STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295006	A. Building B. Wing	04/06/2026

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

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to ensure a resident was free from physical abuse for 1 of 3 sampled residents (Resident 3). The deficient practice placed residents at risk for emotional distress.Findings include:1) Resident 3 (R3) was admitted on [DATE], with diagnoses including complete lesion at thoracic vertebra (T11-T12) and chronic kidney disease stage four.On 04/06/2026 at 9:30 AM, R3 had a bandage on the left hand dated 04/05. R3 recounted having an altercation with a former roommate whom R3 described as a crazy person who yelled at staff all day. R3 indicated upon being told to stop yelling, R4 hit R3 with a telephone on the left hand. R3 touched bandage on left hand indicating this was the injury which resulted from the incident.A Resident Event form dated 03/27/2026, documented R3 was involved in a resident-to-resident altercation with roommate.An Incident Narrative dated 03/27/2026, documented R4 hit R3 with a phone on the hand R3 refused X-ray but a skin tear was noted. Treatment orders obtained.A Skin/Wound Progress Note dated 03/27/2026, documented skin assessment done. Noted with left dorsal hand skin tear measuring Length 1.5 centimeters (cm) x Width 0.5 cm x Depth superficial, red, with blood tinge on the site. Also noted with small dark red discolorations on the left dorsal hand. No swelling on left hand. Notified wound doctor with new order, noted and carried out. First aid done.2) Resident 4 (R4) was admitted on [DATE] and readmitted on [DATE], with diagnoses including idiopathic neuropathy, hemiplegia and hemiparesis due to cerebrovascular accident.The admission Minimum Data Set (MDS) dated [DATE], revealed R4 had intact cognition and no behaviors.A Physician Order dated 03/30/2026, documented to transfer R4 to hospital on Legal 2000 (mental health crisis hold) for physical aggression toward another resident.A Nursing Note dated 03/27/2026 revealed R4 hit R3 with telephone on left hand and R4 was transferred to the hospital for psychiatric evaluation. Law enforcement involved.On 04/06/2026 at 11:38 AM, social services indicated the facility substantiated the abuse because R4 admitted hitting R3 with phone on the hand and did so willfully.On 04/06/2026 at 11:39 AM, the Director of Nursing (DON) indicated the incident was not witnessed but a therapy staff member was close by and entered the room upon hearing a commotion. The therapy staff member indicated R4 admitted to hitting R3 with a telephone.On 04/06/2026 at 12:23 PM, the Social Services Director (SSD), DON, Director of Staff Development (DSD) and Assistant Administrator indicated the facility investigation concluded physical abuse was substantiated because R4 hit R3 with willful intent and an injury was sustained by R3.On 04/06/2026 at 12:10 PM, the DSD enumerated the following corrective actions taken by the facility after the incident:- R4 (aggressor) was separated from R3 and was transferred to hospital for psychiatric evaluation and admitted to the sister facility on 04/01/2026.- R3 was provided with a psychiatric evaluation.- Wound consult and treatments were provided for R3's hand injury- In-service on physical abuse was provided to staff on 03/27/2026On 04/06/2026 at 9:30 AM, R3 revealed feeling safe at facility, stated injury did not hurt and the incident did not cause emotional distress or mental anguish. R3 reported the facility took care of the wound and R3 expressed no issues with care.The Patient Abuse and Prevention policy dated October 2010 defined abuse as willful infliction of injury. Physical abuse included assault with a weapon likely to produce bodily harm.FRI 2969209

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure allegations of physical abuse were submitted to the state agency within 24 hours of the facility being informed of the allegation for 2 of 2 reports reviewed. The deficient practice placed residents at risk for abuse.Findings include: 1) Resident 1 (R1) was admitted on [DATE], with diagnoses including multiple fractures from motor vehicular accident and depression.A Facility Incident Report revealed R1 alleged a certified nursing assistant (CNA) on hit R1 on the face on 02/14/2026 at approximately 8:10 PM, after R1 used foul language toward the CNA. Law enforcement came to the facility to interview R1, R1's roommate and the CNA of concern.On 04/06/2026 at 9:08 AM, the Charge Nurse on duty on the evening of the incident indicated completing a Report Event form for the Director of Nursing (DON) and an Incident Narrative form dated 02/14/2026, which was a written form of communicating the alleged physical abuse incident to the DON involving R1.On 04/06/2026 in the morning, the DON explained this incident occurred on a Friday evening and the DON learned of the incident on 02/16/2026 (Monday) after reading the forms completed by the charge nurse. The DON indicated initiating an investigation along with the Social Services Director (SSD) and submitted the report to the state agency as an initial and final on 02/17/2026. The DON acknowledged the facility reports were not submitted to the state agency within the 24-hour mandated window.The state agency received the initial report of the alleged physical abuse on 02/17/2026 at 12:12 PM.2) A Facility Incident Report revealed R4 hit R3 with a phone which resulted in a skin tear to R3's left hand on 03/27/2026 at approximately 5:00 PM. Law enforcement came to the facility and R4 was ordered to be sent to hospital for psychiatric evaluation.The facility submitted the initial report to the state agency on 04/02/2026 at 2:43 PM.On 04/06/2026 in the morning, the DON explained the incident between R3 and R4 occurred on a Friday evening, and the DON learned of the incident on 03/30/2026 (Monday). An initial and final report was submitted to the state agency on 04/02/2026. The DON acknowledged the allegation of physical abuse involving R3 and R4 was not submitted within the 24-hour mandated window.On 04/06/2026 at 12:17 PM, the Assistant Administrator explained being under the impression allegations of abuse were to be reported within 24 hours business days and not calendar days. The Assistant Administrator confirmed the incidents of alleged physical abuse involving Residents 1, 3 and 4 were submitted to the state agency late.The Abuse Investigation and Reporting policy revised July 2017 revealed an alleged violation of abuse would be reported immediately, but not later than 1) two hours if alleged violation involved abuse or resulted in serious bodily harm and 2) 24 hours if the alleged violation did not involve abuse and did not result in serious bodily harm.FRI 2746045FRI 2969209