

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295006	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER Las Vegas Post Acute & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 vulnerable resident was protected following physical abuse allegation for 1 of 4 sampled residents (R1). The deficient practice had the potential to result in increased fear, anxiety, emotional distress, and an increased risk of psychosocial harm. Findings include: Resident 1 (R1) was admitted on [DATE], with diagnoses including difficulty in walking and generalized muscle weakness. The admission Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status score of 15 out of 15, indicating R1's cognitive status was intact. The assessment documented that R1 required extensive assistance with activities of daily living and was dependent on staff for transfers and incontinent care. The Nursing Staff Assignment and Sign in Sheet dated 06/01/2026, documented the involved CNA was assigned in room [ROOM NUMBER]A wherein R1 was residing in 101. A typewritten statement by Social Services Assistant (SSA) dated 06/03/2026, documented that the SSA was notified that R1 was concerned about the involved CNA being in their room and assigned to R1's roommate. On 06/10/2026 at 11:45 AM, R1 was alert, oriented, verbally responsive, and remained in-house. R1 expressed frustration when the involved CNA from a recent physical abuse incident entered R1's room after R1 had been assured that the involved CNA would no longer provide care or enter the room. R1 reported on 05/02/2026, during incontinent care, the involved CNA jabbed the resident in the buttocks area three times. R1 explained, There is a difference between wiping you and jabbing you. R1 reported feeling terrible following the incident and stated, It was not by accident. R1 also reported another incident during care in which R1 felt something poke the leg and stated, I said, oh, something stuck me. According to R1, the involved CNA responded, That's your imagination. R1 reported that after being informed the CNA would no longer come near the resident or enter the room, the CNA was later assigned to the roommate in the same room. R1 stated, I was promised that (name) would not come anywhere near me again, would not come in the room again. But last week, she did. She came in the room at night. R1 reported repeatedly asking, Who are you? What do you want? and stated that the individual did not respond. R1 stated, I got scared, with somebody coming in, and I screamed for help. R1 reported that the individual left the room without identifying herself and later learned from staff that the individual was the involved CNA. R1 stated, I feel safe as long as she's not around me. R1 further stated, I just want them to keep her as far away from me as they can get, because I don't trust her. R1 indicated, Even if she was assigned to be there, she should have said, I cannot go into that room, assign me somewhere else. R1 indicated the facility had informed R1 that the involved CNA would not provide care to or be near R1. R1 expressed concern and distrust toward the CNA and reported becoming frightened after learning that the CNA had entered the room despite those assurances. On 06/10/2026 in the morning, the Social Services Assistant (SSA) confirmed the involved CNA had been assigned to R1's room on 06/01/2026. The SSA indicated it was not appropriate for the involved CNA to be assigned to the same room and that the involved CNA should not have been in R1's room following the abuse allegation reported on 05/02/2026. The SSA indicated that during the interview, R1 appeared more agitated and stressed after learning the involved CNA had (continued on next page)		

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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	entered the room and repeatedly verbalized that the CNA was not wanted in the room. On 06/10/2026 at 12:28 PM, during a telephone interview, the involved CNA denied jabbing, pinching, hitting, or intentionally causing harm to R1 during incontinent care. The involved CNA acknowledged being suspended during the facility's investigation and being reinstated with instructions not to provide care to R1 and not to enter R1's room. The involved CNA stated the assignment to the roommate in the same room occurred on 06/01/2026, to provide care to R1's roommate. The involved CNA acknowledged awareness of the instruction not to have contact with R1 or enter R1's room but entered the room to care for the roommate and did not respond when R1 asked who was in the room, because the CNA believed communication with R1 was prohibited. The involved CNA indicated no attempt was made to notify the Scheduler or facility leadership regarding the assignment or to request a reassignment despite the prior instructions. The involved CNA stated the assignment was accepted because it appeared on the schedule and the CNA believed it was permissible to care for the roommate. The involved CNA acknowledged being instructed after the incident not to enter R1's room at all. The involved CNA indicated education regarding abuse prevention had been received. On 06/10/2026 at 1:30 PM, the Scheduler indicated awareness that the involved CNA was not to be assigned to R1; however, the Scheduler believed the restriction was based on resident preference and was unaware the involved CNA had been associated with a physical abuse allegation. The Scheduler stated, I was advised she couldn't work with the patient, so that's why I scheduled her to still work with Bed A. The Scheduler acknowledged becoming aware of the concern only after R1 complained that the involved CNA should not have been assigned to R1's room. The Scheduler acknowledged that assigning the involved CNA to the same room could have caused fear and emotional distress to R1 and stated, I would be scared too. Following R1's complaint, the involved CNA was removed from all assignments involving the room only after that incident. On 06/06/2026 at 2:15 PM, the Director of Nursing and the Social Worker indicated the involved CNA was suspended pending investigation of abuse allegation and reinstated. The Social Worker indicated the involved CNA was instructed not to be assigned to or provide care for R1 and should not be in the room at all. The Director of Nursing indicated that if the involved CNA entered R1's room, such action was inconsistent with prior instructions. The Social Worker indicated the involved CNA was expected to follow the instruction not to enter R1's room following the abuse allegation. A facility policy titled Patient Abuse Prevention (undated) revealed that the facility was responsible for ensuring residents were free from all forms of abuse, including physical abuse, and for protecting residents from abuse, neglect, exploitation, and mistreatment. FRI #3002223		