STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295052	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Las Vegas	6151 Vegas Drive Las Vegas, NV 89108

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(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 interview, record review, and document review, the facility failed to protect residents from ongoing and repeated sexual and/or physical contact by a cognitively impaired resident with a history of continued repeated behaviors for 1 of 6 sampled residents (Resident 2) and 3 of 3 unsampled residents (Resident 7, 8, and 9). The deficient practice placed the residents at risk for continued nonconsensual physical contact and potential psychosocial distress.Findings include:Resident 2 (R2) was admitted [DATE], with diagnosis including dementia unspecified severity with anxiety/psychotic disturbance, depression, and adult failure to thrive.On 05/13/2026 at 1:17 PM, R2 was observed in the hallway seated in a wheelchair holding a stuffed animal. R2 looked toward the surveyor, immediately looked away, and did not acknowledge the surveyor's greeting. R2 did not interact with the surveyor and did not respond to questions. R2 was observed calm.A Minimum Data Set assessment dated [DATE], documented R2's cognitive skills were severely impaired. A Care Plan dated 11/20/2025 documented dementia and related concerns including behavior and communication deficit.A Care Plan dated 04/22/2026 included dementia, R2 was confused and very forgetful. R2 had communication deficits, and was rarely understood and sometimes understood, related to dementia. The care plan documented a resident-to-resident sexual altercation on 01/18/2026. A Facility Reported Incident Report documented on 01/18/2026 a male resident grabbed R2's right breast. On 01/19/2026 a (Late Entry) Health Status Note, documented on 01/18/2026 at 1:40 PM, it was reported by staff R2 was seen with a male resident in the hallway, having inappropriate touching behavior towards R2. Both residents were separated. R2's chest was assessed in R2's room, with no redness or bruises noted.Medical record review identified Resident 1 (R1) as the male resident involved in the documented incident with R2.On 05/13/2026 at 1:24 PM, a Social Worker, during discussion of the incident between R2 and R1 on 01/18/2026, reported there had been no other incidents of that kind involving R1.On 05/13/2026 at 1:30 PM, the Abuse Coordinator, during discussion of the incident between R2 and R1 on 01/18/2026, reported no other sexual behavior was identified with R1 after the incident. The Abuse Coordinator reported there was only one incident of sexual behavior with R1. Record review identified three additional documented incidents of sexual and/or physical behaviors by R1, following the incident of 01/18/2026, involving three separate female residents including:Resident 7 (R7) was admitted [DATE], with diagnoses including major depressive disorder recurrent, personal history of traumatic brain injury, and post-traumatic stress disorder.On 05/14/2026 at 3:24 PM, R7 denied any incidents of unwanted physical contact involving residents or staff.On 05/14/2026 at 12:45 PM, the Activities Director and the Abuse Coordinator reported R7 was involved in a documented incident with Resident 1 (R1) on 04/23/2026. Review of R1's medical record revealed R1 approached R7 in the hallway, encroached in R7's space, R1 placed a hand on R7's knee and triggered R7 to yell for help to get R1 away from self.Resident 8 (R8) was admitted [DATE], with diagnosis including Alzheimer's disease, dementia unspecified severity with psychotic disturbance, and altered mental status.On 05/14/2026 at 3:28 PM, R8 did not speak or engage in conversation. R8 made gentle nodding motions intermittently, however, no clear acknowledgment or response to (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	questions was observed. The Activities Director explained R8 was non-verbal.A Minimum Data Set assessment dated [DATE], documented cognitive skills severely impaired. On 05/14/2026 at 12:45 PM, the Activities Director and the Abuse Coordinator reported R8 was involved in a documented incident with Resident 1 (R1) on 04/26/2026. Review of R1's medical record revealed R1 wheeled self next to R8, encroached into R8's space, placed a hand and rubbed R8's knee/leg.Resident 9 (R9) was admitted [DATE], with diagnoses including dementia unspecified severity with agitation, cognitive communication deficit, and depression.On 05/14/2026 at 3:38 PM, R9 reported being unable to recall an incident involving another resident attempting to touch R9 in an unwanted manner.A Minimum Data Set assessment dated [DATE], documented R9 had severe cognitive impairment.On 05/14/2026 at 12:45 PM, the Activities Director and the Abuse Coordinator reported R9 was involved in a documented incident with Resident 1 (R1) on 05/05/2026. R1 rolled self at a fast pace to 100 hall, grabbed R9 by the hand, and triggered R9 to curse and yell at him.Resident 1 (R1) was admitted [DATE], with diagnoses including metabolic encephalopathy, and other specified anxiety disorders.On 05/13/2026 at 9:29 AM, R1 was observed in bed lying in bed. R1 opened their eyes, lifted head and nodded yes to their name being called. R1 did not engage in conversation, looked away and closed their eyes.On 05/14/2026 at 3:33 PM, R1 was lying in bed with a blanket covering their face. R1 responded to greeting by sitting up in bed and repeatedly said thank you. R1 did not answer any questions, laid back down in bed and covered their head with a blanket.A Minimum Data Set assessment dated [DATE] documented R1's cognitive skills were severely impaired.A Behavior Note dated 10/18/2025, documented R1 exhibited sexually aggressive verbal and physical behavior towards staff. Additional record review revealed this entry was the initial documented occurrence of aggressive sexual and physical behaviors, followed by continued documented sexual and/or physical behaviors throughout R1's medical record.A Care Plan revised 11/17/2025, documented R1 had the potential of verbal aggression and inappropriate sexual behaviors towards staff, related to dementia.A Care Plan dated 01/18/2026, documented R1 had an incident of touching a female resident inappropriately.On 01/18/2026 a Facility Reported Incident report documented R1 grabbed a female resident's right breast.Additional record review for R1 revealed 12 additional documented incidents of sexual and/or physical behaviors exhibited by R1 involving staff from 03/05/2026 through 05/05/2026.The medical record lacked documented evidence interventions were reassessed, revised, or evaluated for effectiveness despite R1's continued behaviors.On 05/14/2026 at 3:30 PM, a Certified Nursing Assistant (CNA) stated R1 was not like this before. The CNA reported the resident did not previously display sexual and physical behaviors and described the behaviors as new.On 05/14/2026 in the afternoon, a Licensed Practical Nurse (LPN) and a Unit Care Coordinator, explained R1 was able to wheel around independently. The LPN reported resident showed behavior with staff and acknowledged some of the incidents documented in the medical record involved female residents.On 05/14/2026 at 12:28 PM during a telephone interview, a Psychiatric Nurse Practitioner (APRN), reported providing medication management, including non-pharmacological interventions for R1. The APRN indicated R1 was prescribed Hydroxyzine for anxiety. The APRN verbalized they could not medicate the behaviors out of the resident and the facility was responsible for monitoring R1 and implementing interventions. The APRN did not answer questions regarding their approach for R1's continued behaviors and directed the surveyor to read the APRN's notes.On 05/14/2026 at 12:45 PM, in a joint interview with the Activities Director and the Abuse Coordinator, the Activities Director described the incidents with R1 and three female residents on 04/22/2026, 04/26/2026 and 05/05/2026. The Activities Director reported the incidents were not reported to the state agency. The Abuse Coordinator explained the incidents were deemed not reportable in part due to the immediate response of the staff to separate residents. The Activities Director explained not all incidents of this nature would be reported to the psychiatric provider, as the psychiatric provider could independently search R1's medical record for information regarding incidents and behavior.On 05/14/2026 at 4:36 PM, the Abuse Coordinator reported the process of abuse coordination started upon hire at staff (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	orientation. The Abuse Coordinator explained requested all staff who witnessed abuse call the Abuse Coordinator directly and reported Social Services as well as the Unit Managers worked hand in hand to investigate abuse.A facility policy titled Abuse Prevention revised 04/01/2026, documented it was the policy of this facility to prevent and prohibit all types of abuse, neglect, misappropriation of resident, and exploitation. Identify, correct, and intervene in situations in which abuse, neglect, exploitation, and or misappropriation of resident property is more likely to occur.

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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 reassess, revise, or reevaluate the effectiveness of care plan interventions, despite continued sexual and/or physical behaviors for 1 of 6 sampled residents (Resident 1). The deficient practice had potential to result in ineffective management of continued sexual and physical intrusive behaviors.Findings include:Resident 1 (R1) was admitted [DATE], with diagnosis including metabolic encephalopathy, and other specified anxiety disorders.On 05/13/2026 at 9:29 AM, R1 was observed in bed lying in bed. R1 opened their eyes, lifted their head, and nodded yes to their name being called. R1 did not engage in conversation, looked away and closed eyes.On 05/14/2026 at 3:33 PM, R1 was lying in bed with blanket covering their face. R1 responded to greeting by sitting up in bed and repeatedly said thank you. R1 did not answer any questions, laid back down in bed and covered their head with a blanket.A Minimum Data Set assessment dated [DATE] documented R1's cognitive skills were severely impaired.A review of R1's medical record revealed four documented incidents of sexual and/or physical behaviors involving female residents, as well as 12 additional documented incidents of sexual and or physical behaviors exhibited by R1 involving staff from 01/18/2026 through 05/05/2026.A Care Plan dated 01/18/2026, documented R1 had an incident of touching a female resident inappropriately with goals and interventions listed. The Care Plan documented a revision date of 04/02/2026, entered by a Licensed Practical Nurse (LPN). The Care Plan lacked documented evidence interventions were revised or updated despite the document revision date of 04/02/2026.On 05/14/2026 at 12:28 PM during a telephone interview, a Psychiatric Nurse Practitioner (APRN), reported providing medication management including non-pharmacological interventions for R1. The APRN stated the facility was responsible for monitoring R1 and implementing interventions.On 05/14/2026 at 1:43 PM, a Licensed Practical Nurse (LPN) explained the LPN's responsibilities included revising and updating resident care plan interventions when changes were identified. The LPN confirmed entering R1's care plan revision dated 04/02/2026 and acknowledged a revision date was entered on R1's care plan, however, no interventions were added, revised or updated. The LPN was unable to explain why the revision date was entered without documented intervention changes and confirmed revision entry should have reflected intervention changes. On 05/12/2026 at 1:43 PM, the Executive Director (ED) explained care plan revisions occurred when changes to care or interventions were identified. The ED confirmed a revision date of 04/02/2026 was entered on R1's care plan without documented changes or updates to the interventions. The ED reported additional interventions had been identified for R1, including increased staffing for resident monitoring in the halls and to move the resident to a specific area following meals. The ED acknowledged the new interventions had not been added to the care plan. The ED stated the interventions may have been missed when care plan revision date was entered and confirmed the interventions should have been updated and included in R1's care plan.R1's care plan lacked documented evidence of new or updated interventions related to R1's continued sexual and physical intrusive behaviors since 01/21/2026, including increased staffing for resident monitoring in the halls and moving the resident to a specific area following meals. R1's care plan lacked documented evidence existing interventions had been reassessed or reevaluated for effectiveness.A facility policy titled Comprehensive Care Plans and Revisions reviewed 08/29/2025, documented the facility should monitor the resident over time to help identify changes in the resident condition that may warrant an update to the person-centered plan of care. When these changes occur, the facility should review and update the plan of care to reflect the changes to the care delivery, this can include additional interventions or existing problems and updating goal or problem statements.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review, the facility failed to implement, and accurately complete physician ordered behavior monitoring for agitation, sexual behavior, interventions, and outcomes for 1 of 6 sampled residents (Resident 1). The deficient practice had the potential to result in failure to identify, monitor, and manage continued sexual and physical behaviors.Findings include:Resident 1 (R1) was admitted [DATE], with diagnosis including metabolic encephalopathy, and other specified anxiety disorders.On 05/13/2026 at 9:29 AM, R1 was observed in bed lying in bed. R1 opened their eyes, lifted their head, and nodded yes to their name being called. R1 did not engage in conversation, looked away and closed eyes.On 05/14/2026 at 3:33 PM, R1 was lying in bed with blanket covering their face. R1 responded to greeting by sitting up in bed and repeatedly said thank you. R1 did not answer any questions, laid back down in bed and covered their head with a blanket.A Minimum Data Set assessment dated [DATE] documented R1's cognitive skills were severely impaired.A physician order dated 11/17/2025, documented to monitor behavior exhibited including agitation and inappropriate sexual behavior, along with interventions, instructions to chart to progress notes every shift, monitor number of behavior episodes, and outcome including improved, worsened or unchanged.A review of R1's medical record revealed 14 incidents of sexual and/or physical behavior exhibited by R1 between 03/05/2026 and 05/05/2026.A review of R1's Medication Administration Record (MAR) from 03/01/2026 through 05/13/2026 lacked documented evidence behaviors, interventions, and outcomes were monitored for 12 of the14 incidents. The MAR documented zero or not applicable.A Behavior Monitoring and Interventions Report dated 03/01/2026 through 05/14/2026 lacked documented evidence behaviors and interventions were monitored for 13 of the 14 incidents. The Behavior Monitoring and Interventions Report documented No behaviors Observed.On 05/14/2026 at 12:28 PM, a Psychiatric Nurse Practitioner (APRN), reported providing medication management including non-pharmacological interventions for R1. The APRN indicated the facility was responsible for monitoring R1 and implementing interventions.On 05/13/2026 at 1:30 PM, Executive Director (ED) reported monitoring new behaviors, changes, and redirections for R1 were discussed in facility rounds. R1 would continue to be monitored and interventions would be implemented.On 05/14/2026 at 3:12 PM, a Licensed Practical Nurse (LPN), reported familiarity with R1. The LPN explained when a physician order for behavior monitoring was in place, the electronic medical record prompted monitoring for residents. The LPN explained staff were to click on the prompt and answer yes or no to document whether behaviors were observed, as well as interventions performed and whether interventions were effective. The LPN reported the purpose for behavior monitoring was to assist physicians in creating or updating treatment plans. The LPN acknowledged monitoring should have been completed for R1 to accurately reflect the behaviors because it was an important part of resident care.On 05/14/2026 at 4:36 PM, the ED confirmed behavior monitoring was not completed for the R1 on the reviewed incident dates. The ED explained since the resident was monitored in other ways, staff may not have entered behavior under the behavior monitoring task. The ED confirmed staff should have monitored and documented behaviors on the behavior monitoring task. The ED reported behavior monitoring helped identify behavior triggers, trends, effectiveness of interventions, possible changes to medication, whether the interventions were effective, and whether the behavior continued to occur. A facility policy titled Abuse Prevention reviewed 04/01/2026, documented to identify, assess, care plan for appropriate interventions, and monitor residents with needs and behaviors which might lead to conflict or neglect, such as verbally, physically, and sexually aggressive behaviors.A facility policy titled Clinical Leadership Resource Pathway, Area of Focus: Behavior Management reviewed 12/01/2025, documented the facility would monitor the residents (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	closely including expressions or indications of distress, and accurately document the changes, including the frequency of occurrence and potential triggers in the resident's record.