STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295021	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Health & Rehabilitation Center of LV, LP	2945 Casa Vegas Street Las Vegas, NV 89169

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to ensure nursing staff completed required steps when a resident was discharged against medical advice (AMA). Specifically, there was no documentation of: (1) a discussion of the risks associated with leaving; (2) a signed AMA form; and (3) notification of the physician and the administrator or director of nursing for 1 of 8 sampled residents (R1). The deficient practice placed the resident at risk for an unsafe or uncoordinated discharge, which could have resulted in unmet care needs or rehospitalization.Findings include:Resident 1 (R1) was admitted on [DATE] with diagnoses including narcolepsy without cataplexy (excessive daytime sleepiness without sudden loss of muscle tone), edema, type 2 diabetes mellitus and morbid obesity. R1 was admitted for physical and occupational therapies and continuation of medical management. R1 discharged AMA on 10/19/2025. A case management note dated 10/17/2025 documented the family wanted to take the resident home, but nurse practitioner verbalized family needed care giver training prior to discharge. Care giver training was scheduled for 10/20/2025.A health status note dated 10/19/2025 documented R1's family member demanded an in-person visit from the physician or nurse practitioner to discuss the resident's care. The Charge Nurse explained that providers did not come in on weekends unless the situation was emergent, and since R1 was stable, there was no reasonable rationale for transfer. The note documented the family member called 911, and EMS arrived approximately 10 minutes later, transferred the resident, and left without speaking to staff. The family member approached the nurses' station and stated, we are out of here, before leaving with the paramedics.On 12/19/2025 at 12:57 PM, the Director of Nursing (DON) explained the process for residents who wished to leave the facility AMA. An AMA form would have been explained along with the risks and why the doctor was not discharging the resident and signed by the resident. If the resident refused to sign the AMA form, it would have been documented. The DON confirmed the incident with R1 would have been considered a case of leaving against medical advice.On 12/19/2025 at 2:52 PM, a Licensed Practical Nurse (LPN) explained if a resident wanted to leave AMA, the resident would have talked with the doctor or charge nurse first. The LPN would have spoken with the resident about risks/benefits of leaving and explained how it was not safe because the resident could end up back at the hospital. If a resident still wanted to leave, they would have been asked to sign the AMA form, and informed the facility would not have provided transportation, a walker, or a wheelchair. After the resident left, LPN would have notified the physician and documented a progress note with the reason why the resident left AMA, that the risk/benefits were explained and who was notified.On 12/19/2025 at 2:58 PM, the Assistant Director of Nursing explained if EMS took a resident out of the building, staff would have been expected to find out why they were taking the resident, notify the physician and family, document the incident.On 12/19/2025 at 3:20 PM, a Certified Nursing Aide explained if a resident wanted to leave AMA a nurse would have been notified right away.On 12/19/2025 at 3:30 PM, the DON explained If a resident refused to sign the AMA form, two nurses would have witnessed the refusal, signed it and kept it on file, and documented the incident. The DON explained the expectation was for the nurse to speak with EMS, document the situation, contact the physician, and follow the AMA policy. The DON verbalized that the nurse had called the physician, but there was no documentation of the call. The medical record lacked documented evidence of a signed AMA form and documentation that the risks and benefits were explained to R1 and their family.On 12/19/2025 at 3:39 PM, RN5 recalled the AMA discharge and explained that on the day of discharge, R1's family member said they would take R1 to the hospital for better care and demanded to speak with a provider face-to-face within 10 minutes. RN5 explained providers did not come to the facility on Sundays unless it was an emergency. RN5 stated they called the nurse practitioner, who said they were not coming. RN5 told the family, who said, thank you, and about 10 minutes later paramedics came and removed the resident. RN5 said R1 was stable. RN5 explained there was no documentation showing the provider had been contacted and did not recall calling again after R1 left. RN5 said another employee let EMS in through the side door, and no one spoke to EMS about the resident or the discharge. RN5 stated EMS just showed up, and RN5 did not notice them until they were leaving. RN5 said the Administrator, DON, and physician were normally notified per protocol but was unsure if it was documented.On 12/19/2025 at 4:11 PM, the DON explained when EMS came to the facility, they pushed a button located at the side door, which rang at the nurses' station, and staff then let them in. EMS did not have a code for self-entry and did not enter through the front doors.On 12/19/2025 at