STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295070	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Plaza Regency Post Acute Rehab	6021 W. Cheyenne Ave. 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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review, the facility failed to ensure adequate supervision and appropriate postˆfall assessment following an unwitnessed fall of a resident identified as high risk for falls. The facility failed to recognize and respond in a timely manner to a significant change in condition, did not initiate required frequent and systematic neurological assessments, and did not ensure timely medical evaluation for 1 of 7 sampled residents (Resident 1). This deficient practice resulted in a delay in the identification and treatment of a serious head injury, as evidenced by findings of a left subdural hematoma (blood collecting between the brain and its covering on the left side) and subarachnoid hemorrhage (bleeding in the space around the brain), resulting in actual harm to the resident. Findings include:Resident 1 (R1) was admitted on [DATE], with diagnoses including cerebrovascular accident (CVA), intracranial hemorrhage (ICH), osteoarthritis, hypertension, and bilateral knee replacement.A Nursing Progress Note dated 11/20/2025, documented R1 was alert and oriented to person and place with periods of confusion. R1 had a history of dementia, cerebrovascular accident (CVA), intracerebral hemorrhage (ICH), osteoarthritis, congestive heart failure (CHF), hypertension, diabetes mellitus, and bilateral knee replacement. R1 was noted to have left knee swelling with limited range of motion.A Nursing admission assessment dated [DATE] documented R1 had a history of falls, including a fall within the month prior to admission, a fall within the previous 2-6 months, and a fracture related to a fall within the 6 months prior to admission.A Care Plan dated 11/21/2025 documented R1 was at risk for falls related to decreased mobility associated with infected knee hardware, pain requiring narcotic use, and a history of falls. R1 required assistance with mobility, including positioning, transfers, and ambulation, due to decreased mobility and weakness. Interventions included oneˆperson assistance and keeping commonly used items within easy reach.A Minimum Data Set, dated [DATE], documented the admission assessment reflected a Brief Interview for Mental Status score of 14, indicating R1's cognitive status was intact.Nursing Progress notes dated 12/12/2025 through 12/15/2025 documented R1's baseline mentation prior to the fall was alert and oriented to person, place, and time, pleasant, cooperative, and without neurological concerns.A Fall/Post Fall assessment dated [DATE], documented R1 was found on the floor in their room at 6:05 AM, lying on their back in a dark room, with the call light activated. R1 was unable to see where to go.The Situation, Background, Assessment, Recommendation (SBAR) dated 12/16/2025 at 4:09 PM, documented R1 received Oxycodone 10 mg, and was subsequently noted to be confused and disoriented, with continued confusion later in the evening. The physician was notified, and Oxycodone was discontinued, with a new order for Tramadol received.A Nursing Progress Note dated 12/17/2025 at 6:59 AM, the documented R1 was monitored overnight and continued to exhibit delirium and confusion.The SBAR dated 12/17/2025 at 1:00 PM, documented R1 was confused, lethargic, and forgetful following the fall on 12/16/2025, with decreased awareness of surroundings and refusal to eat. R1's family member requested transfer to the hospital, and the nurse practitioner approved the transfer for further evaluation.A Skilled Nursing Progress Note dated 12/17/2025 at 2:23 PM, documented R1 was alert but disoriented, lethargic, non-responsive at times, unable to hold (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	conversation, and exhibited hallucination-like behaviors, with poor oral intake and decreased participation in therapy.On 04/13/2026 at 10:30 AM, a Registered Nurse (RN) assigned to the 100 hall, indicated upon admission, staff assessed fall risk by reviewing the residents' history and obtaining information from the residents or family, and implemented appropriate interventions. Following an unwitnessed fall, staff performed a body assessment, notified the physician and family, and followed physician orders. The RN indicated when signs of head injury were reported or observed, staff initiated neurological assessments and notified the physician for possible transfer for a head computed tomography (CT) scan.On 04/14/2026 at 2:10 PM, a nightˆshift Registered Nurse (RN) recounted on 12/16/2025 at approximately 6:00 AM, they were preparing to administer R1's medications before the end of the shift. The RN reported R1's room door was closed, and upon entering, the room was dark, the callˆlight indicator was activated, and the callˆlight button was found on the floor. The RN recalled finding R1 on the floor lying on their back, slightly to the side, with their head positioned near the dresser, following an unwitnessed fall. The RN indicated R1 had likely attempted to ambulate to the bathroom without assistance and denied hitting their head. The RN reported R1's baseline was alert and oriented, with occasional forgetfulness, and that R1 required assistance with transfers and ambulation due to knee limitations. The RN indicated an SBAR and neurological assessment were not initiated at the time of the fall; however, a fall assessment was completed, and the nurse practitioner and family were notified. The RN confirmed R1 developed increased confusion, lethargy, and poor oral intake following the fall and was transferred to the hospital the next day at the family's request.On 04/14/2026 in the afternoon, a dayˆshift Registered Nurse (RN) indicated they had received report regarding R1's unwitnessed fall on 12/16/2025 at 6:05 AM. The RN indicated, per report, R1 denied hitting their head and no neurological assessment was initiated; however, increased confusion and lethargy were later observed. The RN indicated the change in R1's condition was reported to the Nurse Practitioner (NP), and Oxycodone was changed to Tramadol. The RN indicated R1's condition continued to worsen on 12/17/2025 and indicated that, given R1's condition, more aggressive orders or interventions should have been considered.The RN confirmed the Nurse Practitioner (NP) evaluated R1 on 12/17/2025 in the morning, no CT scan was ordered, and laboratory tests were ordered for completion on 12/18/2025. The RN indicated the family visited on 12/17/2025 and requested a transfer due to R1's worsening condition. R1 was transferred to the hospital per family request.On 04/14/2026 at 4:35 PM, a Physician Assistant (PA) indicated the primary concern following a fall was resident safety. The PA indicated increased confusion and altered mental status following a fall represented a significant change in condition and constituted an emergency, particularly when the fall was unwitnessed. The PA indicated standard clinical practice required immediate evaluation, including ordering a STAT CT (An immediate Computed Tomography or head scan done without delay to check for brain injury or bleeding) without contrast to rule out intracranial injury.On 04/15/2026 at 10:30 AM, the NP indicated R1 had baseline periods of forgetfulness prior to the fall, with intermittent confusion noted during longer interactions, but was able to answer simple questions appropriately. The NP indicated following notification of the unwitnessed fall on 12/16/2025, the standard process included determining whether R1 hit their head and was on anticoagulants. The NP considered R1's confusion was attributed to multiple factors, including diagnoses and medication effects, and Oxycodone was changed to Tramadol. The NP indicated a STAT CT scan of the head was not ordered because R1 denied a head strike, was not on anticoagulants, and did not demonstrate findings during assessment that suggested intracranial injury.The NP indicated laboratory tests were ordered on 12/17/2025, for completion on 12/18/2025, and no immediate imaging or transfer was initiated based on assessment findings. The NP indicated there was no plan to transfer R1 to the hospital due to pending laboratory tests, and the plan was to await completion of the ordered tests and review of results prior to further intervention. The NP indicated transfer to the hospital occurred on 12/17/2025, after continued R1's confusion and lethargy per family request.The NP indicated in the case of an unwitnessed fall, it was unknown (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	whether the resident sustained a head injury. The NP indicated staff were expected to initiate neurological assessments when a change in condition was present following an unwitnessed fall. The NP indicated neurological assessments differed from routine vital signs, as they required more frequent monitoring and a more in-depth evaluation of neurological status.The NP indicated if a resident struck their head and developed intracranial bleeding, it could result in neurological changes, including increased confusion and lethargy, and required prompt evaluation and intervention. The NP acknowledged that failure to address intracranial bleeding in a timely manner could lead to poor outcomes, depending on the severity and location of the bleed. The NP indicated potential outcomes could include significant harm or death if the condition was not promptly identified and treated.On 04/15/2026 at 2:50 PM, the Residential Care Manager (RCM) indicated facility protocol required initiation of a neuro assessment following an unwitnessed fall, consisting of every 15 minutes for the first hour, then hourly, and then every two hours thereafter. The RCM indicated neuro assessments were documented on a neuro assessment form separate from vital signs records. The RCM confirmed no neuro assessment was initiated or documented for R1 following the unwitnessed fall despite continued confusion.On 04/15/2026 in the afternoon, the Assistant Director of Nursing (ADON) indicated staff were expected to monitor R1 and report changes in condition following the unwitnessed fall on 12/16/2025. The ADON indicated increased confusion and lethargy were identified, but documentation did not reflect consistent neurological assessment. The ADON indicated neuro assessments were separate from routine vital signs and required specific documentation.On 04/15/2026 in the afternoon, a Physical Therapist Assistant (PTA) indicated familiarity with R1. The PTA indicated R1 required supervision for ambulation and was not safe to ambulate independently. The PTA indicated an unsupervised ambulation, especially in a dark environment increased the risk for falls.A hospital Transfer Summary dated 11/20/2025, documented a CT scan of the head revealed a chronic infarct with no evidence of acute intracranial bleeding.On 04/15/2026 at 10:50 AM, the NP confirmed R1's prior CT head findings reflected a chronic infarct, which represented a previous condition and not an active or acute process. The NP indicated that a chronic infarct did not represent active bleeding and confirmed there was no acute intracranial bleeding identified prior to the resident's admission to the facility. The NP indicated acute findings would represent new or recent changes and clarified the resident's prior imaging did not demonstrate any acute bleeding at the time of admission.On 04/15/2026 in the afternoon, the ADON confirmed R1's baseline CT prior to admission at the facility on 11/20/2025, documented as remarkable and showed no intracranial bleeding.The Nursing Progress Note dated 12/17/2025 at 4:56 PM, documented R1 was sent to the hospital. The facility Discharge summary dated [DATE] documented R1 sustained a fall on 12/16/2025 and denied head strike at the time. Following the fall, R1 exhibited increased confusion, lethargy, inability to hold conversation, and decreased oral intake. R1 remained disoriented, sleepy but arousable, and continued to demonstrate confusion. Per family request due to worsening conditions, R1 was transferred to the hospital on [DATE], for further evaluation.The Emergency Department records dated 12/17/2025 documented R1 presented from the facility following an unwitnessed fall on 12/16/2025, with subsequent confusion and altered mental status, and noted sudden worsening of mental status and bruising to the left cheek concerning for head strike; a CT scan of the head revealed a 4 mm left subdural hematoma (blood collection on the left side of the brain) and posterior left temporal subarachnoid hemorrhage (bleeding around the back-left part of the brain) with no significant mass effect (no pressure on the brain).A facility policy titled Managing Falls and Fall Risk dated 11/2022, indicated staff were required to monitor and document the resident's response following a fall and reassess and revise interventions when a fall occurred or condition changed.A facility policy titled Neurological Assessment - Level III (undated), indicated neurological assessments were to be performed upon physician order, following a fall involving head trauma, or with a change in condition. The policy indicated staff were to conduct frequent neurological checks and vital signs, monitor for lethargy, decreased level of consciousness, and weakness, and report any change in neurological status to the physician immediately.Complaint numbers 2742199 and 2730297