

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 03/12/2025
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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51395</p> <p>Based on interview, record review and document review, the facility failed to ensure a resident was kept safe from physical abuse for 1 of 5 sampled residents (Resident 2) and a resident was protected from abuse by another resident with increasingly aggressive behaviors for 1 of 5 sampled residents (Resident 4). The deficient practice had the potential for the residents to experience emotional and physical harm.</p> <p>Findings include:</p> <p>Resident 2 (R2)</p> <p>R2 was admitted on [DATE] with diagnoses including other specified disorders of bone density and structure of left ankle and foot, type 2 diabetes, and chronic obstructive pulmonary disease.</p> <p>Resident 3 (R3)</p> <p>R3 was admitted on [DATE] and discharged on [DATE] with diagnoses including unspecified psychosis, schizophrenia, and unspecified dementia.</p> <p>The facility reported incident (FRI) dated 09/24/2024 documented the following:</p> <p>-On 09/18/2024 at approximately 7:00 PM, R3 was observed being physically aggressive with R2 and striking R2's body.</p> <p>- R2 and R3 were immediately separated by a Certified Nurse Assistant (CNA) and R3 was placed on one-to-one supervision.</p> <p>-Conclusion: The incident was verified and R3 was transferred to an acute care hospital for psychiatric evaluation.</p> <p>A Psychiatry consultation note dated 09/20/2024 documented R2 was pleasant and stated being more comfortable that R3 was taken to an acute hospital for inpatient management of disrupted behaviors. R2 denied feeling depressed or anxious and stated feeling safe in the facility.</p> <p>Social Service notes documented the following:</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
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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>-09/19/2024 R2 stated everything was fine, feels safe, aware R3 is gone, no problems.</p> <p>-09/20/2024 R2 smiled and stated everything was still fine, no problems and feels safe.</p> <p>-09/22/2024 R2 stated everything is fine and feels safe.</p> <p>On 03/12/2025 at 10:25 AM, R2 stated gets along well with residents and has not had any negative interactions with anyone. R2 stated feels safe in the facility.</p> <p>During the onsite investigation on 03/12/2025, the facility's correction of the past non-compliance related to the incident occurred as evidenced by:</p> <ul style="list-style-type: none"> -Observation of resident-to-resident interactions were polite and courteous. - R3 was discharged from the facility on 09/18/2024 and had not returned. - Staff indicated the facility provided continuing education regarding Resident-to-Resident altercations. -Review of the facility's training records corroborated the staff interviews regarding training. <p>Facility Reported Incident #NV00072264</p> <p>Resident 4 (R4)</p> <p>R4 was admitted on [DATE] and discharged on [DATE] with diagnoses including low back pain, idiopathic peripheral autonomic neuropathy, and type 2 diabetes with hyperglycemia.</p> <p>Resident 5 (R5)</p> <p>R5 was admitted on [DATE] and discharged on [DATE] with diagnoses including schizoaffective bipolar type disorder, anxiety disorder, and abnormalities of gait.</p> <p>The FRI dated 11/04/2024 documented the following:</p> <ul style="list-style-type: none"> -On 11/03/2024 at 10:30 PM, R5 struck R4's face causing a fall to the floor and bleeding nose. The residents were immediately separated and R5 placed on one-to-one monitoring. -R5 was placed on legal hold, transferred to an acute hospital, and metro police were notified. - R4 was sent to the hospital for evaluation. <p>-Conclusion: The incident was verified. R4 returned to the facility with psychiatry and social services to follow. R4 reported feeling safe in the facility. R5 was transferred to an acute hospital.</p> <p>A care plan dated 11/05/2024 documented R4 had potential for emotional distress related to altercation with interventions to monitor R4 for verbalizing fear or not being safe.</p> <p>(continued on next page)</p>		

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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>A Psychiatry progress note dated 11/05/2024 documented R4 feels safe and denied negative thoughts.</p> <p>Social Service notes documented the following:</p> <ul style="list-style-type: none"> -11/05/2024, R4 stated feeling fine and safe, not afraid of anyone. -11/06/2024, R4 walking down hallway stated being fine, no problem with face or nose and feels safe. -11/07/2024, R4 stated feels safe and not afraid of anyone. <p>A Radiology Interpretation of nasal bones x-ray dated 11/11/2024 documented no displaced facial fracture detected.</p> <p>On 03/12/2025 at 3:38 PM, the Director of Nursing (DON) stated the expectation of staff when a resident was aggressive, and another resident was attempting to approach was for staff to intervene and separate them for safety.</p> <p>During the onsite investigation on 03/12/2025, the facility's correction of the past non-compliance related to the incident occurred as evidenced by:</p> <ul style="list-style-type: none"> -Observation of resident-to-resident interactions were polite and courteous. - Staff indicated the facility provided continuing education regarding Resident-to-Resident altercations. -Review of the facility's training records corroborated the staff interviews regarding training. <p>Facility Reported Incident #NV00072620</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>51395</p> <p>Based on observation, interview and document review, the facility failed to ensure medications left on top of a medication cart were secured. The deficient practice had the potential risk of unauthorized access to medications, medication errors, theft, or misuse of medication within the facility.</p> <p>Findings include:</p> <p>On 03/12/2025 at 12:24 PM, a medication cart with a medication card containing 20 tablets of Divalproex Sodium delayed release (DR) 500 milligram (mg) (a medication used to treat seizures), was parked unattended at the entrance of the northeast hallway in front of a resident room while staff, visitors and resident were in the hallway.</p> <p>On 03/12/2025 at 12:27 PM, a Registered Nurse (RN) exited a resident room and approached the medication cart. The RN acknowledged the card of pills stating should not have been left on top of the cart unattended as someone could get the pills and take them.</p> <p>On 03/12/2025 at 2:15 PM, the Director of Nursing (DON) stated medications were to be secured in the medication cart when not being administered. Leaving medications on top of the medication cart unattended would risk safety and allow residents or others to access the medication.</p> <p>The facility policy titled Storage of Medication, revised November 2020, documented the facility stores all drugs and biologicals in a safe, secure, and orderly manner.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>51395</p> <p>Based on observation and interview, the facility failed to ensure a blood glucose monitor with a used test strip was not left unattended on top of medication cart. The deficient practice had the potential to compromise the safety and well-being of residents by allowing exposure to blood borne pathogens.</p> <p>Findings include:</p> <p>On 03/12/2025 at 12:24 PM, a medication cart was parked unattended at the entrance of the northeast hallway in front of a resident room while staff, visitors and resident were in the hallway. A blood glucose monitor with a test strip inserted into the device, was lying on top of the medication cart. The testing strip had a dark red type of substance visible.</p> <p>On 03/12/2025 at 12:27 PM, a Registered Nurse (RN) exited a resident room and approached the medication cart. The RN acknowledged the glucometer had been used to obtain a resident blood sugar and the testing strip needed to be discarded, and the blood glucose monitor needed to be disinfected. The RN stated the glucometer should not have been left unattended.</p> <p>On 03/12/2025 at 2:15 PM, the Director of Nursing (DON) acknowledged for infection control, blood glucose monitors were to be cleaned and stored away after use and were not to be left unattended on top of the medication cart.</p> <p>On 03/12/2025 at 3:12 PM, the Director of Staff Development/Infection Preventionist verbalized blood glucose monitor testing strips were to be disposed of immediately after use to prevent the spread of infection.</p>		