STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	295055		C 09/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE PARK REHABILITATION CENTER	2856 E. CHEYENNE AVE. NORTH LAS VEGAS, NV 89030

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F 000	INITIAL COMMENTS	F 000		
	This Statement of Deficiencies was generated as a result of a complaint investigation which was conducted at your facility on September 12, 2008. The census at the time of the survey was 97. There were 2 complaints investigated: Complaint # 18347 - Substantiated (Tag F328) Complaint # 19007 - Unsubstantiated. A deficiency unrelated to the complaint was identified. (Tag F323) The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiencies were identified.			
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure appropriate supervision and monitoring of a resident following elopement from the facility for 1of 4 residents (#1).	F 323		12/3/08

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.

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F 323	Continued From page 1 Findings include: Resident #1 Resident #1 was a 51 year old female who was admitted on 8/9/08 with diagnoses of Osteomyelitis, Status Post Amputation of Toe, Anemia, Drug Dependence, Hypertension and Diabetes. She was alert and oriented. Record Review Nurse's notes revealed: - "8/26/08 0215 (2:15am) - Resident left the facility to cash a check. States she is going to Texas Casino with her daughter to cash her check. She had another resident accompany her. They both returned at 0230 (2:30am) unable to cash her check. MD (medical doctor)notified. Administration notified." - "8/26/08 0530 (5:30am) - Resident left the facility again to cash her check. This time in the company of an older gentleman. Resident signed herself out on pass at 0525 (5:25am) to go cash her check." - "8/26/08 0600 (6am) - Rec (Received) report that resident was out on pass to cash her check...1740 (5:40pm) - pt (patient) still out. Has not returned. Charge nurse aware and social service... 2000 (8pm) No return at this time." The nurse's notes revealed no further documentation regarding this resident. Social Services Progress Notes revealed: - "8/26/08 8 am - Patient left the facility this am	F 323		

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F 323	Continued From page 2 (2:30 am) to cash a check. As of 10am, patient has not returned. Dr. notified... MSW(Master in Social Work) placed a call to the ombudsman to review this case." - "8/27/08 8:30 am - MSW phoned 311 to place a missing persons as patient has not returned to our facility as of 8:30 am on 8/27/08. MSW was informed by dispatcher that patient was in jail. Administrator to notify the state today." Document Review Review of the Nursing Policies and Procedures - Subject - Elopement: "Policy: A prompt investigation and search will be conducted if a patient/resident is considered missing. Procedure: 1. Once it has been established that a patient/resident is missing, the following staff members are notified immediately: the Charge Nurse, Administrator, Director of Nursing, and Social Service Designee. Complete the missing resident profile. 2. The DON or designee organizes and institutes an immediate and thorough search of the center and surrounding grounds..... 3. The entire search process of the facility and grounds, from the time the resident is found to be missing, will be completed within thirty(30) minutes. 4. If the search fails to locate the missing patient/resident within thirty(30) minutes from the time the patient/resident is found to be missing, the Administrator and/or designee contacts the appropriate community agencies (Police, Local	F 323		

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F 323	Continued From page 3 Health Department) and Administration, the patient's/resident's legal representative and attending physician. Staff will provide the Police with all physical identifying information.... 5. The search is continued. Two staff members search the surrounding streets by car for a two(2) mile radius around the facility." Interview On 9/12/08 at 12:00pm, the Administrator revealed the resident went on pass to cash a check. The resident did not return to the facility. The facility received a telephone call from the police stating the resident was in jail and had been arrested. On 9/12/08 at 3:30 pm, the Social Worker stated that the resident had been very difficult and non-compliant. The Social Worker stated that she had been aware of problems between the resident and and staff due to the resident's behavior. The Social Worker added that she was informed that the resident left the facility on 8/26/08 and had not returned. The SW notified the police on 8/27/08 in the am, more than 24 hours after the resident was known to be missing from the facility. The SW also stated that the policy for notification of authorities, as defined in the Elopement Policy & Procedure had not been followed. On 9/12/08 at 3:34 pm the resident's MD stated that this resident was allowed on pass for 2 hours. If the resident did not return, he/she was considered an elopement. If the resident does not return after 24 hours, the facility would not take the resident back. The MD confirmed that he was notified of the resident not returning to the facility.	F 323		

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F 323	Continued From page 4 The facility failed to ensure the safety of a resident through implementaion of a timely search for a resident who was missing from their facility.	F 323		
F 328 SS=D	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and document review, the facility failed to ensure a resident received proper respiratory care when a non-rebreather mask was used to provide oxygen for 1 resident (#2). Findings include: Resident #2 Resident #2 was an 87 year old female admitted on 5/14/08 with the following diagnoses including: Acute Middle Cerebral Artery Stroke with Right Hemiparesis, Staphylococcal Bacteremia, and Status Post Treatment for Pneumonia. Record Review	F 328		12/3/08

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F 328	Continued From page 5 Nurse's notes revealed: - "5/18/08 at 0745 (7:45am): Resting c (with) eyes closed. Resp (respirations) slight labored c 3l/NC (3 liters per nasal cannula)...at 1115 (11:15am): Eyes closed. Very lethargic, no reaction to (pupils) light. No responsive to verbal stimuli nor painful stimuli O2 sat (oxygen saturation) dec (decreased) 88% c 3l/NC. BP (blood pressure) 135/66...Notified Dr (doctor)...ordered to transfer to North Vista Hosp (hospital) ER (emergency room)...Charge nurse called 911@ 1110 (11:20am)..." The "Patient Transfer Form" completed on 5/18/08, stated the following under nursing assessment and recommendations: "Found very lethargic. Non responsive to verbal stimuli. Sluggish pupil reaction. Resp. labored c 4 L/NC (4 liters per nasal cannula) 89% Applied NRM (non-rebreather mask) 6L (6 liters)/95% BP 135/66 P (pulse) 128 R (respiration) 28 BS (blood sugar) 239." Document Review - The policy and procedure titled, "Emergency - 911" stated the following: "2. Qualified staff initiates the appropriate emergency procedures, i.e., oxygen, suction, CPR... 3. Qualified staff attempt to stabilize and monitor the patient/resident until the advance medical team arrive." - The policy and procedure titled, "Oxygen Therapy General Policy" stated the following	F 328		

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F 328	Continued From page 6 under "Oxygen Delivery Devices": "Device: Non rebreather" "Comments: Good for short term delivery, good mobility, easy access to patient/resident" "Complications: Skin Irritation, May aspirate Vomitus, May cause claustrophobia." - The policy and procedure titled "Non-Rebreathing Mask" stated the following: "Purpose: To deliver an FiO2 (oxygen blood level) of 80% to 100% at liter flows of 10 LPM (liters per minute) or greater, depending on ventilatory pattern and mask fit." "Procedure:" "10. Start O2 flow rate at the prescribed liter flow." "11. Insure (ensure) that O2 is flowing out of the mask." "12. Insure reservoir bag is fully inflated." "13. Place mask over patient's/resident's nose and mouth and secure the strap around the patient's/resident's head. ENSURE THAT THE BAG DOES NOT DEFLATE COMPLETELY ON INSPIRATION, increase flow if indicated." "TROUBLESHOOTING:" "1. Reservoir bag not inflating:" "A. Check flow rate for proper flow." Observation On 9/12/08 in the late morning, room 31, bed A, in Hall C was unoccupied. Near the head of bed A was an oxygen concentrator, light brown in color, with the maximum flow rate of 5 L/minute. There was no wall oxygen system observed for bed A in room 31.	F 328		

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F 328	Continued From page 7 Interview On 9/12/08 in the early afternoon, an emergency responder reported the bag of the non-rebreather mask used on Residenr #2 was collapsed when he entered the room. On 9/12/08 in the early afternoon, the Assistant Director of Nursing (D.O.N.)/Director of Education related that resident rooms in Hall C were not equipped with oxygen "in the walls." An oxygen concentrator was required to provide residents in Hall C with oxygen. The Assistant D.O.N./Director of Education confirmed Resident #2 was in Hall C in room 31, bed A. On 9/12/08 in the early afternoon, the DON reported the flow rate of oxygen needed to inflate the bag of a non-rebreather mask: "10 liters/minute--I know now because we had inservices with the North Las Vegas Fire Department." The inservices reportedly took place on August 27 and August 28 for all staff and covered topics which included appropriate delivery of oxygen among other topics. Complaint #18347	F 328		