photograph of the resident could not be substantiated. Review of the medical | | | |

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| | record revealed the Matrix Medical Systems had a photograph on file to aid the care givers in identifying the resident. Interviews with the Director of Nursing (DON) and nurses revealed all residents must have a resident photograph in the system. Allegation #2: The facility did not have a good time frame of when the resident was last seen at the facility. The allegation could not be substantiated. Interviews with the DON, two Charge Nurses, an RN and two Certified Nurse's Aides (CNA)s indicated the resident had been seen in the facility after lunch had been served. The last documented date and time the resident had been seen was 04/06/2020 at 3:45 PM. The resident was found to be missing during the dinner meal, which was between 5:00 PM to 5:30 PM. Allegation #3: The facility was not secured for elopement risk residents. The allegation could not be substantiated. Observation of the exit doors revealed the doors were secured and could only be opened with a coded keypad or a key from lead nursing staff member. A test of the courtyard exit gate revealed an alarm sounded throughout the facility. Staff members were observed responding to the alarm. Allegation #4: The Night Shift Manager was not cooperative with the responding law enforcement officer. The Night Shift Manager refused to provide employee information. The allegation could not be substantiated. Observations revealed the nurses to be cooperative during the complaint survey. Interviews with two Charge Nurses, two RN, and a LPN revealed staff were cooperative and pleasant. The Charge Nurse and the DON indicated the staff members would cooperate to assist law enforcement officers with an investigation. Allegation #5: A resident was "dumped" at the hospital. The allegation could not be substantiated. Review of the medical record revealed when the resident had been returned to the facility by the police and a physician's order had been given for the resident to be | | | |

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| | transferred to the hospital for evaluation. Complaint #NV00060522 with the following allegations was substantiated. Allegation #1: A resident was admitted to the facility for rehabilitation services and was not seen by a Physical Therapist until five days after admission. This allegation was substantiated. (See Z 420). Allegation #2: A resident was in extreme pain while receiving therapy services and as a result tore their right meniscus. This allegation could not be substantiated. The Director of Therapy Services and the DON revealed if a resident was injured while receiving physical therapy services an incident report would have been completed. The medical record lacked documented evidence the resident tore their right meniscus as a result of physical therapy. Allegation #3: A resident developed pressure ulcers and did not receive treatment for the wounds. This allegation could not be substantiated. Interviews with a CNA, an LPN, and two RNs revealed the resident's skin was assessed weekly. If any skin breakdown had been identified the Charge Nurse and Physician would have been notified. The medical record lacked documented evidence the resident had developed a pressure ulcer while at the facility. The medical record indicated the resident had a surgical wound upon admission, which had healed prior to discharge. Allegation #4: Call bells were not being answered in a timely manner. This allegation could not be substantiated. Observations of the facility's 100, 200, 300, and 400 halls revealed staff members had responded to call lights within one to five minutes of when the call light was activated. Interviews conducted with three CNAs, an LPN, and an RN revealed call lights should be responded to immediately, or within one to five minutes of the call light being activated. Allegation #5: A resident was never assessed by a physician. This allegation could not be substantiated. Interviews with two RNs revealed residents were seen by their | | | |

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| | physician daily or every other day. The medical record contained documented evidence the resident had been seen by a physician on admission and had been assessed by the physician every other day. Allegation #6: A resident did not receive a bath for 40 days. This allegation could not be substantiated. Interviews with a CNA, two RNs revealed residents were scheduled to be bathed two times per week and as needed. The facility had a system in place to ensure residents were bathed twice a week or as needed. Allegation #7: A resident was not groomed adequately. This allegation could not be substantiated. Observations of residents revealed the residents were well groomed and Activity of Daily Living (ADL) care provided. Interviews with two CNAs, an RN revealed ADL care had been provided. Allegation #8: A resident was left soiled for an extended period. This allegation could not be substantiated. Interviews with three residents revealed a staff member had never left them soiled for an extended period. Interviews with two CNAs, and an LPN revealed if a resident was soiled, care would be provided immediately. Allegation #9: The facility lacked sufficient staffing. This allegation could not be substantiated. Observations of staff members providing care to residents revealed staff members were not rushed or appear to be overwhelmed. Interviews conducted with three residents indicated they were satisfied with the care they had received and did not believe there was an issue with lack of staffing. Interviews with three CNAs, and an RN revealed the staff members did not feel rushed or overwhelmed providing care to the residents. The staff members indicated they were able to provide care to residents with their current staffing level. Complaint #NV00060444 with the following allegations could not be substantiated. Allegation #1: A resident was administered the wrong medication and was not treated properly afterwards. This allegation was could not be | | | |

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| | substantiated. The resident of concern revealed the wrong medication had been administered. An interview with the DON revealed it could not be proven the wrong medication had been administered. There had been conflicting responses from the resident and the nurse who had administered the medication. Allegation #2: A resident was unable to file a formal complaint. This allegation could not be substantiated. Interviews with four residents revealed they were aware of how to file a complaint against the facility with the State Long Term Care Ombudsman. Interviews with two Social Workers, and the DON revealed residents were educated upon admission about how to file a grievance and a formal complaint with the State Long Term Care Ombudsman's office. A review of the grievance log indicated the resident had filed three grievances against the facility. Allegation #3: A resident was informed by the Director of Nursing not to speak to State Surveyors when on a visit. This allegation could not be substantiated. An interview with the resident revealed the resident was not told to not speak to the State Surveyors. The DON revealed residents were had not been told to not speak with the State Surveyors. A review of the facility's policy revealed residents had been educated upon admission on how to contact State Agencies. Allegation #4: A resident had fallen as a result of the staff not ensuring the bed was locked. This allegation could not be substantiated. The resident of concern revealed a fall had occurred as a result of the staff being negligent, not ensuring the bed was locked. The allegation could not be substantiated. A progress note documented maintenance staff had checked the bed to ensure there was no malfunction with the bed and determined the bed was locked. A post fall assessment documentation in the medical record revealed the result of the fall was not a result of the facility's negligence. The findings and conclusions of any | | | |

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| | investigation by the Health Division 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. | | | |
| 064 SS= D | NAC 449.74429 - Transfer or Discharge of Patient - 5. A facility for skilled nursing shall prepare a patient for his transfer or discharge in such a manner as to ensure the safe and orderly transfer or discharge of the patient from the facility.<br><br>Inspector Comments: Based on record review, interview and document review, the facility failed to ensure home oxygen had been arranged for a resident in accordance with a physician's order and to provide oxygen for a resident during transportation home from the facility for 1 of 6 residents (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 05/14/2020, with diagnoses including congestive heart failure, acute kidney failure and pain. A signed Physician Order dated 06/06/2020 documented R1 was to be discharged home with oxygen and the oxygen was to be delivered by a Home Health Agency. The Physician's order indicated R1 was to receive two liters of oxygen via nasal cannula when discharged from the facility. The Transition of Care/Discharge Summary dated 06/06/2020, lacked documented evidence arrangements had been made with a Home Health Agency for home oxygen and oxygen delivery. A Nursing progress note dated 06/06/2020 at 4:27 PM, documented R1 had left the facility without oxygen. On 07/29/2020 at 8:50 AM, a Certified Nursing Assistant (CNA) indicated if a resident was being discharged and needed oxygen, the process was to ensure a full tank of oxygen was set up at the correct flow rate and functional when the resident left the facility. The facility would provide an oxygen cylinder if ordered by the physician. On 07/29/2020 at 9:08 AM, a | 064 | 064<br><br>SS=D<br><br>**What corrective actions(s) will be accomplished for those patients found to have been affected by the deficient practice?**<br><br>Resident #1 has discharged.<br><br>**How will you identify other patients having the potential to be affected by the same practice and what anticipated corrective action will be taken.**<br><br>Residents admitted to Spanish Hills Wellness Suites have the potential to be affected by this alleged practice.<br><br>**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur.**<br><br>Case Managers were re-educated by the Director of Nursing on ensuring that home oxygen has been arranged for a home discharge and that oxygen is provided for a resident who has an order for home oxygen upon transporting resident home.<br><br>**How the facility will monitor its corrective actions to ensure that the deficient practice** | 08/14/2020 |

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| | Licensed Practical Nurse (LPN) indicated the Case Manager was responsible to set up home oxygen delivery. If a resident was being discharged, the LPN would check the physician discharge order to see if oxygen had been ordered. The LPN would confirm with the family or resident the oxygen had been delivered or there was oxygen in the home before the resident could leave the facility. If the family did not bring an oxygen cylinder to the facility for the ride home, the facility would provide the oxygen cylinder. On 07/29/2020 at 9:35 AM, an LPN indicated the nurse was responsible for ensuring the residents were safely discharged. Residents being discharged with physician's order for oxygen would not be sent home if they did not have oxygen. On 07/29/2020 at 10:05 AM, a Registered Nurse (RN) confirmed the Case Manager worked with the physician and the Home Health Agency to ensure oxygen was provided in the resident's home. This information should be documented in the resident's medical record. On 07/29/2020 at 10:15 AM, the Director of Nursing (DON) indicated if a resident needed oxygen for the trip home, the facility would provide the oxygen cylinder. On 07/29/2020 at 3:05 PM, the Case Manager and the DON confirmed R1's medical record lacked documented evidence an oxygen cylinder had been provided to the resident at the time of discharge and there was no documented evidence a Home Health Agency had been notified of the Physician's order for the resident to receive oxygen at the home. The Admission, Discharge and Transfer - Code of Ethics policy (revised 10/23/2019), indicated all aspects of discharge were documented in the medical record including physician orders. Sufficient preparation was provided for a safe and orderly discharge. Severity: 2 Scope: 1 Complaint #NV00061285 | | **is being corrected and will not recur.**<br><br>An audit was completed to validate that current discharges home that have home oxygen ordered have the home oxygen arranged and oxygen is provided for transportation home.<br><br>Director of Nursing and/or designee will audit discharges home with orders for home oxygen to validate that home oxygen has been arranged and oxygen is arranged for transportation home, once a week for four weeks, then monthly for two additional months, then randomly thereafter.<br><br>The audit findings will be presented to the Quality Assurance and Performance Improvement Committee monthly for tracking and trending monthly for three months and quarterly thereafter, or until deemed no longer necessary. Any areas of concern will be addressed at the time of discovery.<br><br>**Individual Responsible:** Director of Nursing or designee.<br><br>**Completion Date: 8/14/2020** | |
| 420 SS= D | NAC 449.74527 - Specialized Rehabilitative Services - 1. A facility for skilled nursing | 420 | **420** | 08/14/2020 |

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| | shall provide to a patient in the facility, according to his plan of care, specialized rehabilitative services, including, without limitation, physical therapy, speech pathology, occupational therapy and services for mental illness and mental retardation. Such services must be provided by the facility or obtained from qualified outside sources pursuant to NAC 449.74587.<br><br>Inspector Comments: Based on interview, record review, and document review, the facility failed to ensure a resident had been evaluated for physical therapy services in accordance with the facility's policy for 1 of 6 sampled residents. (Resident #6) Findings include: Resident #6 (R6) R6 was admitted to the facility on 05/18/2019, with diagnoses including type two diabetes mellitus with diabetic neuropathy and an acquired absence of the left leg below the knee. A physician's order dated 05/18/2019, documented Physical Therapy Evaluation and Treatment. The Physical Therapy Evaluation and Plan of Treatment dated 05/22/2019, documented R6 had been evaluated for Physical Therapy services on 05/22/2019. On 07/29/2020 at 10:32 AM, a Physical Therapy Assistant indicated when a resident was admitted to the facility, physical therapy services should assess the resident within the first two days of admission. On 07/29/2020 at 12:41 PM, the Director of Therapy Services revealed when a resident was admitted to the facility therapy services should evaluate the resident on the day of admission or the day after. On 07/29/2020 at 2:50 PM, the Director of Nursing (DON) confirmed R6 had not been evaluated by rehabilitation services within 48 hours of the physician's order. The facility policy titled Rehabilitation Services Policies and Procedures revised on 03/01/2019, documented a therapy evaluation will be performed and documented for all residents with therapy orders. The evaluation was to be completed | | **SS=D**<br><br>**What corrective actions(s) will be accomplished for those patients found to have been affected by the deficient practice?**<br><br>Resident #6 has discharged.<br><br>**How will you identify other patients having the potential to be affected by the same practice and what anticipated corrective action will be taken.**<br><br>Residents admitted to Spanish Hills Wellness Suites have the potential to be affected by this alleged practice.<br><br>**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur.**<br><br>Director of Rehabilitation was re-educated by the Director of Nursing on ensuring that physical therapy evaluations are completed per policy (within forty-eight hours from order date).<br><br>**How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.**<br><br>An audit was completed to validate that current census that had physical therapy evaluation orders were completed per policy.<br><br>Director of Nursing and/or designee will audit physical therapy evaluation orders as ordered to validate that physical therapy evaluated the resident per policy,once a week for four weeks, then monthly for two additional months, then randomly thereafter.<br><br>The audit findings will be presented to the Quality Assurance and Performance | |

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| | within 48 hours of receipt of the order. Severity: 2 Scope: 1 Complaint #NV00060444 | | Improvement Committee monthly for tracking and trending monthly for three months and quarterly thereafter, or until deemed no longer necessary. Any areas of concern will be addressed at the time of discovery.<br><br>**Individual Responsible:** Administrator and/or designee.<br><br>**Completion Date: 8/14/2020** | |