STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295055	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
College Park Rehabilitation Center	2856 E. Cheyenne Ave. North Las Vegas, NV 89030

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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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on document review and interview, the facility failed to ensure residents mail were delivered on Saturdays for 1 of 23 sampled residents (Resident 12) and 2 unsampled residents (Residents 54 and 57). The deficient practice had the potential for residents' mail not to be delivered on the weekend. Findings include:1) Resident 12 (R12) was admitted to the facility on [DATE] with diagnoses of acute and chronic respiratory failure with hypoxia, metabolic encephalopathy, and other specified sepsis.R12 had a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition. 2) Resident 54 (R54) was re-admitted to the facility on [DATE] and was a long-term care resident.3) Resident 57 (R57) was re-admitted to the facility on [DATE] and was a long-term care resident.On 09/18/2025 in the morning, during a resident council meeting, R12 indicated mail was not delivered to residents on Saturdays. If mail were delivered to the facility on Saturday, the residents would have to wait until Monday to get the mail. R54 and R57 indicated residents did not receive mail from the post office on Saturday. R54 indicated orders from Amazon were delivered to resident rooms. On 09/18/2025 at 2:18 PM, the Social Services Director (SSD) explained the mail person delivered the mail to the front desk. The front desk Receptionist would give the mail to the Business Office Manager (BOM) to sort. The BOM sorted the mail between facility mail and resident mail. Then the BOM called the SSD to collect the mail. Once the SSD received the mail, the SSD delivered the mail to the residents. The SSD revealed any mail which came on Saturday would be held until Monday until the process would be restarted.On 09/18/2025 at 3:11 PM, the Administrator stated the receptionist would separate the mail delivered on Saturdays for the facility and residents. After the mail was sorted, the activity staff would be notified to deliver the mail to the residents. On 09/18/2025 at 3:51 PM, the Activity Director (AD) stated activity staff had not delivered resident mail since the AD had been working at the facility. The AD explained the SSD was responsible for delivering resident mail on weekdays and thought the charge nurse had the responsibility on Saturdays.On 09/18/2025 at 4:05 PM, the Charge Nurse affirmed resident mail had not been given to nursing to distribute to the residents on Saturdays.The facility policy titled Communication, Effective - Resident Right For, revised on 06/09/2023, indicated the facility-designated individual delivered mail to the residents on the date it was received.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that mattresses and equipment used in resident rooms were maintained in a clean and sanitary condition for 2 resident rooms observed (rooms [ROOM NUMBERS]). The deficient practice had the potential to contribute to an environment that was not homelike and posed a risk for cross-contamination and infection for residents.Findings include:On 09/17/2025 at 10:00 AM, during an inspection of resident room [ROOM NUMBER], two floor mattresses were observed placed bilaterally on the floor near a resident's bed, close to the door, and a pole used to hang gastrostomy feeding formula was located on the right side of the bed. The mattresses and the pole were visibly soiled with dried feeding formula residue, dust, and other unidentified stains.On 09/17/2025 at 10:40 AM, during an inspection of Resident room [ROOM NUMBER], a floor mattress was observed on the left side of the bed near the window. The mattress was visibly soiled with dust and other unidentified stains.On 09/18/2025 at 8:30 AM, the floor mattresses and the pole remained unchanged in resident room [ROOM NUMBER] and 41. A Registered Nurse (RN) and the Infection Preventionist (IP) were present and confirmed the observations. The IP stated the mattresses, and pole should have been cleaned daily and as needed, especially when formula or other fluids were spilled. The IP acknowledged that failure to maintain cleanliness could lead to cross-contamination and attract pests.On 09/19/2025 at 1:18 AM, the Environmental Services Supervisor explained residents' rooms were cleaned twice daily and as needed. The Supervisor indicated the floor mattresses should have been cleaned as part of the housekeeping task and nurses should have cleaned the pole.The facility policy titled Patient/Resident Room Cleaning/Bathroom Cleaning dated 10/03/2006 documented a routine procedure that would be performed to clean and disinfect resident rooms and their bathroom to provide a clean, safe decontaminated environment for all the residents.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review, the facility failed to ensure a copy of the discharge notice was sent to a representative of the Office of the State Long-Term Care Ombudsman for 1 of 23 sampled residents (Resident 11). The deficient practice had the potential for resident rights not being advocated for improper discharges.Findings include:Resident 11was re-admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy, cellulitis of abdominal wall, gastrostomy malfunction, and pain.R11 had a Brief Interview for Mental Status (BIMS) score of 0 indicating severe cognitive impairment. The facility was not able to provide records of the resident's discharge notice having been sent to a representative of the Office of the State Long-Term Care Ombudsman when the resident was sent to the hospital.On 09/19/2025 at 3:32 PM the Social Services Director (SSD) was not aware discharge notices for residents who had been discharged to a hospital had to be submitted to the Ombudsman's office. The SSD thought discharge notices for residents who had been discharged to the community were to be sent to the Ombudsman's office.On 09/19/2025 at 3:36 PM, the Administrator confirmed the SSD should have been sending all discharge notices, regardless of the discharge destination, to the Ombudsman's office. A facility policy titled Discharge Notification, revised on 05/09/2025, indicated the Social Services Staff/ or designee was charged with ensuring systems were in place to provide written notification of transfer or discharge to the resident and, if known, a family member or legal representative prior to the resident's transfer/discharge and the Long-Term Care Ombudsman. The notifications must be documented in the residents' medical record. The transfer/discharge notice must have complied with federal and state regulations.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and document review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessment for 1 of 20 sampled residents (Resident 4), by inaccurately coding a psychiatric diagnosis. This deficient practice had the potential to have a negative impact on the residents' care planning, and the coordination and delivery of services.Findings include: The Minimum Data Set (MDS) was a standardized assessment tool used to assess the clinical needs and functional capabilities of individuals residing in a skilled nursing facility.Resident 4 (R4) was admitted to the facility on [DATE] with diagnoses including dementia, depression, and schizophrenia.A Psychiatric Consult note dated 02/27/2025 documented a diagnosis of schizoaffective disorder bipolar type.A Nursing Progress Note dated 05/06/2025 indicated R4 was transferred to the hospital for gastrostomy tube (G-tube) re-placement.The MDS Discharge assessment dated [DATE] listed schizophrenia as the only psychiatric diagnosis and non-Alzheimer's dementia as a neurological diagnosis. The assessment did not include bipolar disorder as a diagnosis, despite the earlier psychiatric documentation.The medical record revealed R4 returned to the facility on [DATE]. The hospital Discharge summary dated the same day listed a history of schizophrenia but did not include bipolar disorder.The MDS Quarterly assessment dated [DATE] newly documented diagnosis of bipolar disorder. However, R4's medical record lacked evidence of a psychiatric evaluation or physician documentation supporting the diagnosis.On 09/18/2025 at 2:24 PM, a Social Services Assistant (SSA) stated R4 was admitted to schizoaffective disorder, bipolar type, but had not been diagnosed with bipolar disorder alone. The SSA acknowledged the bipolar diagnosis in 08/06/2025 MDS appeared to be an error.On 09/19/2025 at 10:00 AM, the MDS Coordinator confirmed R4 did not have a current diagnosis of bipolar disorder, and the entry in the 08/06/2025 MDS was likely a data entry error. The facility's policy titled Minimum Data Set (MDS), last revised 09/28/2023, stated the facility was responsible for addressing all resident needs and that staff were accountable for the accuracy of data entered into the MDS.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review, the facility failed to ensure a baseline care plan was initiated after a resident was admitted for 1 of 23 sampled residents (Resident 104). The deficient practice had the potential to place residents at risk for inappropriate care, supervision, and other incidents.Findings include:Resident 104 (R104) was re-admitted to the facility on [DATE] with diagnoses including other sequelae of other cerebrovascular disease, metabolic encephalopathy, non-ST elevation myocardial infarction, atherosclerotic heart disease, hemiplegia and hemiparesis.The hospital discharge records documented R104 was to be transferred to a nursing facility with hospice for end-of-life care.A Nursing Progress Notes on 05/13/2025 at 5:28 PM revealed the resident was seen by the hospice nurse who stated the resident was officially under hospice now, and the family were already informed and signed the consents.A hospice company consent was signed by the family representative on 05/14/2025 and the hospice staff on 05/13/2025 with the effective date of 05/13/2025.The facility lacked documentation, a baseline care plan was initiated which included hospice care or services. On 09/19/2025 in the morning, the Medical Records Director was unable to find documentation of a baseline care plan which included hospice care or services.On 09/19/2025 at 1:33 PM, the Assistant Director of Nursing (ADON) stated once the resident was on hospice, the hospice provider would provide the facility with a binder which contained the resident's care plan. The facility would then update their care plans in the residents' medical record so the two care plans would be aligned. A facility's policy titled Care Plan Process, Person-Centered Care, revised on May 5, 2023, documented the facility would develop and implement the baseline person-centered care plan within 48 hours of a resident's admission which would include the minimum healthcare information necessary to properly care for the resident including, but not limited to initial goals based on admission orders, dietary orders, therapy services, social services, and PASARR (Pre-admission Screening and Resident Review) recommendations, if applicable.

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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 observation, interview, record review and document review, the facility failed to ensure that 1 of 20 sampled residents (Resident 1) had an updated comprehensive person-centered care plan. The deficient practice had the potential to place residents at risk of not receiving the appropriate care. Findings include:Resident 1 (R1) was admitted on [DATE] with a diagnosis of Parkinson's disease with dyskinesia.On 09/17/2025 at 10:00 AM, observed R1 with a mitten on the right hand. A Physician Order dated 07/08/2025, documented R1 to have a right-hand mitten to prevent resident from pulling out tubing's for 14 days. A Physician Order dated 07/23/2025, documented for R1 to have a right-hand mitten to prevent resident from pulling out tubing's for 14 days. A Behavior Note dated 07/10/2025, documented R1 had disconnected self from ventilator four times in 20 minutes and was observed pulling at tracheostomy once and was disconnected. A Progress Note dated 07/22/2025, documented the respiratory therapist (RT) was alerted to R1's room because the ventilator alarm was going off. R1 pulled off the ventilator circuit and removed the pulse oximeter sensor off.A Progress Note dated 08/17/2025, documented the respiratory therapist (RT) noted R1 had pulled the closed suction catheter off and had disconnected self from the ventilator. On 09/17/2025 at 3:42 PM, a Registered Nurse (RN), stated the facility did utilize restraints. The facility used mittens to protect the residents from pulling on their tubes, ventilators, tracheostomy or wires. On 09/17/2025 at 2:50 PM, a Registered Nurse (RN) provided a hard copy of R1's care plan, which showed the care plan was created on 09/17/2025 for the hand mittens.On 09/18/2025 at 8:40 AM, the Assistant Director of Nursing (ADON), stated when a resident had a change in condition or new physician orders were placed the resident's care plan was updated. The ADON verified that R1's care plan was not updated at the time when the mitten order was placed and clarified the care plan was created on 09/17/2025 and should have been updated once the order was placed on 07/08/2025 and on 07/23/2025.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review, and document review, the facility failed to ensure heel protective devices were implemented for 1 of 20 sampled residents (Resident 22). This deficient practice had the potential to contribute to the development or worsening of pressure injuries, pain, and impaired skin integrity.Findings include: Resident 22 (R22) was admitted on [DATE] with diagnoses including atrial fibrillation, congestive heart failure, diabetes mellitus, and non-ST elevation myocardial infarction (NSTEMI).A Wound Management Record dated 03/20/2025 documented a left heel pressure ulcer (PU).The Pressure Ulcer Scale for Healing (PUSH) chart dated 03/20/2025 recorded left hell PU length of 0.7 centimeters (cm) and width of 1.0 cmA Braden Scale assessment dated [DATE] identified R22 as being at moderate risk for pressure ulcer development. The care plan dated 07/25/2025 documented interventions for pressure injury prevention, including the use of a low air loss mattress, daily mattress setting checks, repositioning using draw sheets or similar devices, and use of pillows or pads to offload pressure from bony prominences.A Physician Order dated 05/05/2025 directed staff to apply heel protectors, check placement daily, and replace as needed.On 09/16/2025 at 10:45 AM, R22 was observed in bed without heel protectors in place.On 09/17/2025 at 3:50 PM, a Registered Nurse (RN) confirmed R22 was not wearing heel protectors and acknowledged a physician order to protect the heels while the resident was in bed.On 09/17/2025 at 4:00 PM, a Wound Care Physician (WCP) confirmed R22 had a Stage 3 pressure ulcer on the left heel. The physician stated heel protectors were ordered to prevent further deterioration and should be applied whenever the resident was in bed.The facility's policy titled Movement or Management of Tissue Load, last revised 09/07/2017, emphasized the importance of reducing pressure on heels and elbows due to their small surface area, especially for residents at risk for pressure ulcer development.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure residents were free from medication errors exceeding 5 percent during observed medication administration passes. Three errors were identified out of 25 medication administration opportunities, resulting in a medication error rate of 12 percent. This deficient practice had the potential to result in reduced therapeutic effectiveness, adverse drug reactions, and compromised resident safety.Findings include:1) On 09/18/2025 at 8:15 AM, a medication administration observation was conducted with Registered Nurse (RN1) and Resident 13 (R13). RN1 administered Fluticasone 200 micrograms (mcg), 1 puff via inhalation (a steroid nasal spray used to treat allergy symptoms), to R13. RN1 did not direct R13 to rinse their mouth with water following administration.A Physician Order dated 07/02/2025 specified Fluticasone 200 mcg, 1 puff once daily for chronic obstructive pulmonary disease, with special instructions to rinse the mouth with water after administration and not to swallow.On 09/18/2025 at 11:00 AM, RN1 acknowledged the omission and confirmed that Fluticasone could cause oral fungal infections if the mouth was not rinsed after use.2) On 09/18/2025 at 8:15 AM, a medication administration observation was conducted with Registered Nurse (RN2) and Resident 49 (R49). RN2 administered:- Aspirin 81 milligrams (mg) in chewable form. The Physician Order dated 12/08/2024 specified Aspirin delayed-release/enteric-coated 81 mg once daily for cerebral infarction.- Vitamin D3, 1 tablet, the Physician Order dated 01/08/2025 directed 2 tablets (25 mcg each) once daily for vitamin D deficiency.On 09/18/2025 at 11:10 AM, RN2 acknowledged the discrepancies and stated the physician orders should have been verified prior to administration.The facility's policy titled Medication Management Program, last revised 01/15/2025, directed staff to validate the physician order, match the medication and label with the Medication Administration Record (MAR), and read the medication label before removing it from the drawer, and again before and after administration to ensure the correct administration of medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and document review, the facility failed to ensure that raw food, residents and staff food was stored by guidelines and facility policies. This deficient practice had the potential to contaminate and spread bacterial growth. Findings include: On 09/16/2025 at 8:10 AM, prep refrigerator had employee food stored inside, which contained a container of blueberries and a protein drink. On 09/16/2025 at 8:21 AM, walk-in refrigerator had employee food stored inside with contents containing a container of kimchi, an avocado and a cucumber.On 09/16/2025 at 8:22 AM, walk-in refrigerator had a box of raw shrimp, raw chicken and raw turkey stored above of cooked food.On 09/16/2025 at 8:23 AM, the Assistant Kitchen Manager voiced that raw meats should not be placed above any cooked food and employee food was not allowed where resident foods were stored.On 09/16/2025 at 8:30 AM, the Administrator expressed employees were not allowed to store personal food items in the kitchen refrigerators. The Administrator explained that employees were to store personal food items in the employee refrigerator, located in the employee breakroom. The facility policy titled Food Safety in Receiving and Storage, dated 06/20/2023, documented store raw animal foods by placing on shelves in order of cooking temperatures with the food requiring the highest cooking temperature, such as chicken, on the lowest shelf. The facility policy titled Safe Food Handling, dated 06/20/2023 documented all foods and beverages in the facility that belong to employees were stored in employee refrigerators or other designated areas and labeled with the employee's name and the date the item was placed in the facility storage area.