STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295006	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Las Vegas Post Acute & Rehabilitation	2832 S. Maryland Parkway Las Vegas, NV 89109

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50289 Based on observation, interview, record review, and document review the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) level two referral was completed for 1 of 24 sampled residents (Resident 52). The deficient practice had the potential for residents to not receive necessary behavioral health services. Findings include: Resident 52 (R52) R52 was admitted on [DATE], with primary diagnoses including hypertension, neuropathy, atrial fibrillation, and right hip fracture. A PASARR level one document dated 03/22/2022, revealed R52 did not have dementia, mental illness (MI), intellectual disability, (ID) mental retardation (MR) or any related condition (RC) and was deemed appropriate for nursing facility placement. The resident face sheet noted on 10/01/2022, R52 had been diagnosed with dementia. A Psychiatry Note dated 05/29/2024 revealed R52 had disorganized thought process and limited concentration and insight. The resident had a neurocognitive disorder with intermittent agitation and behavioral disturbances that improved with the patient's compliance with medications. The resident was taking Risperidone 0.5 milligrams (mg) for psychosis and Vistaril 50 mg for anxiety. The Division of Health Care Financing and Policy- Medicaid Services Manual- for Nursing Facilities Policy dated 05/01/2015, documented when an individual has been identified with possible indicators of mental illness, intellectual disabilities, or related condition, a PASARR Level II screening must be completed to evaluate the individual and determine if nursing facility services and/or specialized services are needed and can be provided in the nursing facility. Examples include: a resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting a presence of a mental disorder (where dementia is not the primary diagnoses), or an intellectual disability or related condition was not previously identified and evaluated through PASARR. Social services would be responsible for keeping track of each resident's PASARR screening status and referring to appropriate authority. The medical record lacked documented evidence R52 was referred for a PASARR level two. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/27/2024 in the afternoon, the Social Worker (SW) explained the SW was responsible for completing the online PASARR requests. The SW indicated not being aware of some residents who should have been identified for meeting criteria and referred for PASARR two reviews. The SW agreed a PASARR two referral for R52 had not been done.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33980 Based on interview, record review and document review, the facility failed to provide documented evidence a discharge plan was initiated and discussed with the resident and/or resident representative for 1 of 24 sampled residents (Resident 190). The deficient practice had the potential for the resident to be unprepared for discharge. Findings include: Resident 190 (R190) R190 was admitted on [DATE], with diagnoses including schizoaffective disorder (bipolar type) and suicidal ideations. The Admission Care Plan dated 06/12/2024, documented the interventions to be provided to R190 which included to begin discharge planning. R190's medical record lacked documented evidence a discharge plan was initiated and discussed with the resident and/or resident representative. On 06/28/2024 at 7:29 AM, the Social Services (SS) Director indicated the SS Assistant would have talked to the resident and/or resident representative within 24 hours upon admission and discussed briefly about discharge planning. The SS Director would have followed-up within a week and thoroughly discussed the discharge planning with the resident and/or resident representative. The SS Director explained the discussion and interview about discharge planning would have been documented in the SS Notes. The SS Director revealed the Interdisciplinary Team (IDT) would have discussed the discharge plan with the resident and/or resident representative within 14 days from admission. The SS Director acknowledged there was no documentation of the resident's discharge planning, discussion with the resident and/or resident representative about the discharge plan, IDT notes regarding R190's discharge plan, and no Social Services Progress Notes completed and filed in R190's medical record. On 06/28/2024 at 8:52 AM, the Medical Records Supervisor indicated R190's medical record did not contain IDT Notes. On 06/28/2024 at 11:18 AM, the SS Assistant revealed being in-charge with scheduling the IDT meeting for each resident every 14 days upon admission, quarterly, and as needed. The SS Assistant confirmed there was no IDT meeting scheduled for R190 this week (from 06/23/2024 to 06/29/2024) and next week (from 06/30/2024 to 07/06/2024). The SS Assistant provided a copy of the IDT Weekly Planner which corroborated the interview. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled Discharge Planning dated October 2012, documented discharge planning should be developed at the time of admission and reviewed at least once in every quarter. Discharge plans should be documented in the resident's clinical (medical) record. Upon admission, Social Services should determine the potential for the resident to be discharged to a lower level of care or home care. Reasons for lack of potential should be documented in the social services progress notes and discharge plans. Resident and/or family or responsible party should be involved in the formulation of discharge plans and post discharge care.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37718 Based on interview, record review and document review, the facility failed to ensure as needed (PRN) psychotropic medications were initially ordered for a duration not to exceed 14 days for 3 of 24 sampled residents (Resident 11, 64, and 188); and consents for the administration of psychotropic medications were obtained for 2 of 24 sampled residents (Resident 64 and 188). The deficient practices had the potential to cause an adverse medication effect and not honoring the resident's rights to be fully informed of the care and services being provided. Findings include: 1) Resident 11 (R11) R11 was admitted on [DATE] with diagnoses including generalized anxiety. On 06/27/24 at 9:20 AM, R11 reported taking a medication to treat symptoms of intermittent anxiety. The resident reported they asked a nurse for the medication when the symptoms occurred. A physician order dated 05/24/2024 indicated to give Alprazolam (an antianxiety agent) 0.5 milligrams (mg) by mouth every six hours as needed for anxiety manifested by inability to relax for 30 days. On 06/27/2024 at 2:36 PM, the Director of Nursing (DON) reviewed R11's order for Alprazolam and verbalized the medication was a sedative and should not have been initially ordered for a duration of more than 14 days. On 06/27/2024, at 3:35 PM, the Consultant Pharmacist verbalized initial orders for psychotropic medications should not exceed 14 days duration. 33980 2) Resident 188 (R188) R188 was admitted on [DATE], with diagnoses including major depressive disorder, bipolar disorder, and post-traumatic stress disorder. The physician order dated 06/14/2024, documented Lorazepam (an antianxiety agent) 0.5 milligram (mg) one tablet by mouth every 24 hours as needed (PRN) for anxiety manifested by inability to relax for 30 Days. R188's Medication Administration Record (MAR) for June 2024, documented the resident received the medication on 06/17/2024. R188's medical record lacked documented evidence of the rationale for the duration of the PRN order beyond 14 days and a consent was obtained for the administration of Lorazepam 0.5 mg. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/27/2024 at 11:38 AM, the Director of Nursing (DON) confirmed the findings. The DON explained PRN orders for psychotropic medications should have been limited for 14 days, then could have been extended by the physician with the justification for ordering the medications beyond 14 days. The justification should have been documented in the resident's medical record. The DON confirmed the PRN order for R188's Lorazepam dated 06/14/2024 was for 30 days. The DON acknowledged the duration of the PRN order should have been 14 days. The DON explained a consent for the administration of psychotropic medication should have been obtained whether the medication was scheduled or PRN. The DON confirmed there was no consent obtained for R188's Lorazepam. On 06/27/2024 at 12:24 PM, the Medical Records Supervisor confirmed there was no consent for R188's Lorazepam. On 06/27/2024 at 12:49 PM, a Licensed Practical Nurse (LPN) explained the duration of the order for PRN psychotropic medications should have not exceeded 14 days. The LPN revealed the nurse should have called the physician if they received a PRN psychotropic order for more than 14 days. The nurse would have informed the physician the PRN order should have been for 14 days only. The LPN indicated the nurse who received the physician order for the administration of psychotropic medications should have obtained a consent from the resident or resident representative. 3) Resident 64 (R64) R64 was admitted on [DATE], with diagnoses including dementia and shortness of breath. The physician order dated 06/14/2024, documented Hydroxyzine Hydrochloride (HCl) (an antianxiety agent) 25 mg one tablet by mouth three times a day as needed for anxiety manifested by inability to relax for 30 days. R64's medical record lacked documented evidence of the rationale for the duration of the PRN order beyond 14 days and a consent was obtained for the administration of Hydroxyzine HCl 25 mg. On 06/27/2024 at 1:44 PM, the Medical Records Supervisor and the DON confirmed there was no consent obtained for R64's Hydroxyzine HCl. The Acknowledgment of Psychoactive Medication Use form (consent) for the resident's Hydroxyzine HCl was not completed. The DON acknowledged the duration of the PRN order for R64's Hydroxyzine HCl 25 mg was 30 days and there was no justification for the PRN order beyond 14 days. The DON indicated the duration of the PRN order should have been 14 days. The facility's policy titled Psychotropic Drug Treatment dated December 2016, documented psychotropic drugs included antianxiety agents, antidepressants, hypnotics, antipsychotics, and other drugs which would affect behavior. The need to continue PRN orders for psychotropic medications beyond 14 days required the practitioner documented the rationale for the extended order. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident or his/her representative would be given information regarding the need for, the desired effects and the potential side effects of the medication. This would enable the resident or his/her representative to make an informed decision regarding the use of any psychoactive medication. The resident or their representative should be involved in the medication management process and aware of the benefits and risks of medications and the goals of treatment.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50289 Based on observation, interview, record review and document review, the facility failed to ensure dietary orders were followed for a resident on a renal diet for 1 of 24 sampled residents (Resident 47). This deficient practice placed the resident at risk for weight loss. Findings include: Resident 47 (R47) R47 was readmitted on [DATE] with diagnoses including end stage renal disease, anemia, debility, benign prostatic hyperplasia, and hypertension. The Admission Care Plan dated 06/07/2024, indicated the resident required skilled nursing due to the need to medically manage assistance with meals, offering and encouraging fluid intake, monitoring of weekly weights, and providing and serving diet as ordered to avoid any declines in nutrition. A Physician Order dated 05/31/2024, with a start date of 06/08/2024 documented a renal diet, with regular texture, and thin liquids. A telephone Physician Admission Orders form dated 06/07/2024, indicated a renal diet consisting of regular textures with thin liquids. On 06/27/2024 at 3:07 PM, the Admission Nurse indicated the report was taken from the referring facility. When the referring facility called, they provided all the information to the accepting facility's admission nurse. The admission nurse takes down the information and documents it in the telephone Physician Admission Orders form. The admissions nurse validated the diet written in the orders was renal diet, regular texture, with thin liquids. On 06/25/2024 in the afternoon, R47 voiced the food was always the same. They never change it up. It was always a meat, mashed potatoes or rice, and a vegetable. R47 did not really like the food was all chopped up. R47 complained they never serve salads due to the ordered diet. R47 really wanted a salad. The meal ticket documented a renal diet with mechanical soft texture and thin liquids. On 06/28/2024 at approximately 9:46 AM, the Dietary Manager explained upon admission the kitchen received a written notification from nursing as to the diet, consistency, and allergies. Within a couple days, if there was an upgrade or a down grade, the kitchen would get a written notification. Within the first 48 hours of admission, the kitchen would complete a food preference and snack availability form. The Dietary Manager stated R47 came to the kitchen all the time requesting a salad. The Dietary Manager discussed having to explain to R47 that a salad was not within the mechanical soft texture requirements. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/27/2024 at approximately 1:10 PM, a Speech Therapist explained the process of receiving diet orders when a resident was admitted to the facility. The resident was given the diet of the last place they were at unless the physician ordered a Speech Therapy evaluation for food diet and/or textures. The Speech Therapist acknowledged there was not an order written for this evaluation after R47 was readmitted . A facility document titled Diet Order Form and Communication dated 06/08/2024 was completed by a Licensed Practical Nurse (LPN) who was not available for an interview. The regular diet was crossed out and the renal diet was checked. The mechanical soft texture was checked. The regular fluid consistency was checked. On 06/27/2024 at 12:17 PM, a Registered Dietician explained R47 was on a mechanical soft diet for a very long time before the resident left here. At the rehabilitation facility, the resident's diet was upgraded to a regular texture diet. The dietician stated it was possible this facility just kept R47 on the last known diet from this facility being that R47 had been on this texture diet for so long before leaving to go to Rehab. A facility document titled Weekly Weight Record, dated 06/07/2024, indicated the patient had lost 1.5 pounds from 06/17/2024 to 06/24/2024. A facility policy titled Food and Nutritional Services, revised October 2017, indicated each resident will be given a resident-centered diet and nutritional plan that is based on a multidisciplinary assessment to provide a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33980 Based on interview, record review and document review, the facility failed to ensure the medical record contained the nurse's notes and weekly summary form for 1 of 24 sampled residents (Resident 188). The deficient practice had the potential for the resident not to receive the timely interventions needed and for the facility missing the opportunity to identify care issues. Findings include: Resident 188 (R188) R188 was admitted on [DATE], with diagnoses including major depressive disorder, bipolar disorder, and post-traumatic stress disorder. A review of R188's medical record revealed there were no nurse's notes and weekly summary form completed and filed in the resident's medical record. On 06/27/2024 at 11:38 AM, the Director of Nursing (DON) confirmed the findings and revealed the nurses were expected to complete the 72-Hour Nurses Charting form every shift upon a resident's admission and a weekly summary form for each resident. On 06/27/2024 at 12:24 PM, the Medical Records Supervisor confirmed there were no nurse's notes, 72-Hour Nurses Charting form, Daily Skilled Nursing Notes, and Weekly Summary charting in the medical record of R188. On 06/27/2024 at 12:56 PM, a Licensed Practical Nurse (LPN) indicated the following forms should have been completed and filed in the resident's medical record: - 72-Hour Nurses Charting form for all residents upon admission - Daily Skilled Nursing Notes for Medicare residents and residents receiving therapy - Weekly Summary charting for all residents The facility's policy titled Order of Record Assembling dated December 2006, documented the contents of a resident's medical record which included nurse's notes and assessment.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 37718 Based on interview, record review and document review, the facility failed to develop and implement at least one Performance Improvement Project (PIP) per year. The deficient practices had the potential to adversely impact each resident's well-being. Findings include: On 06/28/2024 at 1:17 PM, the Administrator revealed Quality Assurance Performance Improvement (QAPI) committee meetings were held monthly and usual attendees included the Administrator, the Medical Director, and the Director of Nursing. On 06/28/24 at 1:25 PM, the Director of Nursing (DON) reported the facility had a PIP planned for improving laboratory result timelines. There had been a problem with laboratory studies not being completed because of sample degradation through hemolysis. The DON described an intention to improve the laboratory service but was unable to provide documentation of the method of data collection, the analysis of the data, development of an action plan, implementation of the action plan, evaluation of the action plan, and any modifications to the plan if needed, and the target goal. The DON verbalized development of the PIP had not been done yet. The DON verbalized lacking documentation of a PIP which had been completed over the past year. On 06/28/24, in the afternoon, the Administrator indicated the facility was unable to furnish documentation of a PIP completed within the past year. The Quality Assurance/Process Improvement (QAPI) Plan dated 01/12/2023 indicated QAPI committee meetings would be held monthly. Performance Improvement Projects (PIPs) were established by the committee based on potential for negative outcome, number of residents affected, and if the issue was recurring. Data would be reviewed, and improvement or deterioration would be readdressed. Depending on findings the PIP would continue until improvement was maintained. Data would be maintained in the QAPI binder.