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	01/09/2026

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

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 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 observation, interview, record review and document review, the facility failed to ensure a care plan intervention to provide one-on-one (1:1) feeding assistance for a resident who was assessed to be at risk for malnutrition was implemented for 1 of 40 sampled residents (Resident 19). The deficient practice had the potential to place the resident at an increased risk for malnutrition.Findings include:Resident 19 (R19) was admitted on [DATE] with diagnoses including hepatic encephalopathy, protein calorie malnutrition and altered mental status. On 01/07/2026 at 8:07 AM, R19 was seated in a chair by the bedside eating slowly and independently. R19's breakfast meal included scrambled eggs, bacon strips and milk. There were no staff members nearby or inside R19's room.A physician order dated 10/16/2025, documented to provide 1:1 feeding assistance. On 01/07/2026 at 8:24 AM, the Registered Nurse (RN) confirmed R19 had a care plan intervention to provide 1:1 feeding assistance as determined by the inter-disciplinary (IDT) team due to weight loss and poor meal intakes. The RN confirmed R19 was eating alone in the room with no staff present. The RN stated R19 did not have swallowing difficulties but had poor meal intakes which was why the resident was placed on 1:1 feeding. The RN confirmed R19's care plan was not followed.On 01/07/2026 at 8:26 AM, a Certified Nursing Assistant (CNA) indicated being steadily assigned to R19. The CNA stated R19 did not require feeding assistance but set up for meals and occasional supervision since R19 was able to eat independently. The CNA explained 1:1 feeding assistance meant staff needed to be with the resident from set up to meal completion while actively feeding the resident. The CNA was not aware R19 had a care plan intervention for 1:1 feeding assistance.On 01/07/2026 at 8:48 AM, the Registered Dietitian (RD) explained the dietary team was closely monitoring R19 due to a history of significant weight loss. The RD stated R19 was to be provided with 1:1 feeding assistance for all meals even if recent weights were stable, the meal intakes had improved, and body mass index (BMI) went up to 14.5 because R19 was still underweight. The RD indicated this was the first time the dietary team learned the CNA steadily assigned to R19 was not providing 1:1 feeding assistance but set up assistance.On 01/07/2026 at 8:55 AM, the RD confirmed R19's care plan intervention to provide 1:1 feeding assistance was not implemented.The comprehensive care plan policy reviewed 08/29/2025, documented the facility monitored the resident over time to help identify changes in the resident condition that may warrant an update to the person-centered care plan.The Person-Centered Care Planning revised 08/29/2025, documented the facility developed a person-centered care plan to attain or maintain the resident's highest practicable well-being and prevent avoidable decline. The care plan was developed and implemented to ensure consistency across all shifts.

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure physician orders were followed to provide one-on-one (1:1) feeding assistance for a resident assessed to be at risk for malnutrition for 1 of 40 sampled residents (Resident 19). The deficient practice had the potential to place the resident at an increased risk for malnutrition.Findings include: Resident 19 (R19) was admitted on [DATE] with diagnoses including hepatic encephalopathy, protein calorie malnutrition and altered mental status. On 01/06/2026 in the morning, R19 responded with nonsensical speech (used words, phrases with no meaning). R19 had a gaunt face (appearing thin, bony and hollow with sunken cheeks).On 01/07/2026 at 8:07 AM, R19 was seated in a chair by their bedside eating breakfast slowly and independently. The breakfast meal included scrambled eggs, bacon strips and milk. There were no staff members nearby or inside R19's room one-on-one (1:1) feeding assistance with the meal.R19's meal ticket indicated R19 was on a regular diet, regular texture and thin liquids with beverage of choice.A physician order dated 10/16/2025, documented to provide 1:1 feeding assistance. On 01/07/2026 at 8:24 AM, the Registered Nurse (RN) confirmed personally entering R19's orders for 1:1 feeding assistance on 10/16/2025 after attending the inter-disciplinary (IDT) team which determined R19 would have benefited from 1:1 feeding assistance due to weight loss and poor meal intakes. The RN confirmed R19 was eating alone in room with no staff present. The RN stated R19 did not have swallowing difficulties but had poor meal intakes which was why the resident was placed on 1:1 feeding. The RN emphasized the order for 1:1 feeding assistance was active and had not been discontinued.On 01/07/2026 at 8:26 AM, a Certified Nursing Assistant (CNA) indicated being steadily assigned to R19. The CNA stated R19 did not require feeding assistance but meal setup and occasional supervision since R19 was able to eat independently. The CNA explained 1:1 feeding assistance meant staff needed to be with the resident from set up to meal completion while actively feeding the resident. The CNA was not aware R19 had a care plan intervention for 1:1 feeding assistance and acknowledged this order was not followed.A nutrition note dated 10/08/2026, documented R19 had a significant weight loss of five pounds or 5.1 percent (%), over 30 days. Average meal intakes ranged from 47% to 75%. New interventions included nutritional treat with meals, Med pass (a dietary supplement) twice daily and Megace (an appetite stimulant).A nutrition note dated 10/22/2026, documented R19 had a significant weight loss of three-pound or 3.2 %, over seven days. Average meal intakes ranged from 53% to 76%. New interventions included 1:1 feeding assistance initiated on 10/16/2025 to promote adequate meal intake.A change of condition note dated 11/18/2025, R19 had a significant weight loss of 26 pounds or 23 %, over 180 days. R19 weighed 87 pounds and had a body mass index (BMI) of 14.0 (normal range: 18 to 25). R19 was underweight related to decreased caloric intake.On 01/07/2026 at 8:48 AM, the Registered Dietitian (RD) explained the dietary team was closely monitoring R19 due to a history of significant weight loss. The RD stated R19 was to be provided with 1:1 feeding assistance for all meals even if recent weights were stable, the meal intakes had improved, and BMI went up to 14.5 because R19 was still considered underweight. The RD indicated this was the first time the dietary team learned the CNA steadily assigned to R19 was not providing 1:1 feeding assistance but set up assistance.On 01/07/2026 at 8:55 AM, the RD verbalized 19 should continue to receive 1:1 feeding assistance which was still an active order.The Feeding a Resident policy revised 07/17/2021, documented a resident who was unable to carry out activities of daily living (ADLs) would receive necessary services to maintain good nutrition, based on the comprehensive assessment.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, document review, the facility failed to ensure information gathered by hospice staff related to the resident's hospice recertification reflected the improving nutritional status for a resident with a primary hospice diagnosis of protein-calorie malnutrition for 1 of 40 sampled residents (Resident 177). The deficient practice had the potential to deprive the resident of a higher level of medical care outside hospice services. Findings include:Resident 177 (R177) was admitted on [DATE] and readmitted on [DATE], with diagnoses including protein-calorie malnutrition and hospice status.The Hospice-Nursing Facility Agreement signed 10/01/2025, documented hospice and facility shall communicate with one another regularly and as needed for each hospice resident. Each party was responsible for documenting such communications in its respective clinical record. On 01/07/2026 at 8:02 AM, a certified nursing assistant (CNA) was observed providing feeding assistance to R177. The breakfast meal included scrambled eggs, bacon strips, milk, fortified cereal, and vanilla ice cream. During the meal, R177 told the CNA, More bacon. On 01/07/2026 at 8:04 AM, the CNA stated R177 had consumed 100 percent (%) of the breakfast meal and was finishing the vanilla ice cream. The CNA indicated R177 was a hospice resident and required one-on-one (1:1) feeding assistance due to malnutrition. The CNA explained R177's meal intake varied but lately the resident had been consuming 100% of most meals.On 01/07/2026 at 2:27 PM, R177 with clear speech R177 asked the surveyor for a snack because R177 was hungry. A CNA who was closely behind responded that a sandwich had been requested from the kitchen and was on its way. A certification of terminal illness (CTI) revealed R177 was enrolled into the hospice program for period 09/29/2025 to 12/27/2025 with a primary diagnosis of protein-calorie malnutrition. On 01/07/2026 at 2:28 PM, a Licensed Practical Nurse (LPN) assigned to R177 indicated the resident was recertified by the hospice provider on 12/28/2025 and a copy of the updated CTI had been requested from the hospice provider.A quarterly nutrition data collection completed on 12/30/2025, referenced an inter-disciplinary (IDT) team meeting held on 12/03/2025 which revealed R177 had a weight gain of five pounds or a 5.4 percent (%) over a 30-day period. R177 weighed 93 pounds on 11/03/2025 and 98 pounds on 12/02/2025. Average meal intakes were 64% to 85% each meal. The weight gain was considered significant, beneficial and planned.On 01/08/2026 at 11:00 AM, the Director of Clinical Operations (DCO) for the hospice provider indicated R177 was admitted into the hospice program on 07/01/2025 with a primary diagnosis of protein- calorie malnutrition. A hospice nurse practitioner (NP) had a face-to-face encounter with R177 on 12/18/2025 for the purpose of upcoming recertification for the third benefit period beginning 12/28/2025.On 01/08/2026 at 11:10 PM, the DCO indicated R177 was recertified for the third benefit period due to information gathered by the hospice NP which revealed R177 had poor appetite and was consuming one meal a day at 50% to 100%. R177 was experiencing weight loss, appeared cachectic (wasting syndrome), was in decline and only spoke in one or two words. R177 would continue to benefit from hospice services due to decline and was expected to continue to decline. On 01/08/2026 at 11:15 AM, the DCO indicated not being aware R177 had a significant weight gain of five pounds or 5.4 % identified by the IDT before the hospice NP's visit on 12/18/2025. The DCO indicated recorded meal consumptions by the facility indicated R177 was consuming 64% to 85% of each meal. A meal observation of R177 consuming 100% of the morning meal and a clear request for a snack in the afternoon did not align with the hospice NP's information. This resulted in the medical director's recertifying R177 for a new benefit period from 12/28/2025 to 02/25/2026. The DCO stated if the hospice nurse and NP gathered information pertinent to R177's diagnosis of protein-calorie malnutrition, there was a possibility the medical director may not have decided to recertify R177 into the hospice program.On 01/08/2026 at 11:30 AM, two nutrition coordinators indicated hospice staff had not reached out to the dietary team regarding R177's (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nutritional status.On 01/08/2026 at 11:40 AM, the Registered Dietitian (RD) indicated hospice staff had not reached out to the RD regarding R177's nutritional status.On 01/08/2026 at 12:22 PM, the Director of Nursing (DON) confirmed the hospice visit note dated 12/18/2025 was for the purpose of R177's recertification for a new benefit period. The DON confirmed R177 had significant weight gain of 5.4% from 11/03/2025 to 12/01/2025, and this information was available to hospice personnel prior to the face-to-face encounter by the hospice NP. The DON expected the hospice personnel to gather information from the appropriate member of the IDT, which in this case should have been the nurses, the RD and the dietary team because they would have been more knowledgeable regarding the resident's nutritional status and whether it was improving or declining. On 01/08/2026 at 12:58 PM, the Executive Director (ED) indicated the hospice provider assumed primary oversight of residents under hospice care while the facility would provide room and board. The ED explained the agreement specified responsibilities of hospice and the facility along with proper coordination of care. According to the ED, based on the agreement the hospice and the facility were expected to communicate regularly, and each party was responsible for documenting communication in respective records. On 01/09/2026 at 11:10 AM, a hospice registered nurse (RN) indicated being employed by the hospice provider for four months and visited R177 once a week. The RN was not aware R177 had improved meal intakes because the RN was present for one lunch observation where R177 consumed only 50% of the meal. The RN indicated not being aware R177 had significant weight gain because the RN had not spoken to the dietary team.The facility's hospice coordination of care policy (revised 09/03/2025) documented hospice care was provided under a written agreement. Hospice representatives coordinated with facility staff during care planning. The facility communicated with the hospice medical director, attending physicians, and other practitioners, and obtained the following: hospice plan of care, hospice election form, physician certification/recertification of terminal illness, and physician's orders.