STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295045	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Torrey Pines Post Acute and Rehabilitation	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interviews, record review and document review, the facility failed to ensure residents were free from physical abuse for four sampled residents (Residents 1, 4, 5 and 10). The deficient practice placed other residents at risk of being physically abused.Findings include:Incident #1 - Residents 2 and 10Resident 10 (R10) was admitted on [DATE], with diagnoses including fibromyalgia and unspecified intracranial injury.A nurse progress note dated 11/27/2025, revealed R10 called law enforcement after getting punched in the face by R2 in the smoking area. Law enforcement arrived and spoke with both residents. The physician assistant and social services director (SSD) was made aware. The SSD was to inform Administrator.A change of condition evaluation form dated 11/27/2025, revealed R10 reported being slapped and cursed at by R2 in the smoking area. R2 had attempted to strike R10's face with a lit cigarette. Redness was noted on R10's left mandible area. An X-ray was ordered which was negative for injury.Resident 2 (R2) was admitted on [DATE] and readmitted [DATE], with diagnoses including schizophrenia and paranoid personality disorder.A nurse's progress note dated 11/27/2025, revealed R2 was in a physical altercation with R10 in the smoking area. When the writer approached R2 in the smoking area, R2 explained R10 was being annoying and deserved it. Law enforcement arrived at facility due to R10 pressing charges against R2 for battery.Incident #2 - Residents 1 and 2Resident 1 (R1) was admitted on [DATE], with diagnoses including unspecified psychosis due to a substance or unknown physiological condition, schizophrenia, and major depressive disorder.A change of condition evaluation form dated 12/19/2025, revealed R1 was found on floor with a bleeding nose, a skin tear to left forearm, and redness of left forehead. R2 started pushing and kicking R1 because R1 entered R2's room.The admission minimum data set (MDS) dated [DATE], revealed R1 had moderately impaired cognition and did not have aggressive or wandering behaviors.Resident 2 (R2) was admitted on [DATE] and readmitted [DATE], with diagnoses including schizophrenia and paranoid personality disorder.The admission minimum data set (MDS) dated [DATE], revealed R2 had intact cognition and no aggressive behaviors.A nurse's progress note dated 12/18/2025, documented a certified nursing assistant (CNA) informed the nurse R2 had a behavioral outburst and became upset when R1 entered the room. R2 reported to staff pushing R1 to the floor and kicking R1 on right lateral side. The physician was notified and ordered the nurse to send R2 to the hospital for psychiatric evaluation.A physician Discharge summary dated [DATE], revealed R2 had a significant history of schizophrenia, anxiety disorder, and homicidal ideation and was recently admitted to a psychiatric hospital for chasing a person with a knife and threatening police.Incident #3 - Residents 5 and 6Resident 6 (R6) was admitted on [DATE], with diagnoses including peripheral vascular disease, heart failure and neuropathy.An admission MDS dated [DATE], documented R6 had moderately impaired cognition.A nurse's progress note dated 03/12/2026, revealed R6 reported being punched by roommate (R5) the night before. The progress indicated noted mild elevation on forehead. R6 indicated not doing anything to R5 and did not understand why the resident hit them.A skin/wound note dated 03/12/2026, revealed the wound care team performed a head-to-toe assessment after the reported altercation and a slight swelling to mid forehead was noted.Incident #4 - Residents 4 and (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 - Some	5Resident 4 (R4) was admitted on [DATE], with diagnoses including chronic obstructive pulmonary disease, heart failure and schizoaffective disorder.A nurse's progress note dated 03/12/2026, revealed R4 was punched by roommate (R5) very early in the morning. The nurse assessed R4 who was observed with discoloration around left eye socket with sensitivity.A skin/wound note dated 03/12/2026, revealed R4 had a head-to-toe assessment by wound team who identified a nose bridge abrasion and skin tear to left forehead.Resident 5 (R5) was admitted on [DATE] and readmitted on [DATE], with diagnoses including neuroleptic induced Parkinsonism, schizoaffective bipolar type and psychosis.A nurse's progress note dated 03/12/2026, revealed R5 was noted to be screaming violently inside the room. A CNA reported to the nurse R5 hit their roommate (R4). The note indicated R5 was hostile and physically aggressive. R4 was assisted to vacate the room and the nurse asked R5 to calm down.A social services note dated 03/12/2026, revealed the Social Services Director (SSD) attempted to speak with R5 regarding altercation with R4. The resident became agitated, started screaming and yelling and used inappropriate language toward staff. Due to the R5's behavior, the SSD could not obtain further information at this time.A nurse's progress note dated 03/12/2026, indicated R5 was showing hostile and aggressive behavior towards residents and staff, non-redirectable. The physician ordered to transfer R5 to hospital under a legal hold (an emergency involuntary hold for individuals undergoing mental health crisis). A physician Discharge summary dated [DATE], revealed R5 was transferred to this facility from a psychiatric hospital where R5 was evaluated for exacerbation of schizophrenia symptoms. R5 had been noncompliant with psychotropic medications.On 04/22/2026 at 11:39 AM, the Director of Nursing (DON) confirmed the incidents involving R1, R4, R6 and R10 met the facility's definition of willful infliction of injury. The DON indicated aggressors R2 and R5 both had intact cognition and a history of inpatient psychiatric stays - R2 due to homicidal ideations and R5 for exacerbation of schizophrenic symptoms. Injury was evident when R1 sustained a bleeding nose, skin tear to left forearm, and redness of left forehead; R4 sustained discoloration around left eye socket; R6 sustained mid forehead swelling and R10 sustained redness to mandible area. The DON indicated R2 and R5 both acted with intent.On 04/22/2026 at 11:44 AM, the SSD corroborated with the DON and indicated R2 and R5's actions were classified as abuse.On 04/22/2026 at 11:45 AM, the DSD confirmed the abuse incidents where R1, R4, R6 and R10 were harmed by R2 and R5 were all purposeful acts which caused harm and therefore considered physical abuse.On 04/23/2026 at 10:40 AM, the DSD indicated the facility had a high behavior population and the facility assessment took this into consideration specifying there was an average of 45 behavior residents at this time and the facility had increased staffing and tried to decrease admission of behavior residents.On 04/23/2026 at 10:42 AM, the Assistant Administrator there was currently a pattern with regards to resident altercations particularly physical abuse, and the inter-disciplinary team (IDT) had identified the root cause to be a lack of support from the psychiatric provider particularly the nurse practitioner (NP) who rounded in the facility and the medical director.On 04/23/2026 at 10:45 AM, the Assistant Administrator indicated being dissatisfied with the psychiatric NP who did not conduct thorough evaluations, made infrequent and delayed visits to the facility. The Assistant Administrator indicated communicating this pattern of abuse with the medical director in hopes of receiving support specifically to screen admission to ensure the level of behavioral care could be met by the facility, but the medical director did not address this request.On 04/23/2026 at 10:47 AM, the DON indicated R2 and R5 were both inpatient psychiatric patients who were both refusing to take psychotropic medications. This was reported to both psychiatry provider and the medical director. The medical director did not give much support, for example the physician did not allow administration of intramuscular (IM) psychotropics to control aggressive or crisis events. The Assistant Administrator, the DSD and DON indicated R2, R5 and residents like them should contract into a behavioral agreement wherein if they were medically noncompliant with care plan and medications this could lead to involuntary discharge for the safety of the other residents who resided at the facility.On 04/23/2026 at 2:40 PM, the Director of Staff Development (DSD) clarified (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the altercation between R5 and R6 occurred on 03/11/2026 at approximately 9:00 PM. After this incident R6 was removed from the room to separate both parties and R4 moved in as R5's new roommate. An altercation between R5 and R4 occurred on 03/12/2026 at 4:00 AM. R5 was ordered to be transferred for legal hold after the second physical altercation involving new roommate R4The facility's Patient Abuse and Prevention policy (undated), defined abuse as the willful infliction of injury. Physical abuse may include assault and battery. FRI 2699069FRI 2804144FRI 2806325

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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. Based on interviews and document review, the facility failed to ensure allegations of physical abuse were reported to the state agency in a timely manner for four sampled residents (Residents 1, 4, 6 and 10). The deficient practice had the potential to place residents at risk from abuse.Findings include:A facility investigation report of alleged physical abuse between Resident 1 and Resident 2 reportedly occurred on 12/18/2025 at 6:26 PM. According to the report, Resident 2 pushed Resident 1 to the ground and started kicking Resident 1. Resident 1 was found with a bleeding nose, skin tear on arm and redness to left forehead.The report was submitted to the state agency on 12/19/2025 at 5:04 PM.A facility investigation report of alleged physical abuse between Resident 2 and Resident 10 reportedly occurred on 11/27/2025 during the day in the smoking area. R10 was noted to have redness on mandible area after being hit on the face by Resident 2.The report had not been submitted to the state agency.A facility investigation report of alleged physical abuse between Resident 4 and Resident 5 reportedly occurred on 03/12/2026 at 4:00 AM. Resident 4 was observed to have discoloration around left eye socket after being punched by Resident 5.The report was submitted to the state agency on 03/13/2026 at 3:05 PM.A facility investigation report of alleged physical abuse between Resident 5 and Resident 6 reportedly occurred on 03/11/2026 at approximately 9:00 PM. Resident 6 was found to have swelling on forehead after being hit on the head by Resident 5.The report was submitted to the state agency on 03/13/2026 at 3:51 PM.On 04/22/2026 at 3:25 PM, the Director of Nursing (DON), Director of Staff Development (DSD) and the Assistant Administrator indicated the four incidents of physical abuse which were confirmed to be true physical abuse resulting in bodily injury should have been reported to state agency within two hours and all were submitted late to the state agency.The facility's Abuse Investigation and Reporting policy revised July 2017, documented an alleged violation of abuse would be reported immediately but not later than two hours if the alleged violation involved abuse or resulted in serious bodily injury.FRI 2699069FRI 2804144FRI 2806325

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review, the facility failed to investigate an incident of physical abuse for 1 of 10 sampled residents (Resident 10). The deficient practice placed other residents at risk for abuse.Findings include:Resident 10 (R10) was admitted on [DATE], with diagnoses including fibromyalgia and unspecified intracranial injury.A nurse's progress note dated 11/27/2025, revealed R10 called law enforcement after getting punched in the face by R2 in the smoking area. Law enforcement arrived and spoke with both residents. The physician assistant and social services director (SSD) was made aware. The SSD was to inform the Administrator.A change of condition evaluation form dated 11/27/2025, revealed R10 reported being slapped and cursed at by R2 in the smoking area. R2 had attempted to strike R10's face with a lit cigarette. Redness was noted on R10's left mandible area. An X-ray was ordered which was negative for injury.Resident 2 (R2) was admitted on [DATE] and readmitted [DATE], with diagnoses including schizophrenia and paranoid personality disorder.A nurse's progress note dated 11/27/2025, revealed R2 was in a physical altercation with R10 in the smoking area. When the writer approached R2 in the smoking area, R2 explained R10 was being annoying and deserved it. Law enforcement arrived at facility due to R10 pressing charges against R2 for battery.A physician Discharge summary dated [DATE], revealed R2 had a significant history of schizophrenia, anxiety disorder, and homicidal ideation and was recently admitted to a psychiatric hospital for chasing a person with a knife and threatening police.A The facility did not report this incident to the state agency. On 04/22/2025 at 11:18 AM, the Director of Nursing (DON) indicated working in the facility at this time but was not the DON yet. The DON indicated hearing about the incident but was not well-versed due to being busy with unit assignment.On 04/22/2026 at 11:20 AM, the Director of Staff Development (DSD) indicated based on review of R10 and R2's medical records there was a physical abuse incident on 11/27/2025 but this was not investigated nor reported. The DSD could not speak to the efforts made by the former DON who had more knowledge on the incident.On 04/22/2026 at 11:29 AM, the social services director (SSD) recalled informing the Administrator regarding this incident but could not speak to why the incident was not investigated or reported. The SSD indicated the Administrator was on leave and was not available for interview.On 04/22/2026 at 11:33 AM, the DSD indicated when alleged abuse occurred the facility was to report to state agency within two hours if abuse led to serious bodily harm and 24 hours if it does not involve abuse or serious injury. This was an abuse incident and should have been reported within two hours and complete investigation submitted within five working days.The faciity's Abuse Investigation and Reporting policy revised July 2017, revealed an incident or suspected resident abuse would be reported to the Administrator who will assign the investigation to the appropriate individual. The individual conducting the investigation will review documentation forms, interview the persons reporting the incident, residents and witnesses, and review all events leading up to the alleged incident.FRI 2699069

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review, the facility failed to ensure a resident's care plan was developed for a newly identified wandering behavior for 1 of 10 sampled residents (Resident 1). The deficient practice placed the resident at risk for a repeat resident to resident altercation.Findings include:Resident 1 (R1) was admitted on [DATE], with diagnoses including unspecified psychosis due to a substance or unknown physiological condition, schizophrenia, and major depressive disorder.The admission minimum data set (MDS) dated [DATE], revealed R1 had moderately impaired cognition, no wandering behaviors.A change of condition evaluation form dated 12/19/2025, revealed R1 was found on floor with bleeding nose, a skin tear to left forearm, and redness of left forehead. R1 wandered into another resident's room and was pushed to the ground and kicked by the resident in the room.The medical record lacked documented evidence a care plan for R1's newly identified wandering behavior was developed following the incident on 12/18/2025.On 04/22/2026 at 10:35 AM, the Director of Nursing (DON) indicated R1 was admitted with no wandering behaviors but wandered into R2's room on 12/18/2025. At this point, the nurse assigned to R1 was responsible for developing a care plan for wandering which was considered a new behavior. According to the DON, typical interventions for wandering behaviors included close monitoring, transferring resident near nurse's station, activities involvement to keep busy and one-one-one sitter when needed.The facility's Comprehensive Person-Centered Care Plan policy revised December 2016 revealed assessments were ongoing and revised as information about the residents and conditions changed.FRI 2699069

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record, and document review, the facility failed to:1) provide a trauma evaluation after a physical abuse incident for 2 of 10 sampled residents (Residents 1 and 4), and2) implement meaningful interventions for 2 residents (Residents 2 and 5) with psychiatric histories, aggressive behaviors, and refusal of prescribed psychotropic medications.These failures placed residents at risk for mental and emotional harm and increased the risk of physical abuse.Findings include:1) Resident 1 (R1) was admitted on [DATE], with diagnoses including unspecified psychosis due to a substance or unknown physiological condition, schizophrenia, and major depressive disorder.A change of condition evaluation form dated 12/19/2025, revealed R1 was found on floor with bleeding nose, a skin tear to left forearm, and redness of left forehead. R2 admitted to pushing and kicking R1 because R1 entered R2's room.A psychiatry progress note dated 12/19/2025, documented R1's chief complaint was Good and revealed the psychiatric nurse practitioner (NP) saw R1 per staff request.The medical record lacked documentation the psychiatry provider discussed the altercation/physical abuse incident with R1 and addressed R1's newly identified wandering behavior.On 04/22/2026 at 10:40 AM, the social services director (SSD) explained after each resident-to-resident altercation, involved parties were separated, nurses performed a head-to-toe assessment, and a psychiatric consult would be ordered to evaluate the resident's trigger, review medication regimen, identify mental and emotional distress and other interventions as necessary.On 04/22/2026 at 10:46 AM, the director of staff development (DSD) reviewed the psychiatry progress notes on 12/19/2025 and confirmed there was no concrete documentation of purpose which should have been trauma evaluation from R1's abuse incident on 12/18/2025. The DSD stated there was no documentation of root cause of the altercation which was R1's wandering behavior.R4 was admitted on [DATE], with diagnoses including chronic obstructive pulmonary disease, heart failure and schizoaffective disorder.A nurse's progress note dated 03/12/2026, revealed R4 was punched by roommate (R5) very early in the morning. Nurse assessed R4 who was observed with discoloration around left eye socket with sensitivity.A skin/wound note dated 03/12/2026, revealed R4 had a head-to-toe assessment by wound team who identified a nose bridge abrasion and skin tear to left forehead.R4's care plan for emotional distress initiated on 03/12/2026, revealed R4 had the potential for emotional distress related to inappropriate behavior by another resident. Interventions included psychiatry evaluation.The medical record lacked documented evidence R4 was seen by the psychiatric provider after being punched by roommate on 03/12/2026.A text message from DSD's phone dated 03/12/2026, revealed the psychiatric NP was informed of the incident with a request to see R4.The medical record lacked documented evidence psychiatrist completed a trauma evaluation post physical abuse incident.On 04/22/2026 at 2:26 PM, the Director of Nursing (DON) confirmed R4 was not seen by psychiatry following physical abuse incident.The facility's Behavioral Assessment and Management policy revised March 2019 documented the facility would provide behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being.2)Resident 2 (R2) was admitted on [DATE] and readmitted [DATE], with diagnoses including schizophrenia and paranoid personality disorder.The admission minimum data set (MDS) dated [DATE], revealed R2 had intact cognition.A nurse's progress note dated 11/27/2025, revealed R10 called law enforcement after getting punched in the face by R2 in the smoking area. Law enforcement arrived and spoke with both residents. Physician assistant and social services director (SSD) made aware, SSD to inform Administrator.A nurse's progress note dated 12/18/2025, a certified nursing assistant (CNA) informed the nurse R2 had a behavioral outburst and became upset when R1 entered the room. R2 reported to staff pushing R1 to the floor and kicking R1 on right lateral side. The physician was notified and ordered the nurse to send R2 to the hospital for psychiatric evaluation.A physician Discharge summary dated [DATE], revealed (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2 had a significant history of schizophrenia, anxiety disorder, and homicidal ideation and was recently treated in a psychiatric hospital for chasing a person with a knife and threatening police prior to admission to this facility.R2's care plan revealed the resident had a behavioral problem specifically, irritability, anger, violent behavior, homicidal ideations, mood swings and had the tendency to push and kick other residents. Interventions included attempts to identify underlying causes.A review of medical record revealed R2 routinely refused medications.Resident 5 (R5) was admitted on [DATE] and readmitted on [DATE], with diagnoses including neuroleptic induced Parkinsonism, schizoaffective bipolar type and psychosis.A nurse's progress note dated 03/12/2026, revealed R6 reported being punched by roommate (R5) the night before. Noted mild elevation on forehead. R6 indicated not doing anything to R5 and did not understand why the resident was [NAME] nurse's progress note dated 03/12/2026, revealed R5 was noted to be screaming violently inside the room. The CNA reported to nurse R5 hit their roommate (R4). R5 was hostile and physically aggressive. R4 was assisted to vacate room and the nurse asked R5 to calm down.A social services note dated 03/12/2026, revealed the SSD attempted to speak with R5 regarding altercation with R4. The resident became agitated, started screaming and yelling and used inappropriate language toward staff. Due to the R5's behavior, the SSD could not obtain further information at this time.A nurse's progress note dated 03/12/2026, indicated R5 was showing hostile and aggressive behavior towards residents and staff, non-redirectable. Physician ordered to transfer R5 to hospital under legal hold (an emergency involuntary hold for individuals undergoing mental health crisis) family notified.A physician Discharge summary dated [DATE], revealed R5 was transferred to this facility from a psychiatric hospital where R5 was evaluated for exacerbation of schizophrenia symptoms. R5 had been noncompliant with psychotropic medications.A Refusal of Treatment form dated 03/08/2026, was signed by R5 after staff explained to the resident refusal of medications could affect stabilizing mood and cause worsening behaviors.On 04/23/2026 at 10:40 AM, the DSD indicated the facility had a high behavior population and the facility assessment took this into consideration specifying there was an average of 45 behavior residents at this time and the facility had increased staffing and tried to decrease admission of behavior residents.On 04/23/2026 at 10:42 AM, the Assistant Administrator there was currently a pattern with regards to resident altercations particularly physical abuse, and the inter-disciplinary team (IDT) had identified the root cause to be a lack of support from the psychiatric provider particularly the nurse practitioner (NP) who was assigned to the facility. On 04/23/2026 at 10:45 AM, the Assistant Administrator indicated being dissatisfied with the psychiatric NP who did not conduct thorough evaluations, made infrequent and delayed visits to the facility.On 04/23/2026 at 10:47 AM, the DON indicated R2 and R5 were both inpatient psychiatric patients who were both refusing to take psychotropic medications. This was reported to both psychiatry provider and the medical director. The Assistant Administrator, the DSD and DON indicated R2, R5 and residents like them should contract into a behavioral agreement wherein if they were medically noncompliant with care plan and medications this could lead to involuntary discharge for the safety of the other residents who resided at the facility.The facility's Abuse Prevention Program revised December 2016, documented residents had the right to be free from abuse which included physical abuse. Resident abuse prevention included protecting residents from other residents.FRI 2699069FRI 2804144FRI 2806325