

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  295045	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/10/2024
NAME OF PROVIDER OR SUPPLIER  Torrey Pines Post Acute and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  1701 S. Torrey Pines Drive Las Vegas, NV 89146	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47860</p> <p>Based on interview, record review, and document review, the facility failed to ensure 1 of 20 sampled residents (Resident 101) was free of abuse by a staff member, specifically, an incident involving a staff member who was witnessed to have pushed a resident, which resulted in a fall. The deficient practice had the potential to cause physical harm to the resident.</p> <p>Findings include:</p> <p>A facility policy titled Abuse Prevention Program (undated) documented the administration will protect residents from abuse by anyone to include facility staff.</p> <p>Resident 101 (R101)</p> <p>R101 was admitted on [DATE] and discharged on [DATE], with diagnosis including bipolar disorder, unspecified psychosis, anxiety disorder, unspecified dementia, and altered mental status.</p> <p>A Brief Interview for Mental Status (BIMS; a tool used to screen and identify the cognitive condition of a resident) on 01/17/2024 documented a score of 11, which indicated moderate cognitive impairment.</p> <p>The facility reported incident (FRI) dated 02/01/2024, documented the following:</p> <p>-On 01/31/2024 at approximately 9:30 AM, a Certified Nursing Assistant (CNA) and Housekeeper/Floor Technician observed a Registered Nurse (RN) push the resident to the ground and grabbed the resident by arm to put the resident back in bed with force.</p> <p>-The resident was assessed indicating no signs of physical harm or mental anguish as a result.</p> <p>-The resident was not able to remember details of incident due to diagnosis involving regular confusion.</p> <p>On 05/09/2024 at 12:00 PM, the Housekeeper/Floor Technician recalled observing the RN and R101 engaged in a verbal dispute. R101 walked towards the RN and the RN raised arm/elbow pushed towards resident, which caused R101 to fall to the ground. The RN no longer worked at the facility following the incident.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 295045
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/09/2024 at 2:18 PM, the Administrator confirmed the RN was suspended pending the facility's investigation, ultimately terminated, and reported to the board of nursing on 01/31/2024. The Administrator indicated staff were trained to not engage with residents during a potential situation and walk away; however, the RN did not follow the facility's training and did not handle the situation in a professional manner.</p> <p>On 05/09/2024 at 2:54 PM, the Director of Staffing Development (DSD) verbalized participation in the facility investigation and facility trainings. The DSD indicated the RN did not keep a distance from the resident during a possible situation as staff were trained. The DSD also facilitated the in-service following the incident.</p> <p>A Personnel Action Request form documented effective date 02/01/2024, involuntary termination of the RN due to standards of conduct violation; specifically confirmed physical abuse of a resident.</p> <p>During the onsite investigation on 05/07/2024 through 05/10/2024, the facility's correction of the past non-compliance related to the incident occurred as evidenced by:</p> <p>-On 01/31/2024, the RN was suspended pending the investigation, ultimately terminated, and reported to the board of nursing.</p> <p>-On 02/01/2024, in-service to staff completed on abuse prevention, to include how to deal with combative and aggressive residents.</p> <p>Facility Reported Incident #NV00070373</p>		