| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295041 | A. BUILDING _____ B. WING _____ | 06/20/2014 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| DELMAR GARDENS OF GREEN VALLEY | 100 DELMAR GARDENS DRIVE HENDERSON, NV 89014 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
|---|---|
| F 0154<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Tell the resident completely about his or her health status, care and treatments.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to ensure a complete consent was obtained for [MEDICAL CONDITION] medications for 2 of 30 sampled residents (Resident #19 and #20). Findings include: Resident #19 Resident #19 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The physician's orders [REDACTED]. The Medication Administration Record [REDACTED]. The physician's orders [REDACTED]. The MAR indicated [REDACTED]. Resident #19's clinical record lacked documented evidence a consent was obtained prior to the resident receiving the medications. On 6/20/14 at 8:50 AM, a Licensed Practical Nurse (LPN) confirmed a consent for the resident's [MEDICATION NAME] and [MEDICATION NAME] XL was not obtained prior to administering the medications to the resident. The LPN verbalized the nurses were not supposed to give [MEDICATION NAME] and [MEDICATION NAME] XL to the resident without the consent. The LPN acknowledged the facility's policy for consents had not been followed. Resident #20 Resident #20 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The physician's orders [REDACTED]. The MAR indicated [REDACTED]. The resident's clinical record contained Informed Consent for Treatment with [MEDICAL CONDITION] Medications dated and signed by the resident on 5/20/14. The following areas in the consent were not filled out appropriately: ( ) I hereby give my consent to treatment with the [MEDICAL CONDITION] medications indicated above as marked with yes or no. ( ) I hereby refuse my consent to treatment with [MEDICAL CONDITION] medications indicated as no. On 6/20/14 at 10:07 AM, a Registered Nurse (RN) confirmed Resident #20's consent was incomplete. The RN verbalized the consent was not valid because the resident did not indicate consent or refusal for treatment with [MEDICAL CONDITION] medications. The RN acknowledged it was not clear whether the resident gave the consent or not. |
| F 0223<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Protect each resident from all abuse, physical punishment, and being separated from others.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview, medical record and document review, the facility failed to ensure a resident who displayed sexually inappropriate behavior was assessed and monitored for 1 of 30 residents (Resident #16). Findings include: Resident #16 Resident #16 was admitted on [DATE], with [DIAGNOSES REDACTED]. On 6/17/14 in the morning, during the tour of the locked unit the licensed nurse revealed Resident #16 thought he was a real ladies man. The nurse explained the resident goes around kissing female residents on the lips. A nurse's note dated 3/30/14 for Resident #16, documented the following, 1830 (6:30 PM) Resident observed kissing a female resident in the dayroom, advised resident that this was not acceptable behavior. Resident became loud and hostile toward the nurse said, Grow-up! get out of here I can do what I want! 1900 (7:00 PM) resident stated he was going to take the same female resident to her bathroom-advised that the Certified Nurses Assistant would take care of her needs. Resident #16's care plan dated 4/03/14, documented the resident was inappropriate sexually with female residents examples included kissing, touching attempting to take female residents into his room. Interventions in the care plan for Resident #16 included re-direct resident when he displayed behaviors. There was no documentation which female residents he had kissed or touched. Employee #3 explained it was Resident #25 who was very confused and spoke only Spanish. Employee #3 indicated Resident #25 thought Resident #16 was her husband. Employee #3 indicated it was just holding hands and kissing. The two residents were like boyfriend and girlfriend. Employee #3 indicated she did not feel this was sexual abuse even though Resident #25 was more confused than Resident #16 and only spoke Spanish. Employee #3 explained she had not noticed Resident #16 paid attention to any other of the female residents in the unit. There was no documentation in Resident #25's medical record concerning the incident on 3/30/14. There was no documentation in Resident #25's care plan that indicated the resident thought Resident #16 was her spouse and wanted his sexual advances. On 6/17/14 in the morning and after lunch, Resident #16 was in his room with the door closed. On 6/18/14 in the morning and after lunch Resident #16 was in his room with the door closed. Resident #16 did not have a roommate. On 6/18/14 in the afternoon an interview was conducted by telephone with the family member of Resident #25. The family member indicated she was told about six months prior Resident #16 and Resident #25 held hands once in a while. Resident #25's family member indicated she would not want the hand holding to go any farther since Resident #25 was very confused. |
| F 0225<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interviews, record review and document review, the facility failed to ensure a self report was investigated for 2 of 30 residents and sent to the state in a timely manner per facility policy for 1) fall with injury (Resident #10) and 2) sexual inappropriate behavior (Resident #16). Findings include: Resident #16 Resident #16 was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #16 resided in the locked unit at the facility. A nurses note dated 3/30/14 for Resident #16, documented the following, 1830 (6:30 PM) Resident observed kissing a female resident in the dayroom, advised resident that this was not acceptable behavior. Resident became loud and hostile toward the nurse said-Grow-up! get out of here I can do what I want!. 1900 (7:00 PM) resident stated he was going to take the same female resident to her bathroom-advised that the Certified Nurses Assistant would take care of her needs. Resident #16's care plan dated 4/3/14 documented the resident was inappropriate sexually with female residents examples included kissing, touching attempting to take female residents into his room. On 6/17/14 in the morning, during the tour of the locked unit the licensed nurse revealed Resident #16 thought he was a, real ladies man. The nurse explained the resident goes around kissing female residents on the lips. On 6/18/14 in the morning, the Administrator explained she was not informed of this incident therefore no report of the inappropriate sexual behavior was reported to the Ombudsman or the Division of Public and Behavioral Health. The Administrator indicated the facility did not feel the incident was reportable since nothing happened between the residents. The Administrator explained that the incident in question occurred with Resident #25 who thought Resident #16 was her husband. The Administrator indicated she did not think the incident was reportable even though Resident #25 was very confused and unable to make her needs known. The facility policy for Alleged Abuse Policy #203 (revised 5/2008) defined Sexual Abuse to include but not limited to, sexual harassment, sexual coercion, or sexual assault.<br><br>Resident #10 Resident #10 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #10 sustained a fall with fracture on 1/27/14 at 09:55 AM and was transferred to the emergency room for evaluation and treatment. A self report |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295041 | A. BUILDING _____ B. WING _____ | 06/20/2014 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| DELMAR GARDENS OF GREEN VALLEY | 100 DELMAR GARDENS DRIVE HENDERSON, NV 89014 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
|---|---|
| F 0225<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>was submitted to the Division of Public and Behavioral Health on 1/29/14 at 4:11 PM. The self report was noted as an initial report and a final report. On 6/20/14 at 1:15 PM, the Nursing Home Administrator (NHA) agreed the report was not timely. The NHA revealed the initial report should have been completed within 24 hours in accordance with state guidelines. NAC 449XXX indicated in part .fall/injury must be reported to the Division of Public and Behavioral Health within 24 hours. A final report must be received within 5 working days. |
| F 0241<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide care for residents in a way that keeps or builds each resident's dignity and respect of individuality.**<br><br>Based on observation and interviews, the facility failed to ensure call lights were answered in a timely manner. Findings include: On 6/19/14 in the morning, a call light on the 600 hall was observed to be on for more than 30 minutes from 8:00 AM to 8:35 AM. On 6/17/14 in the morning, two alert and oriented residents on the 400 Hall who wished to remain anonymous revealed it took at least a half an hour for staff to answer call lights on the day and night shifts. Both residents indicated the staff turn off the lights and do not return.<br><br>On 6/18/14 at 11:00 AM during the Group Interview, residents verbalized the staff do not respond to call bells quickly enough. Residents indicated they felt like the nurses should at least come and acknowledge the resident even if they couldn't come help them right away. Residents made the following statements: -Sometimes they don't answer the call bells for a half hour or longer. -In the middle of the night when I ring the call bell the nurses are so busy talking they don't pay any attention. -I've waited for more than an hour for the nurse to come in the room. |
| F 0281<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Make sure services provided by the nursing facility meet professional standards of quality.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review the facility failed to ensure a Registered Nurse (RN)completed an assessment after a fall for 1 of 30 residents. (Resident #10). Findings include: Resident #10 Resident #10 was admitted on [DATE], with [DIAGNOSES REDACTED]. On 1/27/14 at 9:55 AM, Resident #10 sustained a fall with fracture from a Serita lift (sit to stand) and was assisted to the floor. The Certified Nursing Assistant (CNA) called the Licensed Practical Nurse (LPN) for assistance. (refer to F323). The nurse's notes on 1/27/14 at 09:55 AM, documented Resident #10's legs gave out while in the Serita lift. The CNA assisted/eased resident #10 to the floor. The LPN documented no injuries were noted. On 1/27/14 at 9:55 AM, the nurse's note entry indicated Resident #10's feet were weak and his legs gave up. The CNA eased Resident #10 to the floor. There were no injuries noted. Resident #10 was assisted back to bed and made comfortable. Resident #10 verbalized my knees gave out on me. The clinical record lacked documented evidence a complete assessment was conducted and the mode the resident was transferred from the floor to the bed. On 6/19/14 at 1:00 PM, the RN indicated the LPN could not assess a resident and would have to call the RN to conduct an assessment. On 6/19/14 at 2:00 PM, the LPN indicated the resident did sustain a fracture and revealed an RN should have assessed Resident #10 prior to the transfer from the floor to the bed. The LPN verbalized when Resident #10 was assisted back to bed the team used the hoyer lift. During the transfer the lift tipped forward but the staff was able to pull the lift back so Resident #10 could be lowered to the bed. The LPN indicated he/she could not be certain which transfer caused the fracture. The LPN agreed an RN should have assessed Resident #10 for injury while on the floor. On 6/19/14 in the afternoon, the Director of Nursing (DON) revealed an RN should conduct an assessment. The DON was not notified the Hoyer lift tipped forward. On 6/20/14 at 1:00 PM, the Nursing Home Administrator indicated the expectation was the RN would complete an assessment if a resident had a fall. Nevada State Board of Nursing Nurse Practice Act Revised (October 2012) explained under Practical Nurses NRS 632.230 .May not independently carry out those duties which require the substantial judgement, knowledge and skill of a Registered Nurse. |
| F 0309<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide necessary care and services to maintain the highest well being of each resident**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and clinical record review the facility failed to ensure 1 of 30 sampled residents (Resident #27) had medication administered in accordance with physician's orders [REDACTED].#13); the facility failed to ensure hospice services were provided in accordance with facility's expectations and the agreement with the hospice agency for 1 of 30 residents (Resident #21). Findings include: Resident #27 Resident #27 was admitted to the facility on [DATE], with a [DIAGNOSES REDACTED]. Physician orders [REDACTED]. The Medication Administration Record [REDACTED]. On 6/18/14 at 11:12 AM,<br>the Patient Care Coordinator indicated [MEDICATION NAME] should have been started as soon as the order came in. The Patient Care Coordinator confirmed the physician order [REDACTED]. On 6/18/14, the facility was not able to provide a policy and procedure regarding the administration of anti-biotic medications.<br><br>Resident #13 Resident #13 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The resident was admitted from<br>an acute care hospital. On 6/17/14 at 11:34 AM, the resident's family member indicated the resident experienced decreased functioning related to ambulation, toileting, eating, transferring and range of motion of the arms since admission. The resident indicated increased back pain over the past few weeks which was reported to nursing staff. The resident's family member explained the resident had a history of [REDACTED]. The clinical record revealed: A Physician order [REDACTED]. The resident's Pain Plan of Care (POC) dated 11/10/13, documented chronic pain related to [MEDICAL CONDITION]. Pain site back and bilateral knees. Interventions included assess effects of pain to the the resident (disturbances in sleep, activity, self care, appetite, psychosocial, etc.). The POC was updated on 2/11/14 to reflect [MEDICATION NAME] 5/325 every morning and evening for pain. - The resident's POC lacked documented evidence the resident's cognitive status due to [MEDICAL CONDITION] and intermittent confusion had been identified. - The resident's POC lacked documented evidence pain should have been assessed utilizing the 0-10 scale in accordance with facility policy. - The resident's POC lacked documented evidence the resident's pain status when administering scheduled medication should have been assessed every shift for the effectiveness and intitialed by nursing in accordance with the facility policy. The resident's Medication Administration Records (MAR) from 1/1/14 through 2/11/14 documented: 1/1/14-1/31/14: 25 doses were administered 2/1/14-2/11/14: 135 doses were administered - The 1/11/14-2/11/14 MARs lacked documented evidence the pain was assessed using the 0-10 scale in accordance with the facility policy. A Physician order [REDACTED]. [MEDICATION NAME] 5/325 mg every morning and evening and<br>[MEDICATION NAME] 5/325 mg every eight hours as needed. The resident's MARs from 2/11/14 through 5/18/14 documented: 2/11/14-2/28/14 Scheduled doses and two as needed doses administered 3/1/14-3/31/14 Scheduled doses and one as needed dose administered 4/1/14-4/30/14 Scheduled doses administered 5/1/14-5/28/14 Scheduled doses administered - The 2/11/14-5/18/14 MARs lacked documented evidence the resident's pain status was assessed every shift for the effectiveness and initialed by the nurse in accordance with the facility policy. A Physician order [REDACTED]. The resident's MARs from 5/19/14 through 6/11/14 documented pain medication had been administered twice. - The 5/19/14-6/11/14 lacked documented evidence to support the pain severity from 0-10 and the results or response to administration were documented. The Resident Care Assessment undated, provided by nursing staff which directed care provided to the resident by the Certified Nursing Assistants failed to provide information in the Pain Management section. Nursing documentation from 5/31/14 through 6/11/14 lacked documented evidence pain had been assessed on a daily basis. Nursing weekly summaries dated 5/31/14 and 6/7/14 documented the resident had not experienced pain. - The clinical record lacked documented evidence of Pain Management Flow Sheets. On 6/17/14 at 11:30 AM, a LPN was observed preparing and administering oral medications to the resident. The LPN failed to address with the resident the current level of pain. On 6/17/14 in the afternoon, the Director of Nursing (DON) indicated when pain medication had been changed from scheduled to as needed the resident's POC should have been updated and nursing staff should have assessed for pain during the medication pass and when the CNA's provided care. The assessments should have been documented in the nursing notes. On 6/17/14 in the afternoon, the resident and family member indicated the pain administration change from scheduled to as needed had not been discussed nor were they made aware of the change. On 6/20/14 at 8:34 AM, a staff LPN indicated pain assessments should have been documented daily and on the weekly summary. Pain should have been assessed more frequently when the pain medication had been changed from scheduled to as needed. On 6/20/14 at 11:20 AM, the DON indicated pain should have been assessed during every encounter, as needed every four hours and |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295041 | A. BUILDING _____ B. WING _____ | 06/20/2014 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| DELMAR GARDENS OF GREEN VALLEY | 100 DELMAR GARDENS DRIVE HENDERSON, NV 89014 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
|---|---|
| F 0309<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 2)<br>documented in the nursing notes or weekly summary. The facility's Pain Assessment and Management policy, number P-2, undated, documented: .All residents will be assessed for pain and identified by nursing staff. Residents who are nonverbal, non-communicative or demented are evaluated behaviorally for pain indicators for comfort level. Resident with pain will receive individual interventions aimed at reducing chronic and/or acute discomfort utilizing current standards of practice for pain control. .Procedure .2. Develop an individualized care plan for pain management. .3. Pain Management Flow Sheet will be place in each resident's medication record for assessment and documentation of intermittent and breakthrough pain. 4. Pain Assessment will be done using the 0-10 pain scale based o (sic) the resident's cognitive status. .6. Interventions to treat resident's pain will be implemented to manage pain effectively. .7. Evaluate effectiveness of PRN (as needed) [MEDICATION NAME] within an hour of time administered and document effectiveness on back of Medication Administration Record [REDACTED]. 8. Residents receiving routine [MEDICATION NAME] will have their pain status assessed every shift for effectiveness of pain medication as directed by the Medication Administration Record [REDACTED] Resident #21 Resident #21 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The resident's clinical record revealed: The resident's family elected to receive hospice services on 6/5/14. The hospice agency's Plan of Care (POC) dated 6/5/14, documented: -Skilled Nursing Services one to three times weekly or as needed for 13 weeks -Aid Services three times weekly for 13 weeks The clinical record lacked documented evidence to support skilled nursing or aid services had been provided. There was a hospice tab in the clinical record which contained the hospice initial evaluation, POC and Physician Orders. On 6/19/14 in the afternoon, a Licensed Practice Nurse (LPN) reviewed the resident's record and indicated hospice information related to visits should have been under the hospice tab. The LPN called the hospice agency and requested documentation to support the skilled nursing and aid visits. On 6/19/14 in the afternoon, the Director of Nursing (DON) indicated the facility doesn't have a policy related to hospice agencies. The DON acknowledged there was no documentation in the resident's record to support services had been provided in accordance with the POC. The DON provided a document entitled Guidelines For Hospice Admissions which had been given to hospice agencies. On 6/20/14 in the morning, the DON provided information faxed from the hospice provider dated 6/19/14 at 4:42 PM. Documentation revealed skilled nursing services had been provided on 6/9/14 and 6/16/14 and Aid or CNA services had been provided on 6/16/14. The DON acknowledged the hospice had not received the Aid or CNA schedule or provided Aid or CNA services in accordance with the POC. The Guidelines For Hospice Admissions, undated, no reference number, documented: .Hospice CNA (Certified Nursing Assistant) - Hospice will provide the facility with schedule for CNA visits. .Hospice will maintain a section in the facility's hard chart for each of their patients. This section will be kept in the back of the patient's chart with a tab to specify Hospice. Copies of all Hospice documentation will be kept in this section, and must be left in chart at time of each visit. |
| F 0310<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Make sure that each residents' abilities in activities of daily living do not decline, unless unavoidable.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, clinical record and document review, the facility failed to provide restorative services to maintain functional status related to activities of daily living for 1 of 30 residents (Resident #13). Findings include: Resident #13 Resident #13 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The resident was admitted from an acute care hospital. On 6/17/14 at 11:34 AM, the resident's family member indicated the resident experienced decreased functioning related to ambulation, toileting, eating, transferring and range of motion of the arms since admission. The family member reported upon admission the resident ambulated with a walker with standby or one person assistance, transferred from the bed to the chair with standby or one person assistance, ate independently with set up, toileted using a commode with standby or one person assistance and was able to raise arms to comb hair. Since May 2014, the resident had been eating in the Restorative Dining Area due to increased inability to self fed. The resident's family member indicated the Social Worker (SW) explained the resident had been unable to receive therapies because of the insurance. -On 6/17/14 from 11:34 AM-12:00 PM, the resident was observed sitting in a wheelchair and indicated an inability to use the walker for ambulation. The clinical record revealed the following: The Transfer Summary from the acute care hospital dated 10/29/13, documented physical therapy should be continued at an extended rehabilitation facility. The resident had ambulatory dysfunction with falls but had been ambulating with a walker and Physical Therapy (PT) assistance. The resident required moderate assistance with transferring from the bed to chair. The Nursing Admission Resident assessment dated [DATE], documented the resident required one person assistance for transferring and assistance with bathing, dressing and grooming. The assessment did not capture resident's functional ability related to ambulation or toileting. The ADL Functional/Rehabilitation Potential Care Plan dated 11/7/13, documented goals including maintaining the ability to eat independently with set up assistance and maintaining the ability to ambulate with the assistance of one person. Interventions included pain monitoring and reporting deterioration in status to the physician. On 2/11/14, Restorative Assistance (RA) interventions for standing and active range of motion to upper and lower extremities was added. The Nutritional Status Plan of Care (POC) dated 11/10/13, documented goals including tolerating food without gas. The POC was not updated on 12/27/13 when Speech Therapy (ST) identified the resident experienced problems related the swallowing. On 5/6/14, the POC documented RA dining for all meals as an approach but failed to identify the reason for the intervention. The Admission Minimum Data Set (MDS) Resident assessment dated [DATE], documented the following: Bed Mobility: Extensive Assistance/One Person Transfer: Extensive Assistance/One Person Walk in Room: Limited Assistance/One Person Dressing: Extensive Assistance/One Person Eating: Independent Toilet Use: Extensive Assistance/One Person Personal Hygiene: Extensive Assistance/One Person Mobility Devices: Walker/Wheelchair Certified Nursing Assistant (CNA) Activities of Daily Living (ADL) Tool from 11/2013 through 6/2014 indicated the resident required progressively more assistance for repositioning in bed, transferring, eating and toileting. The resident's ability to ambulate was not captured on the flow sheets. Weekly Nursing Summaries from 11/2013 through 6/2014 revealed: -Bed mobility varied from independent to limited assistance. The most recent assessment dated [DATE], indicated the resident was independent. -Transfers varied between independent to extensive assistance. The most recent assessment dated [DATE], indicated the resident transferred independently. - Ambulation varied between walks independently, walks with extensive assistance of one person, propels self in wheelchair or unable to propel self in wheelchair. The most recent assessment dated [DATE], indicated the resident ambulated independently. - Dressing and grooming varied between independent, limited, extensive or dependent assistance. The most recent assessment dated [DATE], indicated the resident was independent. - Nutrition/Hydration varied between independent to limited assistance. The most recent assessment dated [DATE], indicated the resident required limited assistance. Nursing documentation dated 11/7/13, documented the resident fell on [DATE]. The Therapy Screen for Falls Form dated 11/13/13, completed by the charge nurse and distributed to the Rehabilitation Therapy Department documented the resident walked with a front wheeled walker and transferred with one person assistance. The Director of Rehabilitation documented monitor as an intervention. The ST POC dated 12/27/13, documented the resident experienced delayed swallowing with choking and gagging. A diet change to puree food and therapy to determine necessary/optimal compensatory swallow strategies to maximize safe oral intake was recommended. The nursing documentation dated 1/8/14, documented Resident had difficulty swallowing pills. Meds (medications) were given whole in applesauce but still had difficulty. The ST POC Care dated 1/14/14, documented the resident had not met the therapy goals and services were terminated because of insurance denial. The clinical record lacked documented evidence the resident received an evaluation for RA (Restorative Assistance). The nursing documentation dated 1/14/14, documented the resident had some difficulty swallowing medications. The nursing documentation dated 1/22/14, documented the resident fell . The Therapy Screen for Falls Form dated 1/19/14, completed by the charge nurse and distributed to the Therapy Department documented the resident walked with a front wheeled walker and transferred with one person assistance. The Director of Rehabilitation documented insurance must go out of facility for evaluations. The Quarterly MDS dated [DATE] Resident Assessment, documented the following: Bed Mobility: Extensive Assistance/One Person Transfer: Total Dependence/Two Person Walk in Room: Did not occur Dressing: Extensive Assistance/One Person Eating: Supervision/Set Up Toilet Use: Extensive Assistance/One Person Personal Hygiene: Extensive Assistance/One Person Mobility Devices: Wheelchair - The resident's difficulty swallowing identified by ST on 12/27/13 and the difficulty swallowing pills identified by nursing on 1/8/14 was not captured on the MDS. A Physician order [REDACTED]. The resident's clinical record related to RA therapy revealed: - Therapy was not completed in February and March 2014. - Therapy was completed a total of three times in April 2014 - Therapy was not completed from 5/1/14-5/7/14 and inconsistently completed from 5/8/14-5/30/14. The Quarterly MDS dated [DATE] Resident Assessment, document the following: Bed Mobility: Extensive Assistance/One Person |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295041 | A. BUILDING _____ B. WING _____ | 06/20/2014 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| DELMAR GARDENS OF GREEN VALLEY | 100 DELMAR GARDENS DRIVE HENDERSON, NV 89014 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
|---|---|
| F 0310<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 3)<br>Transfer: Total Dependence/Two Person Walk in Room: Did not occur Dressing: Extensive Assistance/One Person Eating: Limited Assistance/One Person Toilet Use: Total Dependence/One Person Personal Hygiene: Extensive Assistance/One Person Mobility Devices: Wheelchair - The resident's difficulty swallowing identified by ST on 12/27/13 and the difficulty swallowing pills identified by nursing on 1/8/14 was not captured on the MDS. ST POC dated 6/6/14, documented the resident had been recommended for ST in the past but due to insurance the treatment was denied. The prior assessment indicated a swallowing deficit of 1-10% impairment and the current assessment indicated a 50-75% impairment. A Physician order [REDACTED]. The PT POC dated 6/6/14, indicated the resident had been a long term resident of the facility since October of 2013 and was initially able to transfer and ambulate in the room with supervision. The resident had a progressive decline in function to the point where extensive assistance from staff was required for all mobility needs. Therapy was initially requested, however was unable to be initiated due to insurance not authorizing treatments. The PT short term goals included performing all functional transfers increasing to moderate assistance, increasing standing and sitting balance, standing for 30 seconds using parallel bars, and decreasing knee flexion contractures ten degrees. OT POC dated 6/8/14, documented the resident was referred due to decline in function and history of falls. Documented noted difficulty with shoulder active range of motion with only at 25% range, short and long term goals included: -Safe transfer to toilet/commode -Utilize regular utensils increasing with initial cueing -Effectively utilizing spill proof cup - Long term goal to complete transfers with minimal assistance - Long term goal to perform self-feeding with minimal assistance * The clinical record lacked documented evidence of correspondence from the resident's insurance company related to the denial of PT, OT or ST. * The clinical record lacked documented evidence the physician had been notified of the resident's inability to swallow medication identified on 1/8/14, the POC was not updated to reflect the problem or the intervention of crushing the medications. * The clinical record lacked documented evidence the physician had been made aware of the Rehabilitation Department's recommendation for a PT evaluation following the January 2014 fall. * The clinical record lacked documented evidence to support the resident was evaluated and treated in accordance with the facility's Restorative Therapy Program in the following areas: - The resident was not evaluated by PT or Occupation Therapy (OT) upon admission, when the resident experienced a change in condition and on a scheduled basis. - The resident's functional ability was not assessed and documented in order to track progress toward goals. - The Restorative CNA did not complete a monthly written summary noting the resident's progress and tolerance of the treatment goals related to range of motion. On 6/17/14 at 11:30 AM, a LPN was observed preparing and administering oral medications. The medications were crushed and added to applesauce. The LPN indicated the resident had experienced difficulty swallowing medications a while ago so medications were crushed to facilitate swallowing. On 6/17/14 in the afternoon, the Registered Nurse (RN) in charge of the Restorative Therapy Program (RTP) confirmed RA services were not provided to the resident in February and March of 2014 because staff had not received an assessment from the Rehabilitation Department with the request and were unsure what to do. The RN became responsible for the RTP in March 2014 and identified the problem related to the resident not receiving RA as ordered. The RN acknowledged the resident did not receive RA in accordance with the physician's orders [REDACTED]. On 6/18/14 at 4:30 PM, the SW indicated the Director of Rehabilitation reported the resident's insurance denied authorization for in house PT and OT several months ago and the only option identified was to send the resident out of the facility for services. The SW reported this was discussed with the family and the family declined sending the resident out of the facility for services. The SW acknowledged the conversation had not been documented in the resident's record. On 6/18/14 at 5:00 PM, the resident's family member denied declining to send the resident out of the facility for services and explained the resident had been sent out on several occasions for evaluations and treatments. On 6/19/14 at 8:25 AM, the Director of Social Services indicated Physician Order's for ST/PT/OT would have been sent from Nursing to the Scheduler with the Order. The Scheduler would have made the appointment and arranged transportation. The form with the appointment would have been returned to the resident's nursing station. On 6/19/14 at 8:44 AM, a LPN indicated Physician order [REDACTED]. The Scheduler would have returned the form to nursing with the appointment date and time. Social Services would have been contacted in the event on a denial. On 6/19/14 in the morning, the Director of Rehabilitation indicated in the past the Restorative Therapy Program was initiated at the end of PT/OT when appropriate. Recently, the RN's in charge of the Restorative Therapy Program have requested input from the Rehabilitation Therapy Department. The Director of Rehabilitation confirmed the resident had not received a Restorative Therapy Assessment upon admission or in response to the 1/2014 fall. The Director of Rehabilitation indicated receiving a request to evaluate the resident from the nursing department in January 2014 and called the resident's insurance company for authorization. The insurance company denied authorization for an in-house PT/OT evaluation. This was noted on the nursing request and a copy was provided to Social Services, the Administrator and the Director of Nursing. The Director of Rehabilitation indicated the PT/OT treatment option through the resident's insurance could have included out patient services or in patient services through the insurance company's provider of choice. Outside providers would have needed to obtain approval from administration. The Director of Rehabilitation indicated the resident's prior functioning on the 6/2014 PT assessment was based on information from the transferring facility and family report. On 6/20/14 at 10:33 AM, the Administrator explained when a resident's insurance company denied a service, a conversation with options including transfer or outside services would have been discussed with the family. Resident #13's insurance prior to January 2014 worked with the facility's in house Rehabilitation Department. The Administrator was unaware of the therapy recommendations. On 6/20/14, the Speech Therapist indicated the resident began services over the past week and the swallowing issue was related to difficulty pushing the food to the back of the mouth. The Speech Therapist showed the surveyor a small long spoon which was reported to be effective. When asked about the prior services being discontinued due to insurance the Speech Therapist commented I would have expected they let the Administrator know. On 6/20/14 at 11:20 AM, the Director of Nursing (DON) indicated regardless of the payer source, the expectation was that necessary services would be provided. In the past when the Director of Rehabilitation Therapy received a denial from a resident's insurance company a notification has been sent to Social Services, Administration and Nursing. The resident's physician should have been contacted and documented in the nursing notes. The DON indicated the facility would be obligated to provided needed services. The facility's Restorative Therapy Program, Number R-5, undated, documented: '.Purpose: The Restorative Therapy Program is designed to meet the needs of each individual resident by providing a specialized treatment program to: 1. Maintain and/or increase functional mobility, strength, range of motion, and balance: and 2. Decrease Pain General: The treatment program is designed through evaluation by a therapist and then taught to the restorative CNA. The therapist is available for consultation or reassessment any time there is a change in the resident. All residents are reviewed by the therapist at least quarterly to ensure that the treatment program continues to be appropriate. Procedure: 1. The Restorative Therapy Record is completed and updated by PT, OT, or ST (Speech Therapy) on admission and with any program changes. 2. The Restorative Documentation Form is completed monthly and signed by the Restorative CNA. 3. The Restorative CNA is responsible each month for a written summary of the Restorative Documentation Form noting the resident's progress and tolerance of the program. The written summary must be reviewed and signed by the charge nurse. 5. Quarterly a screen is completed by the therapist indicating the continuation and appropriateness of the present Treatment Plan. 6. The results of the screen are communicated to the restorative CNA and any minor changes document in the Treatment Plan or the Restorative Documentation Form. 7. Any significant change in condition must be reported to the appropriate therapist for immediate assessment and to the resident's charge nurse. If changes to the restorative program are indicated they must by documented on the Restorative Therapy Record. The Rehabilitation Services Agreement between the Facility and the Rehabilitation Services Agreement Company dated 7/31/2002, documented: .Exhibit A Therapy Provider Responsibilities. 3. The provision of Rehabilitation Services, physical therapy, occupational therapy and speech therapy, such as: (a) Screen all admissions for notational rehabilitation services and screen all current residents for potential rehabilitation services on a scheduled ongoing basis. (b) Evaluate and treat all physician referred residents needing rehabilitation services. |
| F 0314<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review the facility failed to assess, treat, and document on a pressure area for 1 of 30 residents (Resident #18). Findings include: Resident #18 Resident #18 was admitted to the facility on [DATE] and readmitted on [DATE], with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. The Treatment Administration Record |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295041 | A. BUILDING _____ B. WING _____ | 06/20/2014 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| DELMAR GARDENS OF GREEN VALLEY | 100 DELMAR GARDENS DRIVE HENDERSON, NV 89014 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
|---|---|
| F 0314<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 4)<br>(TAR) for March 2014, documented the treatment was completed on 3/25, 3/27, and 3/30. The TAR for April 2014, documented the treatment was received 24 times for the month of April 2014. The physician's progress notes dated 5/12/14 (not timed), documented buttocks healed. There was not [DIAGNOSES REDACTED] (redness) or an open area. The clinical record lacked documented evidence a care plan was in place to address the pressure ulcer to the sacral (buttocks) area. On 6/17/14 at 08:30 AM, during incontinence care, Resident #18 was noted to have an open area to the sacral (buttocks) area. On 6/18/14 in the afternoon, Resident #18 was transferred by two certified nursing assistants using a (sit to stand) Serita lift. The sacral area was open and there was not a treatment in place on observation. The certified nursing assistants explained the area had been there since Sunday but was now larger. On 6/19/14 at 11:00 AM , The RN supervisor/treatment nurse explained the resident had one wound that was treated currently located on the left heel. The RN supervisor explained the resident did not have any other open areas. On 6/19/14 in the afternoon, the charge nurse observed the wound and confirmed an open area over a bony prominence. On 6/19/14 at 2:00 PM, the Director of Nursing revealed the only wound the resident had was to the left heel. The Director of Nursing indicated the compounded cream was used for prevention. On 6/20/14 at 10:30 AM, the Director of Nursing (DON) explained Resident #10 had a history of [REDACTED]. The DON verbalized the physician identified the open area in the progress notes. The physician's progress notes dated 6/9/14 (untimed), documented in part buttocks wound was smaller. On 6/20/14 at 11:00 AM, the DON presented a form titled weekly wound assessment. The documentation revealed a pressure ulcer to the sacrum measured 2 cm (centimeters) x 3 cm (centimeters) and 0.1 cm depth. The wound was identified as a stage II with scant amount of thin watery bloody drainage. The wound was identified as recurring and unchanged. A new order was received for [MEDICATION NAME] foam to change every Monday, Wednesday, and Friday. The policy<br>titled Wound/Pressure Ulcer Management revised (5/20/14), documented when a pressure ulcer is present, daily monitoring should include the following: -evaluation of the status of the dressing, if present. -status of the area surrounding the ulcer that can be observed without removing the dressing. -presence of possible complications, such as signs of increasing area of ulceration or soft tissue infection. -whether pain is present and is being adequately controlled. |
| F 0318<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Make sure that residents with reduced range of motion get propertreatment and services to increase range of motion.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, record review, document review, and policy review, the facility failed to: 1) Ensure 3 of 30 sampled residents with contractures were assessed for and provided with preventative measures to avoid worsening of contractures (Resident #11, #29, #3); and 2) Ensure splints and/or braces were applied on 3 of 30 sampled residents (Resident #11, #20, #29). The facility failed to have a system in place for the Physical Therapy Department, Clinical Nursing Services and Restorative Nursing Services to coordinate care and follow treatment plans for residents with contractures and declining range of motion. Findings include: Resident #29 Resident #29 was admitted on [DATE], with [DIAGNOSES REDACTED]. Resident #29 was discharged to home on 4/5/14. The Physician's admission orders [REDACTED]. The back<br>brace was obtained by the facility on 2/25/14. On 6/20/14, the chart was reviewed with the Director of Nursing (DON), the MDS (Minimum Data Set) Coordinator, and a licensed nurse. The DON and the licensed nurse verified the Medication Administration Records (MAR's) and Treatment Administration Records (TAR's) for February, March, and April of 2014 listed FYI (For Your Information) for application of the brace. There was no documented evidence on the MAR's and TAR's whether the brace was applied during these months. The licensed nurse verified Resident #29 did not wear the brace regularly because she didn't like it. The MDS Coordinator indicated, I remember her. She was not happy with the brace. It was uncomfortable. The DON further indicated that, if a resident was non-compliant with wearing a brace, the facility should notify the physician, discuss the risks of non-compliance, and establish and maintain a care plan regarding the refusals. The DON indicated the Social Worker should also be involved to find out why the resident was refusing, discuss the issue with the responsible party, and try to resolve the refusal if possible. The DON indicated the resident had the potential for delayed recovery from the fractured vertebrae by non-use of the brace. On 6/20/14, the chart was reviewed with the Director of Rehabilitation (Rehab), who indicated she was aware that Resident #29 was non-compliant with wearing the brace. The Director of Rehab further indicated that the rehabilitation department does create a plan of care for the physical rehabilitation, but the care plan only documents the level of function and does not address any approaches or interventions to meet the goals identified. The Director of Rehab indicated she was not directly involved with the facility care plan for Resident #29, that nursing was responsible for care planning for a brace. The Director of Rehab made the following statements: -I knew she was refusing the brace, but I don't know how often she was refusing it. That's up to nursing. -I don't know why she didn't like it. She was in pain with or without the brace. -We (the Rehabilitation Department) wouldn't do a care plan. Nursing would. -We don't have involvement with the nursing part of it. -I don't remember attending any care plan meetings for her. We don't generally attend care plan meetings. -Once they're discharged from therapy, we don't have any involvement. -I'm not aware of any policy that says the therapy department is involved with a resident other than therapy, or that we have to be at the care plan conferences. On 6/20/14 in the afternoon, the MDS Coordinator indicated Resident #29 was care planned that she would wear the brace at all times when sitting up in bed or out of bed, and that the rehabilitation department should have been directly involved with an approach to the resident's refusal of the brace.<br>Resident #11 Resident #11 was admitted [DATE] with [DIAGNOSES REDACTED]. Resident #11 had a contracture of the upper extremity (left hand). The Initial Nursing Assessment indicated a contracture of the upper extremities. However, there was no documentation of a description of the level of the contracture. The Physical Therapy Plan of Care dated 10/8/13 indicated a contracted left upper extremity with flexor [MEDICATION NAME]. There was no documented evidence of a baseline measurement of the hand contracture on the Therapy Initial Assessment. The Physical Therapist Progress and Discharge Summary dated 11/15/13 indicated, .The patient initially showed good progress with therapy, however has reached a plateau in her progress requiring d/c (discharge) from therapy. RNA (Restorative Nursing Assistance) to follow up with restorative program.RNA's instructed on the patient's restorative program with good understanding demonstrated. Resident #11 was evaluated for OT on 3/25/14 and discharged from OT effective 4/15/14. There was no documented evidence of a baseline measurement of the contracture on the OT Initial Assessment and Discharge Summary. Resident #11 was discharged from OT to the RNA Program for dining assistance. However, there was no documented discharge plan specifically regarding prevention of further decline in range of motion and worsening of the hand contracture. On 6/18/14 in the afternoon, the OT indicated she had evaluated Resident #11 on 10/8/13, at which time the left hand was totally contracted. The OT verified there was no baseline measurement of the left hand contracture because they didn't have a finger goniometer to accurately measure and assess the extent of the contracture. The OT indicated she did not attempt to range the fingers because they didn't have a finger goniometer and because the resident was in too much pain. The OT indicated they had never had a finger goniometer that she was aware of since she had been employed at the facility. The Director of Rehab also indicated they did not have a finger goniometer. On 6/17/14, 6/18/14, 6/19/14, and 6/20/14, Resident #11 was not wearing a splint and washcloth on the left hand. There were no preventative measures identified to prevent worsening of the contracture. On 6/18/14 at 3:40 PM, the surveyor observed the resident with the MDS Coordinator. The resident's left hand appeared severely contracted. Resident #11 was not wearing a splint or washcloth on the left hand. The call bell was placed on the bed right next to the left hand. There was a pink sign above Resident #11's bed which indicated to put the splint on when during waking hours. On 6/19/14 at 9:00 AM, interviews with the Director of Rehab, the Occupational Therapist, and two Restorative Nurse Aides (RNA) were conducted during an observation of Resident #11's left hand. The left hand was observed to be contracted and the fingernails were long, and two fingers were in contact with the palm of the hand. The RNA nurses indicated that, per the therapists' instructions, a splint and washcloth were supposed to be applied to the left hand to prevent contact and pressure of the fingers to the palm of the hand. They indicated they did not know why the nurses did not put the splint and washcloth on the hand, and they hardly ever saw the resident with the splint on. There was no evidence of preventative measures to: 1) Prevent worsening of the contracture or 2) Prevent the fingernails from pressing into the palm of the hand. On 6/19/14, the MDS Coordinator verified there was no description of the range of motion of the left hand contracture, and no care plan with interventions in the chart. Resident #3 Resident #3 was admitted [DATE] with [DIAGNOSES REDACTED]. On 6/17/14, 6/18/14, 6/19/14, and 6/20/14, Resident #3 was observed sitting in the wheelchair with all 4 extremities contracted, and the neck contracted (head leaning to 1 side on the headrest). The Admission Resident Assessment indicated Resident #3 had contractures on the bilateral upper extremities, bilateral lower extremities, and neck. There was no description of the level of range of motion of the contractures. There was no documentation of an initial assessment by |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295041 | A. BUILDING _____ B. WING _____ | 06/20/2014 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| DELMAR GARDENS OF GREEN VALLEY | 100 DELMAR GARDENS DRIVE HENDERSON, NV 89014 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
|---|---|
| F 0318<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 5)<br>Physical Therapy. The Care Plan (onset date: 7/7/13) indicated the problem, Dependent on staff of all ADL's (Activities of Daily Living) due to [MEDICAL CONDITION] arthritis with loss of functional use to extremities. There was no approach documented to prevent worsening of functional range of motion. The Weekly Nursing Summaries indicated the following: -10/3/13: Resident's body is very crippled due to [MEDICAL CONDITION] arthritis. -10/24/13: She is total care due to severe crippling due to [MEDICAL CONDITION] arthritis. -11/14/13: Body very disfigured from [MEDICAL CONDITION] arthritis. 12/27/13: She is spoon fed per staff due to deformed arms due to [MEDICAL CONDITION] arthritis. On 6/17/14 in the morning during tour, the licensed nurse indicated there were no interventions to prevent worsening of the contractures because the resident had been on hospice from the time of admission through May of 2014. The licensed nurse indicated, if a resident is on hospice, they are not assessed for contracture interventions (such as a splint, brace, or passive range of motion). The facility's Policy and Procedure regarding Care Plan Meetings (Care Plan Conference, Interdisciplinary, no effective date) indicated, in part, An Interdisciplinary Care Planning Conference identifies resident needs and establishes obtainable goals. An appropriate plan of action is designed to ensure optimal levels of activity and independence for all residents.The Resident Care Plan (RCP) Review is conducted according to the procedure established.4. Included are representatives from nursing, dietary, social work services, rehabilitation, and therapeutic recreation departments.The 21 day review includes at a minimum the following: 1) A review of established long term and short term goals discharge planning. 2) Rehabilitation potential noted on the History and Physical form. 3).Resident care problems, goals, and approaches with appropriate time frames. The facility's Policy and Procedure, Care Plan Update, Interdisciplinary, no effective date, indicated, Purpose: To inform the Interdisciplinary Team of all updates pertaining to resident care immediately. Procedure: 1. Any time a new problem is identified with a resident, the Charge Nurse or member of the Interdisciplinary Team is to fill out an Interdisciplinary Care Planning Update form to identify the new problem, goal, and approach or they may hand write the new problem on the care plan. The facility's Policy and Procedure, Restorative Therapy Program, no effective date, indicated, in part: The Restorative Therapy Program is designed to meet the needs of each individual resident by providing a specialized treatment program to: 1. Maintain and/or increase functional mobility, strength, range of motion, and balance, and 2. Decrease pain. General: The treatment program is designed through evaluation by a therapist and then taught to the restorative CNA. The therapist is available for consultation or reassessment any time there is a change in the resident. All residents are reviewed by the therapist at least quarterly to ensure that the treatment program continues to be appropriate. Procedure: 1. The Restorative Therapy Record is completed and updated by PT, OT or ST on admission and with any program changes. 2. The Restorative Documentation form is completed monthly and signed by the Restorative CNA. This includes the resident's name, room number, treatment plan, and the current month, and year.5. Quarterly a screen is completed by the therapist indicating the continuation and appropriateness of the present Treatment Plan. 6. The results of the screen are communicated to the restorative CNA and any minor changes documented in the Treatment Plan on the Restorative Documentation Form. 7. Any significant change in condition must be reported to the appropriate therapist for immediate assessment and to the resident's charge nurse. The facility's Policy and Procedure, Therapy Initial Evaluation, undated, indicated, Policy: Any resident requiring active treatment will have an initial evaluation completed detailing baseline information, goals, and a plan of care.Purpose: The initial evaluation is used to establish baseline data as well as provide a forum to report the information accurately, objectively and succinctly. Procedures: 1. Upon receipt of each discipline's physician order [REDACTED]. The facility's Policy and Procedure, Procedures for Completion CMS 700 Form (Discipline Specific for Physical, Occupational or Speech Therapy, undated, indicated, .12. Plan of Treatment: Enter procedures requested in physician clarification orders for the patient for this certification period. Procedures must relate to stated goals. Functional Goals: Enter the short term goals to reach the overall long term outcome.20. Initial Assessment: Enter current relevant history from records or resident interview pertinent to this claim. Enter the pertinent functional limitations stated in objective and measurable terms. Include pertinent baseline tests and measurements to establish baseline data to measure future progress. On 6/20/14, the Director of Rehab indicated, I'm not aware of any policy and procedure that we evaluate them (residents who are discharged from therapy to RNA services ) every 3 months. We don't do that. On 6/20/14, the DON indicated the physician's orders [REDACTED]. should always be initialed by the nurse whether the medication and/or treatment was administered.<br><br>Resident #20 Resident #20 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The physician's orders [REDACTED]. The resident's clinical record lacked documented evidence the placement of the elbow cushion brace on the resident's right elbow was monitored every shift. On 6/20/14 at 9:55 AM, the resident was laying in bed and not wearing the elbow cushion brace which was found on top of the resident's bedside table. A Licensed Practical Nurse (LPN) confirmed the observation and verbalized the resident could put the cushion brace on her right elbow and removed it by herself. On 6/20/14 at 10:00 AM, Resident #20 stated CNA (Certified Nurse Assistant) put it on and took it out. I did not wear it last night and up to now. I did not know I should wear it every time. On 6/20/14 at 11:20 AM, the DON verbalized the physician's orders [REDACTED]. On 6/20/14 at 12:30 PM, the DON confirmed there was no documentation in the MAR indicated [REDACTED]. On<br>6/20/14 at 10:07 AM, a Registered Nurse (RN) confirmed the physician's orders [REDACTED]. |
| F 0323<br><br>**Level of harm** - Actual harm<br><br>**Residents Affected** - Few | **Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, record review, and policy review the facility failed to ensure a resident was transferred safely using a lift device for 1 of 30 residents (Resident #10), failed to implement an intervention based on the causal factor for 1 of 30 residents (Resident #10) and failed to ensure fall precautions were implemented after a fall for 1 of 30 residents (Resident #4). Findings include: Resident #10 Resident #10 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. On 1/27/14 at 9:55 AM, Resident #10 had been assisted by one certified nursing assistant into the Serita Lift (sit to stand) to be transferred from bed to wheelchair. After Resident #10 was prepared and assisted into the lift, Resident #10 slid to the floor and sustained a humeral neck fracture (upper arm region). The self report received by the Division of Public and Behavioral Health on 1/29/14 at 4:11 PM, documented the certified nursing assistant(#1) prepared to have another certified nursing assistant (#2) enter the room to help with the transfer. Certified nursing assistant #1 prepared Resident #10 without assistance from another co-worker. Certified nursing assistant #1 positioned Resident #10 on the side of the bed in the upright position. Certified nursing assistant #1 applied the sling and the belt. While the resident was in the belt and the sling, Resident #10 started to slide down and caught his left arm on the sling. The certified nursing assistant assisted Resident #10 to the floor. Staff were called for assistance which included a licensed practical nurse to assess. The report indicated Resident #10 had a complaint of pain to the left shoulder, physician notified, X-ray ordered, and results were humeral neck fracture without displacement. The physician was notified of the results and Resident #10 was transferred to the emergency room for evaluation and treatment. Section 10 of the self report titled Conclusion dated 1/29/14, documented Resident #10 slid off the bed and weighed 263 pounds. The report indicated this was due to muscle weakness Resident #10 may need to be evaluated for a different mode of transport (Hoyer lift). The Minimum Data Set ((MDS) dated [DATE] annual assessment, documented Section G functional status sub- section B. transfers indicated total dependence with full staff performance every time. The support section was coded 3 which indicated two person physical assist. The CAA (care area assessment) section 5. Activities of Daily Living (ADL)/Rehabilitation potential documented in part Resident #10 . needs assist 2 with Hoyer lift for transfers. The MDS dated [DATE], quarterly assessment, documented Section G functional status sub-section B transfers total dependence indicated full staff performance every time. The support section was coded 3 which indicated two persons physical assist. The Transfer and Lift policy (butterfly) dated 10/10/11, indicated in part .To provide communication to staff about resident transfer abilities and to assure we take all precautions necessary to maintain the safety of our residents.an aqua butterfly indicates a mechanical full body lift is required.a pink butterfly indicates a sit to stand lift is required. The residents transfer ability will be indicated on the standard admission order sheet.Transaction analysis reports of resident's transfer ability be run weekly and placed at each nurses station. On 6/18/14 at 10:00 am a licensed nurse indicated a butterfly would be placed over the resident's bed to indicate if the resident used a lift or how the resident transferred. The licensed nurse indicated there would be an order for [REDACTED]. The licensed nurse indicated for any type of lift there should be two staff at all times during the transfer process. This would include application of the sling and belt for a sit to stand lift. The licensed |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295041 | A. BUILDING _____ B. WING _____ | 06/20/2014 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| DELMAR GARDENS OF GREEN VALLEY | 100 DELMAR GARDENS DRIVE HENDERSON, NV 89014 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
|---|---|
| F 0323<br><br>**Level of harm** - Actual harm<br><br>**Residents Affected** - Few | (continued... from page 6)<br>nurse verbalized if a resident had [DIAGNOSES REDACTED] due to a stroke it would not be appropriate to use the sit to stand (Serita lift). On 6/18/14 at 10:15 AM, there was not a butterfly above Resident #10's bed or in the room. There was not a butterfly in the room or over the bed for the remainder of the survey. On 6/18/14 at 10:30, a certified nurse aide indicated during shift report resident transfers were discussed. This included if a resident used a lift the team would find out during shift report. The certified nurse aide revealed if a resident used a lift there should be two staff members to assist from preparation to completion of the transfer. The certified nurse aide verbalized staff should never prepare or transfer a resident alone when the lift was used. On 6/18/14 at 11:00 AM, Resident #10 indicated when the lift was used it caused anxiety for Resident #10. Resident #10 verbalized this was because of the fall from the sit to stand (Serita lift) and due to the fall from the Hoyer lift on the same occasion when the staff assisted him up from the floor. Resident #10 indicated while in the Hoyer lift the lift tipped over and staff was able to grab the lift and assist Resident #10 to the bed. Resident #10 verbalized this also hurt his arm. On 6/18/14 at 4:00 PM, the certified nurse aide who transferred Resident #10 verified transfer preparation was performed alone. The certified nurse aide indicated transfer should have been completed with two staff members. The certified nurse aide verbalized Resident #10 used the sit to stand lift (serita lift) for quite some time and the information was shared with staff during shift change report. On 6/18/14 in the afternoon, two nurse aides transferred a different resident (Resident #18) and used the sit to stand (Serita Lift). Resident #18 wore big puffy bunny boots. The two certified nurse aides transferred the Resident #18 with the boots on. The certified nurse aides indicated the boots had to be on at all times. The nurse aides confirmed the bottom of the boots had no grip material and could be slippery. On 6/19/14 at 4:00 PM, an observation of a different resident (Resident #18) was made for transfer from wheel chair to bed. Two certified nursing assistants were present during the entire time. The two certified nursing assistants used the sit to stand lift and agreed there was not a butterfly code in the room anywhere. The certified nursing assistants verbalized information was received during shift report on transfers. The certified nursing assistants were not aware of the butterfly lift policy. Resident #18 had a bandage on her foot and no other footwear during the transfer. The nursing assistants confirmed Resident #18 should have worn a shoe or non-slid socks during the transfer. There was not a butterfly above the bed or in the room for Resident #18 during the week of the survey. The instructions on the Serita (sit to stand) lift page 12 titled Transferring indicated in part:.(name of the company) recommends two (2) assistants be used for all lifting preparation, transferring from and transferring to procedures. The memo that was attached to the Serita (sit to stand) lift documented things to remember regading lifts. The last bullet documented lifts require two persons. Resident #10 care plan for ADL/functional rehabilitation dated 10/29/13, indicated total dependence with an assist of 2 persons using the Hoyer lift for transfers. On 6/19/14 at 7:40 AM, the licensed practical nurse (LPN) verbalized on 1/27/14 Resident #10 was found on the floor upon entering the room. LPN verbalized Resident #10 was not in pain and seemed okay. The LPN indicated instructions were given to assist Resident #10 back to bed using the Hoyer lift. The LPN acknowledged a Registered Nurse did not assess Resident #10 prior to moving the resident. The LPN revealed once Resident #10 was in the Hoyer lift it did tip forward with Resident #10 in it but the staff members were able to control the balance and move Resident #10 back to bed. The LPN verbalized a Registered Nurse should have been called to assess Resident #10. The LPN confirmed he/she was the only one that completed the assessment because there was not a complaint of pain. The nurse's notes documented Ibuprofen 800 milligrams was given on 1/27/14 at 10:30 AM as Resident #10 reported pain. On 6/19/14, in the afternoon the Director of Nursing verbalized a lack of awareness regarding the Hoyer lift tipping and Resident #10 expressed fear during transfers. On 6/20/14 at 1:00 PM, the Staff Development Coordinator (SDC) revealed training was conducted on the use of the Hoyer lift on 4/9/14. The SDC acknowledged training on the Serita lift had not been conducted over the past year. On 6/20/14 at 1:30 PM, the Nursing Home Administrator (NHA) indicated a Registered Nurse should perform assessments after a fall.<br><br>Resident #4 Resident #4 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #4's clinical record revealed the following: - Activities of Daily Living (ADL) Care Plan dated 12/18/13, documented assist with transfers, one-two persons with gait belt - Post-Fall assessment dated [DATE], indicated the resident attempted to self-transfer while toileting and sustained a fall. - Fall Care Plan dated 12/18/13, documented 1/3/14 tab alarm at all times. - The Interdisciplinary Team (IDT) Summary Post Fall (undated) indicated the resident was confused and nursing placed tab alarm for safety. - Physician order [REDACTED]. - Treatment Records from 1/3/14 through 6/1/14, documented tab alarm at all time to alert staff of unassisted transfers/ambulation. FYI (For Your Information) was written beside the order. Nursing staff did not initial daily to document tab alarm was in placed. - Post-Fall assessment dated [DATE], documented the resident attempted to transfer and fell . The staff did not identify if the tab alarm was in placed and working. -The clinical record lacked documented evidence interventions had been evaluated and the Fall Care Plan was not updated. - Post-Fall assessment dated [DATE], documented the resident attempted to use the bathroom independently because staff did not respond in time. The staff did not identify if the tab alarm was in place and working. - The Fall Care Plan dated 6/16/14 documented, tab alarm to bed/wheel chair to alert staff of unassisted transfers. - Physician order [REDACTED]. - The clinical record lacked documented evidence nursing staff ensured tab alarms were in place. - The clinical record lacked documented evidence the resident was not left unattended in the bathroom or was toileted frequently in accordance with facility policy. On 6/17/14 at 9:30 AM, the resident was observed in bed. There was no tab alarm in place and no observable tab alarm in the room. The resident discussed the fall history and most recent fall. The resident indicated an inability to wait for staff to assist for toileting. The resident denied having a tab alarm in place over the past few months. On 6/17/14 at 2:25 PM, a Licensed Practical Nurse (LPN) indicated post fall interventions had been completed. The LPN reviewed the Treatment Record and Care Plan regarding the tab alarm. The LPN indicated nursing staff had not initialed the Treatment Plan regarding the tab alarm. The LPN indicated the Certified Nursing Assistants (CNA) have routinely applied tab alarms and verified their use. The LPN indicated skilled nursing staff have completed Resident Care Assessment to direct the CNA staff. The most recent Resident Care Assessment was kept in a CNA book and was not part of the resident record. On 6/17/14 at 2:30 PM, a CNA who provided care to the resident indicated being unaware the resident should have a tab alarm. The CNA provided the Resident Care assessment dated [DATE], which did not indicate the resident should have tab alarms or required supervision in the bathroom. On 6/20/14 at 11:20 AM, the Director of Nursing indicated when a tab alarm is ordered by the resident's physician staff are to monitor tab alarm placement and usage by initialing every shift on the treatment record. The facility's High Risk for Falls Guidelines, undated, no policy number, documented: .Assist the resident with all transfers. .Toilet the resident frequently while aware. .The resident is not to be left alone in the bathroom. |
| F 0328<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Properly care for residents needing special services, including: injections, colostomy, ureostomy, ileostomy, tracheostomy care, tracheal suctioning, respiratory care, foot care, and prostheses**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview, clinical record review and policy review, the facility failed to ensure 1 of 30 sampled residents (Resident #27) received oxygen therapy in accordance with the physician's order and facility policy. Findings include: The facility's policy entitled Oxygen Administration dated revised 5/5/09, revealed: #7. Select the number of liters of oxygen to be delivered per the resident's physician's order. Resident #27 Resident #27 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The clinical record documented on 4/9/14 at 9:00 PM, Resident #27 was provided oxygen at 2 liters per nasal cannula. The clinical record lacked documentation a physician's order had been received for oxygen at 2 liters per nasal cannula. The clinical record lacked documented evidence to explain why the resident's oxygen flow rate was increased to 4 liters. A physician's order was received on 4/11/14, to increase the resident's oxygen to 4 liters via nasal cannula continuously. The Medication Administration Record [REDACTED]. On 6/18/14 at 11:12 AM, the Patient Care Coordinator confirmed there was no physician's order for oxygen at 2 liters per nasal cannula on 4/9/14 and an order should have been obtained. The Patient Care Coordinator also verbalized there was no documentation to explain why the resident's oxygen flow rate was increased to 4 liters or to show Resident #27 had continuous oxygen therapy at 4 liters per nasal cannula from 4/11/14 through 4/13/14. |
| F 0329<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.** |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295041 | A. BUILDING _____ B. WING _____ | 06/20/2014 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| DELMAR GARDENS OF GREEN VALLEY | 100 DELMAR GARDENS DRIVE HENDERSON, NV 89014 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
|---|---|
| F 0329<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 7)<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview, clinical record review, and policy review, the facility failed to ensure resident's drug regimens were free from unnecessary drugs for 1 of 30 sampled residents (Resident #27); failed to ensure non-pharmacological interventions were used prior to administering [MEDICAL CONDITION] medications for 3 of 30 sampled residents (Resident #1, #19, #20). Resident #27 Resident #27 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. 1. A physician's orders [REDACTED]. The Bowel Record indicated the resident had no bowel movement on 3/2/14 and 3/3/14, and was given MOM on 3/4/14 during the day shift. The resident had no bowel movement on 3/11/14 and 3/12/14, and was given MOM on 3/13/14 during the evening shift. On 6/18/14 at 10:50 AM, the Registered Nurse (RN) indicated medications for bowel movement were given based on physician orders. The medication should be held and a physician should be notified after 2 loose stools. If a stool was hard and/or a resident complained of constipation, they may provide a medication for the symptoms of constipation. On 6/18/14 at 11:12 AM, the Patient Care Coordinator indicated the physician's orders [REDACTED]. The MOM was given too early. The Nursing Policy and Procedure indicated the following: Revision Date: April 26, 2008 Title: Bowel Regimen Protocol .MOM (Milk of Magnesia) 30 cubic centimeters on day shift if no bowel movement after (3) days. . Notify the Physician if the above measures are ineffective. 2. A physician's orders [REDACTED]. The order lacked documentation regarding the [DIAGNOSES REDACTED]. The Antidepressant Monthly Flow Record indicated the Behavior Description as isolating herself/ not talking to anyone. On 6/18/14 at 11:12 AM, the Patient Care Coordinator indicated the [DIAGNOSES REDACTED]. 3. A physician's orders [REDACTED]. The physician's orders [REDACTED]. The Monthly Flow Record indicated the Behavior Description as verbally aggressive to staff/other residents. On 6/18/14 at 11:12 AM, the Patient Care Coordinator indicated the specific behavior to be monitored and the [DIAGNOSES REDACTED]. 4. A physician's orders [REDACTED].= 0.5 milligrams every four hours, as needed for anxiety. The Medication Administration Record [REDACTED]. The clinical record lacked documented evidence of a behavior monitoring flow record for [MEDICATION NAME]. The clinical record lacked of documented evidence of a signed consent for the medication [MEDICATION NAME]. On 6/18/14 at 10:50 AM, the RN indicated [MEDICATION NAME] should be listed on a behavior monitoring sheet at the time of admission, and a signed consent was required. On 6/18/14 at 11: 12 AM, the Patient Care Coordinator confirmed [MEDICATION NAME] was listed for anxiety, and indicated there was not a specific behavior documented to be monitored. The Patient Care Coordinator was not able to locate the signed consent form in the clinical record. On 6/18/14, the Patient Care Coordinator indicated there was no policy and procedure being used at this time. The Patient Care Coordinator indicated the facility had started to implement a policy and procedure, however nurses did not seen the policy yet. The Patient Care Coordinator indicated the staff would be in-serviced on the policy and procedure for Anti-Psychotic Medications. 5. physician's orders [REDACTED]. - [MEDICATION NAME] 10 mg by mouth daily, hold for systolic blood pressure below 110. - [MEDICATION NAME] 25 mg, by mouth within 12 hours (hold for systolic blood pressure below 110, or heart rate lower than 60). The Medication Administration Record [REDACTED]. The Resident's blood pressure was 90/59. On 6/18/14 at 11:12 AM, the Patient Care Coordinator indicated [MEDICATION NAME] and Lopresor were not held in accordance with the physician's orders [REDACTED]. The physician's orders [REDACTED]. The Medication Administration Record [REDACTED]. On 4/12/14, the resident's blood pressure was 112/52 and the medication was not administered. On 6/18/14 at 10:50 AM, the RN indicated a blood pressure medication should be held based on the physician's orders [REDACTED]. On 6/18/14 at 11:36 AM, the Patient Care Coordinator indicated on 4/9/14, the [MEDICATION NAME] should not have been held, if there was a concern with the resident's blood pressure the physician should have been notified. The Patient Care Coordinator acknowledged on 4/5/14 orders should have been followed regarding the parameters to hold the medications. The Nursing Policy and Procedure Manual indicated the following: Effective Date: 5/07 Title: Medication Administration .Check label on drug container against the physician's orders [REDACTED].<br><br>Resident #1 Resident #1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The physician's orders [REDACTED]. The Medication Administration Record [REDACTED] -3/1/14, 3/2/14, 3/3/14, 3/4/14, 3/5/14, 3/6/14, 3/10/14, 3/14/14, 3/18/14, 3/19/14, 3/24/14, 3/31/14 -4/6/14, 4/7/14, 4/17/14, 4/23/14 -5/8/14 The MAR from March 2014 to May 2014, documented the resident received [MEDICATION NAME] 7.5 mg on the following dates: -3/30/14 -4/6/14, 4/7/14, 4/8/14, 4/22/14, 4/27/14, 4/28/14 -5/13/14 The Anti-Psychotic Monthly Flow Record and Sedative/Hypnotic Monthly Flow Record from March 2014 to May 2014, lacked documented evidence of non-pharmacological interventions used before [MEDICATION NAME] and [MEDICATION NAME] were administered to the resident. On 6/19/14 at 8:50 AM, a Registered Nurse (RN) reviewed the resident's clinical record to verify the findings. The RN acknowledged there was no documentation of non-pharmacological interventions used before Resident #1 received [MEDICATION NAME] and [MEDICATION NAME] from March 2014 to May 2014. The RN verbalized non-pharmacological interventions like re-direction, snacks, activities should be offered prior to administering [MEDICAL CONDITION] medications. Resident#19 Resident #19 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The physician's orders [REDACTED]. The MAR indicated [REDACTED] -6/1/14, 6/3/14, 6/4/14, 6/13/14, 6/14/14 The Anti-Anxiety Monthly Flow Record dated June 2014, lacked documented evidence of non-pharmacological interventions used before [MEDICATION NAME] was administered to the resident on said dates. The resident's care plan for [MEDICAL CONDITION] drug use dated 6/12/14, documented .Approach Start Date: 06/09/14 Implement non-pharmacological interventions prior to administering [MEDICAL CONDITION] meds. On 6/20/14 at 8:50 AM, a Licensed Practical Nurse (LPN) reviewed the resident's clinical record to verify the findings. The LPN acknowledged there was no documentation of non-pharmacological interventions used before the resident received [MEDICATION NAME] from 6/1/14 to 6/14/14 and the care plan was not followed. The LPN verbalized non-pharmacological interventions should be offered prior to administering [MEDICAL CONDITION] medications. Resident #20 Resident #20 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The physician's orders [REDACTED]. The MAR indicated [REDACTED]. The Anti-Anxiety Monthly Flow Record dated May 2014, lacked documented evidence of non-pharmacological interventions used before [MEDICATION NAME] was administered to the resident on 5/21/14 and 5/22/14. On 6/20/14 at 10:07 AM, an RN reviewed the resident's clinical record to verify the findings. The RN acknowledged there was no documentation of non-pharmacological interventions used before the resident received [MEDICATION NAME] on 5/21/14 and 5/22/14. The RN verbalized non-pharmacological interventions should be offered prior to administering [MEDICAL CONDITION] medications. |
| F 0387<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Make sure that doctors visit residents regularly, as required.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and staff interview, the facility failed to ensure physician visits were conducted by the physician every other visit after the first 90 days of admission for 1 of 17 residents. Findings include: Resident #14 Resident #14 was admitted to the facility on [DATE]. Physician visists were documented by the primary physician on 12/18/13, 1/3/14, and 2/10/14. Additionally, a wound specialist physician documented a physician progress notes [REDACTED]. Medical records staff confirmed there were no physician progress notes [REDACTED]. |
| F 0431<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.**<br><br>Based on observation and interview, the facility failed to ensure medications were labeled and expired medications were disposed of properly in 1 of 3 medication rooms. Findings include: On 6/19/14 at 2:30 PM, observation of the medication room on Unit #2 revealed 2 boxes of Acephen suppositories with an expiration date of 11/13 and an open bottle of Tuberculin skin test with no date or time it had been opened. The Registered Nurse (Employee #5) confirmed the suppositories and the undated bottle of tuberculin test should have been removed for disposal. |

| | |
|---|---|
| F 0441<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Have a program that investigates, controls and keeps infection from spreading.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and document review, the facility failed to ensure hand hygiene and glove usage were followed according to facility policy. Findings include: 1) On 6/17/14 and 6/18/14 during lunch in the 300 hall, the Certified Nursing Assistants were observed helping residents to the dining tables, giving out trays and assisting residents with opening containers and not washing hands between assisting residents. 2) On 6/18/14 in the morning , the wound nurse was observed administering wound care to Resident #30. The nurse did not wash hands or use hand sanitizer when gloves were changed during the treatment. The Wound Nurse did not change the left glove during the treatment administered to Resident |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295041 | A. BUILDING _____ B. WING _____ | 06/20/2014 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| DELMAR GARDENS OF GREEN VALLEY | 100 DELMAR GARDENS DRIVE HENDERSON, NV 89014 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
|---|---|
| F 0441<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 8)<br>#30. Policy H-2 Hand Washing (revised 2009) documented: When to wash your hands at a (minimum): -Before and after each resident contact. -After touching a resident or handling his/her belongings. Policy G-8 Gloves, use of for Providing Care to Resident (no date). 4. Wash hands after removing gloves. Gloves do not replace handwashing.<br><br>On 6/17/14 at 11:30 AM, a Licensed Practical Nurse failed to wash hands prior to the application of gloves and administration of eye drops. On 6/20/14 at 9:00 AM, a Certified Nursing Assistant (CNA) failed to wash hands or apply gloves prior to repositioning a resident. The CNA failed to wash hands after providing resident care. On 6/20/14 at 9:00 AM, the CNA indicated hands had been washed in the clean utility room prior to entering the resident's room. On 6/20/14 at 11:20 AM, the Director of Nursing indicated the CNA should have re-washed hands in the resident's room before and after care and applied gloves before care was provided.<br><br>On 6/18/14 at 9:30 AM, a certified nursing assistant (CNA) answered a resident call light. The resident required incontinence care. The CNA performed the following tasks: -entered room -obtained gloves from the box -opened gloves and blew air into the gloves -applied gloves -provided incontinence care -removed gloves -blew on hands -left the room The CNA did not perform hand hygiene before or after glove use. On 6/20/14 at 11:15 AM, The Director of Nursing (DON) indicated the expectation was to wash hands before and after applying gloves. The DON verbalized blowing on hands was not acceptable practice.<br><br>During the medication pass observation on 6/19/14 at 8:25 AM in resident room [ROOM NUMBER]A, a Registered Nurse (RN) took<br>pair of gloves, dropped one glove on the floor, picked up the glove and wore it. On 6/20/14 at 11:20 AM, the DON verbalized nurses were expected to observe infection control practices. The DON revealed glove which dropped on the floor was considered contaminated and should not be used. |
| F 0520<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview, record review and document review, the facility failed to have a Quality Assessment and Assurance Committee which was actively involved with the oversight of the Rehabilitation Therapy Department, affecting coordination of rehabilitative care and services to residents. Findings include: On 6/18/14 and 6/19/14, the Director of Rehabilitation (Rehab) indicated the following: -She does not attend the Quality Assurance (QA) Committee. -The Rehab Department representative does not attend resident care plan meetings. -The Rehab Department does not participate in the care plan for the resident to specifically include the goals and interventions (i.e., splints, braces, and rehabilitation therapy) of residents with identified functional mobility impairment. The Rehab Department has their own plan of care, which does not have baseline levels, approaches and time frames for goals reached identified) and is not directly involved with the nursing plan of care interventions. -Once the resident is discharged from Physical Therapy, there is not further involvement unless the nursing department does a new referral. There is no system in place to monitor residents with contractures, braces and splints, and whether restorative therapy is successful. -The Director of Rehabilitation was not aware of the facility's Restorative Nursing policy and procedure that the therapy department does a quarterly assessment on every resident who is on restorative therapy after discharge from rehab. -The Rehab Department does not directly sign off on the MDS (Minimum Data Set) Assessment. On 6/18/14, the Director of Rehab and the Occupational Therapist (OT) both indicated they were not able to assess the level of contractures of hands and fingers (to accurately measure range of motion) because they did not have a finger goniometer at the facility. On 6/18/14, the OT indicated the facility has never had a finger goniometer since she has been employed, and the Director of Rehab indicated she could not remember if the facility has ever had one since she has been employed at the facility. The Director of Rehab and the OT verified the facility had no way to establish a baseline function of mobility of a resident's hand and assess whether contractures have worsened for residents with finger contractures without the finger goniometer. The Director of Rehab indicated it was nursing's job to describe the contracture, and there was no system in place for the nursing department and the Rehab Department to monitor whether a contracture has worsened. On 6/20/14 in the afternoon, the Administrator and the DON indicated the following: -Only on occasion is there a representative from the Social Services Department who attends QA. -Representatives from the Rehab Department do not usually attend the QA meetings and in the past twelve months they have not attended. -They were not aware the Rehab Department did not actively participate in the interdisciplinary plan of care meetings or document therapy interventions in the resident's care plan. The Rehab Department currently documented all resident rehabilitation information only on rehab specific forms. The Administrator and the DON indicated that the Restorative Nursing policy should be revised, as they were not aware that the quarterly assessment and monitoring of residents functional status by Rehab Department staff existed after residents were discharged from Physical Therapy to Restorative Nursing Assistance. The facility's Policy and Procedure regarding Care Plan Meetings (Care Plan Conference, Interdisciplinary, no effective date) indicated, in part, An Interdisciplinary Care Planning Conference identifies resident needs and establishes obtainable goals. An appropriate plan of action is designed to ensure optimal levels of activity and independence for all residents.The Resident Care Plan (RCP) Review is conducted according to the procedure established.4. Included are representatives from nursing, dietary, social work services, rehabilitation, and therapeutic recreation departments. The facility's Policy and Procedure, Restorative Therapy Program, no effective date, indicated, in part: The Restorative Therapy Program is designed to meet the needs of each individual resident by providing a specialized treatment program to: 1. Maintain and/or increase functional mobility, strength, range of motion, and balance, and 2. Decrease pain. General: The treatment program is designed through evaluation by a therapist and then taught to the restorative CNA. The therapist is available for consultation or reassessment any time there is a change in the resident. All residents are reviewed by the therapist at least quarterly to ensure that the treatment program continues to be appropriate. The facility's Policy and Procedure, Therapy Initial Evaluation, undated, indicated, Policy: Any resident requiring active treatment will have an initial evaluation completed detailing baseline information, goals, and a plan of care.Purpose: The initial evaluation is used to establish baseline data as well as provide a forum to report the information accurately, objectively and succinctly. Procedures: 1. Upon receipt of each discipline's physician order [REDACTED]. The facility's Policy and Procedure, Procedures for Completion CMS 700 Form (Discipline Specific for Physical, Occupational or Speech Therapy, undated, indicated, .12. Plan of Treatment: Enter procedures requested in physician clarification orders for the patient for this certification period. Procedures must relate to stated goals. Functional Goals: Enter the short term goals to reach the overall long term outcome.20. Initial Assessment: Enter current relevant history from records or resident interview pertinent to this claim. Enter the pertinent functional limitations stated in objective and measurable terms. Include pertinent baseline tests and measurements to establish baseline data to measure future progress. The Rehabilitation Services Agreement between the Facility and the Rehabilitation Services Agreement Company dated 7/31/02, documented: .Exhibit A Therapy Provider Responsibilities. 3. The provision of Rehabilitation Services, physical therapy, occupational therapy and speech therapy, such as: (a) Screen all admissions for notational rehabilitation services and screen all current residents for potential rehabilitation services on a scheduled ongoing basis. (b) Evaluate and treat all physician referred residents needing rehabilitation services. The QA Committee failed to have a system in place to ensure the Physical Therapy Department, Clinical Nursing Services, and Restorative Nursing Services to coordinate care and follow through with treatment plans for residents with contractures and declining range of motion. Cross Reference TAG F 318 and TAG F 310. |