STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	295021		R-C 07/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN NEVADA MEDICAL AND REHABILITATION CENTER	2945 CASA VEGAS STREET LAS VEGAS, NV 89109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		
	This Statement of Deficiencies was generated as a result of a revisit survey conducted at your facility on 7/20/10. The revisit was in response to the findings of a previous Medicare Recertification Survey and Complaint Investigation conducted at your facility 5/26/10. The survey was conducted in accordance with 42 CFR Chapter IV Part 483 Requirements for Long Term Care Facilities. The sample size was 13 residents, which was 60% of the original sample size of 21. Note: The facility's plan of correction (POC) dates were 06/18/10. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:			
{F 309} SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	{F 309}		8/19/10

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 309}	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview, record review and document review, the facility failed to ensure medications were administered in accordance with the physician orders for 4 of 13 sampled residents (Resident #5, #1, #6, and #12). Findings include: The facility's policy titled, "Physician Orders -Medication/Treatment," with a date of 3/2006, read, "1. Transcribe the order onto the Medication Admission Record (MAR) or Treatment Record as appropriate ..." The facility's policy titled, "Documentation-Clinical," with a date of 3/2006, stated, "4. Medication and Treatments: The qualified nursing staff notes the time, date, and dosage of all medications and treatments at the time they are administered and initials the note on the medication and/or treatment record." The facility's Plan of Correction (POC) to ensure correct administration of medication read, "3. An admission order audit will be completed daily for new admissions. This audit will verify the admission orders match the transfer orders and the Mars (MAR), and those orders were verified by the attending Provider ..." The POC also included, "Daily audits will be conducted for holes in the MARs. The on-coming nurse will audit the previous shift and provide a copy of any incomplete MAR to the supervisor. MARs will be corrected ..." Resident #5	{F 309}		

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{F 309}	Continued From page 2 Resident #5 was admitted on 7/6/10, with diagnoses including hypertension and dementia. The resident was discharged from the facility on 7/9/10. On the admission physician orders dated 7/6/10, the physician prescribed Namenda, 5 mg (milligrams) by mouth twice a day. A review of the July 2010 MAR for Resident #5 revealed Namenda had not been transcribed to the MAR. The resident did not receive the physician ordered medication during the time the resident resided in the facility. A review of the audit sheet indicated an admission order audit was completed on Resident #5 's record. On 7/20/10 at 2:30 PM, Employee #2 indicated the MAR was checked for correct transcription as part of the admission audit. On 7/20/10 at 3:20 PM, Employee #1 reviewed Resident #5's record and stated, " It's (Namenda) not on the MAR. That should have been caught at the admission audit." Resident #1 Resident #1 was admitted on 7/8/10, with diagnoses including congestive heart failure and hypertension. On 7/15/10, the physician ordered Prilosec 20 mg (milligrams) to be administered twice daily. A review of the July 2010 MAR for Resident #1 revealed "Prilosec 20 mg BID" (twice a day) was	{F 309}		

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{F 309}	Continued From page 3 transcribed on to the MAR. The scheduled time was written on the MAR as 9:00 AM. There was no scheduled time written for the second daily dose as ordered. As of 7/20/10 at 10:00 AM, Resident #1 received Prilosec once a day. On 7/20/10 at 10:05 AM, Employee #3 reviewed Resident #1's record. The employee acknowledged the medication should have been given twice a day. Employee #3 indicated the medication audit for the POC was "just looking for holes (absence of licensed nurses' initials to document the medication was given) on the MAR, not the medication." On 7/20/10 at 3:10 PM, Employee #1 explained it was the facility's practice to have the night nurse perform a 24 hour chart check on each resident's record. The employee indicated the facility did not have a policy. Resident #6 Resident #6 was admitted on 6/30/10, with diagnoses including dehydration and acute kidney failure. On 7/2/10, the physician ordered Vitamin B 12 injections to be given daily for 7 days. A review of the July 2010 MAR for Resident #6 revealed the first dose of medication was not given until 7/4/10. There was no documentation in the record for the delay in starting the medication. The box for the licensed nurse's initials for 7/8/10 was blank. On 7/20/10 at 3:10 PM, Employee #3 stated, "I	{F 309}		

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{F 309}	Continued From page 4 would expect the injection would be started on 7/3/10. I don't know why it wasn't. The blank on the MAR should have been noticed when the MAR audit was done." It was unclear from the medication audit forms if an audit of the MAR for "holes" had been done on Resident #6's MAR. Resident #12 On 7/1/10, Resident #12 was admitted with diagnoses including mild dementia, diabetes mellitus, hypertension, and chronic kidney disease. On 7/1/10 at 9:30 PM, a physician ordered blood glucose checks prior to meals and at bedtime with regular sliding scale insulin. On 7/4/10, Resident #12's diabetic flow sheet indicated nurses performed three blood glucose checks at 6:30 AM, 11:30 AM, and 4:30 PM respectively. On 7/4/10 at 3:00 PM, Employee #1 indicated it was a fair assumption a nurse failed to perform Resident #12's blood glucose check on the evening of 7/4/10, since Resident #12's file lacked documented evidence of a blood glucose check and subsequent documentation of regular sliding scale insulin administration or the lack of insulin administration. The facility's plan of correction for Tag #309, received by the Bureau of Health Care Quality and Compliance on 6/18/10, stated the following: "Nurses will be educated to use the Admission	{F 309}		

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{F 309}	Continued From page 5 Report Checklist, during report, as the way to document information regarding the last doses of medication. The nurse obtaining this information will be responsible for communicating with the admitting and medication nurse. The Admission Report Checklists will be given to the DON who will keep these on file." Employees #1, #2, #3, #4, #5, and #6 identified the Admission Report Checklist form as a transition document tracking medication information from transferring facilities for newly admitted residents. On 7/20/10 at 2:00 PM, Employee #5 explained the facility used the Admission Report Checklist form as outlined in the facility's plan of correction. On 7/20/10 at 2:15 PM, Employee #4 explained the facility used the Admission Report Checklist form as outlined in the facility's plan of correction, and Employee #4 further indicated staff kept the Admission Report Checklist forms in residents' files as a transition tool from admission to in-house status. The facility did not save the forms, and the night nurse shredded them. On 7/20/10 at 2:20 PM, Employee #3 explained the facility used the Admission Report Checklist form as outlined in the facility's plan of correction, and Employee #3 further indicated Employee #1 saved the forms, but some employees were putting them in residents' files, so Employee #3 re-educated employees to turn the forms in to Employee #1 regularly. On 7/20/10 at 2:30 PM, Employee #6 explained the facility used the Admission Report Checklist	{F 309}		

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{F 309}	Continued From page 6 form as outlined in the facility's plan of correction, and Employee #6 further indicated the forms remained in residents' files until discharge. At discharge, medical records personnel decided the Admission Report Checklist forms' dispositions. On 7/20/10 at 3:00 PM, Employee #1 indicated Admission Report Checklists may not be found in every resident's file because the facility could not guarantee nurses filled out checklists for every resident entering the facility. Sometimes nurses of transferring facilities failed to provide requested information contained on the Admission Report Checklist form. Therefore, in those situations, the facility's nurses failed to complete the Admission Report Checklist form. On 7/20/10 during the on site revisit, thirteen resident files were reviewed. The Admission Report Checklist forms were audited for each of the thirteen residents randomly sampled. Eight of 13 residents lacked the Admission Report Checklist form or indications nurses attempted to collect the information contained on the Admission Report Checklist form for Residents #1, #2, #3, #5, #6, #7, #10, and #13.	{F 309}		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient	F 514		8/19/10

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F 514	Continued From page 7 information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain complete and accurate Medication Administration Records (MAR) for 4 of 13 sampled residents (Resident #1, #3, #4, and #8). Findings include: The facility's policy titled, "Documentation-Clinical," with a date of 3/2006, read, "Medication and Treatments: 4. The qualified nursing staff notes the time, date and dosage of all medications and treatments at the time they are administered and initials the note on the medication and/or treatment record...If a scheduled medication is withheld or not given as ordered, the nurse documents this and lists the reason for the patient/resident not receiving the medication." Resident #1 Resident #1 was admitted on 7/8/10, with diagnoses including congestive heart failure and hypertension. A review of Resident #1's July 2010 MAR revealed the administration boxes with the nurses' initials were circled for the following	F 514		

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F 514	Continued From page 8 medications and dates: -Asprin 325 mg (milligrams)-7/15/10; -Lasix 20 mg -7/15/10; and, -Lisinopril 40 mg- 7/15/ and 7/18/10. There was no documentation as to why the medications were withheld or not given as ordered. On 7/20/10 at 10:00 AM, Employee #3 stated, "If the box with the nurses' initials is circled, it means the medication was not given. There should be an explanation on the back of the MAR as to why the medication was not given." Employee #3 reviewed Resident #1's MAR and acknowledged there was no documentation as to why the medications were not given. Resident #3 Resident #3 was admitted on 7/2/10, with diagnoses including congestive heart failure and hypertension, and left sided weakness. A review of Resident #3's July 2010 MAR revealed the administration boxes with the nurses' initials were circled for the following medications and dates: -Temazepam 30 mg- 7/9/10; -Coreg 12/5 mg -7/4/10; and, -Neurontin 100 mg-7/7/10. There was no documentation as to why the medications were withheld or not given as ordered.	F 514		

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F 514	Continued From page 9 On 7/20/10 at 3:10 PM, Employee #1 reviewed Resident #3's MAR and stated, "They (the nurses) should be writing on the back of the MAR why it was not given." Resident #4 Resident #4 was admitted on 6/19/10, with diagnoses including abdominal pain, Alzheimer's Disease, and hypertension. A review of Resident #4's June 2010 MAR revealed the administration boxes with the nurses' initials were circled for the following medications and dates: -Aricept 10 mg-6/20/10. There was no documentation as to why the medications were withheld or not given as ordered. On 7/20/10 at 3:10 PM, Employee #1 reviewed Resident #4's MAR and stated, "They (the nurses) should be writing on the back of the MAR why it was not given." Resident #8 On 7/8/10, Resident #8 was admitted to the facility with diagnoses including left hip fracture. On 7/10/10, a physician ordered MS Contin 30 milligrams every 8 hours for pain. Resident #8's MAR scheduled MS Contin at 6:00 AM, 2:00 PM, and 10:00 PM. On 7/18/10 at 6:00 AM, Resident #8's MAR lacked a nurse's signature for MS Contin administration, although the Pyxis	F 514		

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F 514	Continued From page 10 machine documented a nurse signed out the medication. On 7/19/10, a physician ordered MS Contin 45 milligrams every 8 hours for pain while awake. Resident #8's MAR scheduled MS Contin at 6:00 AM, 2:00 PM, and 10:00 PM. On 7/19/10 at 2:00 PM, Resident #8's MAR lacked a nurse's signature for MS Contin administration, although the Pyxis machine documented a nurse signed out the medication. Resident #8's file lacked documentation Resident #8 was asleep or otherwise unavailable. The facility's plan of correction for Tag #309, received by the Bureau of Health Care Quality and Compliance on 6/18/10, stated the following: "Nurses will be educated to use the Admission Report Checklist, during report, as the way to document information regarding the last doses of medication. The nurse obtaining this information will be responsible for communicating with the admitting and medication nurse. The Admission Report Checklists will be given to the DON who will keep these on file." Employees #1, #2, #3, #4, #5, and #6 identified the Admission Report Checklist form as a transition document tracking medication information from transferring facilities for newly admitted residents. On 7/20/10 at 2:00 PM, Employee #5 explained the facility used the Admission Report Checklist form as outlined in the facility's plan of correction. On 7/20/10 at 2:15 PM, Employee #4 explained the facility used the Admission Report Checklist	F 514		

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F 514	Continued From page 11 form as outlined in the facility's plan of correction, and Employee #4 further indicated staff kept the Admission Report Checklist forms in residents' files as a transition tool from admission to in-house status. The facility did not save the forms, and the night nurse shredded them. On 7/20/10 at 2:20 PM, Employee #3 explained the facility used the Admission Report Checklist form as outlined in the facility's plan of correction, and Employee #3 further indicated Employee #1 saved the forms, but some employees were putting them in residents' files, so Employee #3 re-educated employees to turn the forms in to Employee #1 regularly. On 7/20/10 at 2:30 PM, Employee #6 explained the facility used the Admission Report Checklist form as outlined in the facility's plan of correction, and Employee #6 further indicated the forms remained in residents' files until discharge. At discharge, medical records personnel decided the Admission Report Checklist forms' dispositions. On 7/20/10 at 3:00 PM, Employee #1 indicated Admission Report Checklists may not be found in every resident's file because the facility could not guarantee nurses filled out checklists for every resident entering the facility. Sometimes nurses of transferring facilities failed to provide requested information contained on the Admission Report Checklist form. Therefore, in those situations, the facility's nurses failed to complete the Admission Report Checklist form. On 7/20/10 during the on site revisit, thirteen resident files were reviewed. The Admission	F 514		

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F 514	Continued From page 12 Report Checklist forms were audited for each of the thirteen residents randomly sampled. Eight of 13 residents lacked the Admission Report Checklist form or indications nurses attempted to collect the information contained on the Admission Report Checklist form for Residents #1, #2, #3, #5, #6, #7, #10, and #13.	F 514		