

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Willow Haven Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5538 W Duncan Dr Las Vegas, NV 89130	
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 abuse. A thorough investigation of a resident-to-resident sexual abuse allegation was not conducted, and the resident was not promptly protected or monitored following the allegation for 1 of 52 sampled residents (Resident 45). This deficient practice had the potential to place the resident at risk for continued abuse, emotional distress, fear, anxiety, a diminished sense of safety, and delayed implementation of interventions necessary to protect the resident from further abuse. Findings include: Based on observation, interview, and document review, the facility failed to ensure the protection of a resident's privacy and confidentiality for 1 of 52 residents (Resident 58). This practice had the potential to violate resident rights related to privacy, expose protected health information, and result in unauthorized disclosure to visitors, other residents, or nonclinical personnel. Findings include: Resident 58 (R58) was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease. On 07/28/2026 at 11:45 AM, a handwritten sign was observed posted above R58's bed stated, Attention please no briefs chucks only!! On 07/29/2026 at 7:33 AM, a second observation was conducted, and the same handwritten sign was noted above R58's bed. On 07/29/2026 at 7:36 AM, a Respiratory Therapist confirmed the sign was present and it was a privacy issue and should not be posted above R58's bed. On 07/29/2026 at 7:39 AM, a Licensed Practical Nurse indicated the handwritten sign above R58's bed was a privacy concern and was against facility policy. On 07/29/2026 at 8:40 AM, a Registered Nurse acknowledged the handwritten sign was placed above R58's bed and indicated it was a dignity issue, which was against facility policy. On 07/29/2026 at 7:45 AM, a Certified Nursing Assistant confirmed the sign was above R58's bed and expressed that the sign was a privacy issue, was against facility policy, and should not have been placed. A facility policy titled Residents Rights (undated) documented residents have the right to privacy and confidentiality with personal care and medical records. The policy further stated residents' medical and personal care information is private, and facility staff are required to respect and uphold resident privacy at all times.		

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
--	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Willow Haven Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5538 W Duncan Dr Las Vegas, NV 89130	
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 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 interview, the facility failed to submit a final investigative report to the state agency following an alleged abuse incident for 2 of 37 residents (Resident 84 and resident 85). This deficient practice had the potential to delay state agency review, impede regulatory oversight, and result in noncompliance with mandated abuse reporting requirements. Findings include: Resident 85 (R85) was readmitted to the facility on [DATE] with diagnoses including epilepsy, dementia, schizophrenia and reduced mobility. An initial facility report was submitted to the state agency (SA) on 06/13/2026 documenting physical abuse. The facility did not submit a final report to the SA. The initial report documented on 06/10/2026 at 2:15 AM, a certified nursing assistant (CNA) witnessed and reported a disagreement over the television led to a resident slapping their roommate on the face. The residents were immediately separated, a room change implemented, the administrator notified, and law enforcement called. No injuries, no changes in condition or behavior noted. An investigation and interviews were conducted, and the incident was verified. Law enforcement, the public guardian and the physician were notified. On 07/28/2026 at 3:18 PM, the administrator indicated the facility report process required the initial report to be started within two hours of the incident and clarified the final report must be submitted within 5 days. The administrator reported that social services had been responsible for completing and submitting the initial and final reports; until 05/03/2026 but as of 05/18/2026 they had assumed responsibility for submitting the facility reports. The administrator confirmed there were no barriers or circumstances, which would have delayed the submission of a final report. The administrator acknowledged the final report regarding the incident involving R85 was not submitted due to selecting the incorrect submission button. The facility policy titled Compliance with Reporting Allegations of Abuse, Neglect and Exploitation dated 07/16/2026 documented the requirement to report, within five working days of an incident, sufficient information describing the results of the investigation, indicating any corrective actions taken, and specifying whether the allegation was verified. Resident 84 (R84) was admitted on [DATE] with diagnoses including schizoaffective disorder, bipolar type, schizophrenia and dementia. On 07/28/2026 at 4:00 PM, the Director of Social Services acknowledged the investigation regarding the abuse incident had been completed; however, no final report had been submitted for R84. The Social Services Director confirmed a final report should have been completed and submitted within the required five-day timeframe. A facility policy titled Compliance with Reporting Allegations of Abuse, Neglect and Exploitation (continued on next page)		

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Willow Haven Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5538 W Duncan Dr Las Vegas, NV 89130	
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revised 07/16/2026 documented the requirement to report, within five working days of an incident, sufficient information describing the results of the investigation, indicating any corrective actions taken, and specifying whether the allegation was verified. FRI 3039396		