STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295076	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of South Las Vegas	2325 E. Harmon Ave. Las Vegas, NV 89119

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review, the facility failed to ensure a discharge was completed including a home health referral was accepted by an agency prior to discharging for a resident requiring wound dressing changes for one of five sampled residents (Resident 2). The deficient practice placed the resident at risk for wound complications including infection. Findings include: Resident 1 (R1) was admitted on [DATE] with diagnoses of cellulitis of right lower limb and polyneuropathy.A physician's order dated 04/01/2026 documented the resident may to discharge home on [DATE] and follow up with their primary care physician in one week. The order indicated the resident may go home with current medications on hand. Staff were to provide instruction on medication administration. Home Health services were ordered, including occupational therapy, physical therapy, and nursing for wound care evaluation and treatment.Instructions to cleanse the chronic wound on the left ankle with normal saline, pat dry, apply honey gel, and cover with a dry or foam dressing. The open wound on the right lower extremity and right dorsal foot were to be cleansed with normal saline, patted dry, treated with xeroform, and covered with an abdominal pad secured with Kerlix and a tubular net.The medical record revealed a notice of Medicare non coverage (NOMNC) was completed and signed by the resident on 04/01/2026 with a service end date of 04/03/2026.A discharge summary note dated 04/04/2026 indicated the resident was discharged at 11:30 AM and left with all medications and belongings. The nurse indicated all paperwork was signed and education provided regarding medications; and was understood by the resident. The discharge summary noted documented the resident left with a family member. A social services note entered by the social services assistant on 04/06/2026 indicated the case manager received a voicemail stating the home health and durable medical equipment which was referred to had been denied due to insurance being out of network. The note documented that the resident would need to follow up with their primary care provider, since all places where the referral had been sent did not accept the insurance.On 04/04/2026 at 9:20 AM, the Social Services Director verbalized the social services department worked with the case manager for discharging residents and helped to set up resources for residents as needed when discharging. The Social Services Director indicated the case managers would set up any home health care needs and should have verified acceptance of the resident from the home health agency prior to discharge.On 04/04/2026 at 9:26 AM, a Social Services Assistant (SSA) working as a case manager explained being responsible for discharge planning and would generally see the residents within 24 hours of admission. The SSA indicated the case manager would have interdisciplinary meetings with all services involved with resident care as well as the insurance case manager.The SSA revealed the facility did not wait until a resident was accepted by a home health agency prior to discharge. The SSA indicated if the resident was not accepted the facility would contact the resident and advise them to follow up with their primary care physician. The SSA explained it was the same process regardless of the reason home health was requested. On 04/13/2026 at 10:41 AM, R1 indicated being discharged without any durable medical equipment (DME). R1 was told they would have a walker, but it was not provided. The facility told R1 they would (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have home health, but as of 04/13/2026 the home health agency had not made a visit or contacted R1. R1 verbalized having a conversation with the insurance company and reported that no home health had been approved. As of 4/13/2026, R1 indicated no home health had come to provide care. R1 still had dressings dated 04/04/2026 and indicated they would be seeing their primary care physician (PCP) later today.R1 indicated having right foot cellulitis past the ankle, and a left foot bandage on the ankle, with no other wounds except to the bilateral feet. R1 had not had a full shower due to not wanting to wet the bandages and risk infecting the wounds. No one from the facility had called to check on the R1's welfare or whether the DME or home health had come.On 04/13/2026 at 10:54 AM, R1 indicated they were walking without a walker and holding on to walls or furniture, which placed them at risk for falls. R1 was discharged on 04/04/2026 (a Saturday) and contacted the insurance company on 04/06/2026 (a Monday). The insurance representative explained if R1 required any DME, such as a walker, it should have been discussed during the IDT meetings scheduled every Monday and Thursday. DME would need to be arranged or purchased from an approved vendor. The insurance company had its own home health services, and the home health agency (HHA) would need to be approved by the insurance company. Since R1 was discharged on a Saturday, no care meeting occurred on Thursday, and no DME and home health services were arranged.On 04/13/2026 at 11:16 AM, a Case Manager (CM1) indicated home health was arranged by the insurances healthcare provider system. CM1 indicated the insurance was aware of the discharge and had the responsibility for setting up home care. CM1 indicated working mostly with healthcare provider system. On 04/13/2026 at 11:28 AM, a Case Manager (CM2), indicated the home health agency would call the residents within 24-48 hours, and if not, the residents were advised to contact their primary care physician to set up services. CM2 reported receiving a call from R1 indicating home health had been denied. CM2 indicated they received authorization from insurance for stay and sent out referrals for home health with authorization. CM2 indicated R1's insurance issued the notice of Medicare non-coverage and determined the resident no longer was covered. CM2 reported education was provided on the process of appeal and the family member was informed.On 04/13/2026 at 12:40 PM, a Physical Therapist (PT) familiar with R1 indicated the resident had a walker in their room which was provided by the facility. R1 was independent to walk short distances but a walker was recommended for distances 150 ft and beyond. Once the recommendation was made by therapy, the discharge planners took over.The PT Discharge summary dated [DATE] to 04/03/2026, revealed R1's baseline ambulation level was supervision with touching assistance and progressed to independent at discharge on [DATE]. Discharge recommendations included home health services, and a two-wheeled walker assistive device. Discharge to prior living arrangement which was a private residence.On 04/13/2026 at 2:21 PM, a SSA indicated the best practice would have been to wait until a home health agency had accepted the resident before discharging. The SSA explained having received notification on the day of discharge the referral for home health or DME was not accepted. The only way to get around the delay from insurance would have been to appeal immediately. Provide education regarding following up with the primary care physician and give option to remain at facility for out of pocket due to not being able to find home health agency.The SSA indicated the resident had been authorized by insurance for the stay at the facility and was the insurance on record. The insurance required the resident to be discharged by 04/04/2026. Prior to discharge, the home health agency which should have been in network based on the insurance information was sent as a referral, contacted the facility to inform the resident was denied due to being out of network. The SSA explained there had been confusion with the insurance regarding what services were considered in-network. The insurance used for the facility stay differed from the unit responsible for home health, resulting in home health agencies denying services and indicating the resident was out of network.On 04/13/2026 at 3:09 PM, a wound care nurse revealed the discharge process would have included a consult with SSAs to make the determination if the resident needed to be followed for wound care after discharge. The wound care nurse indicated R1 should have been followed up by an outpatient wound care provider for (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatment. The wound care nurse indicated complications could have occurred for missed wound dressing changes including the possibility of further infection, worsening of cellulitis.On 04/13/2026 at 4:37 the SSA clarified when a resident was admitted , the admission department determined what the resident was at the facility for, the business office verified, and social services took over from there. Clinical records were sent to insurance provider for a week, usually every seven days and the insurance decided the last covered date based off the resident's progress or need for skilled services. The SSA indicated having meetings with insurance case managers two times a week (Monday and Thursday) with the IDT team to include providers, the insurance case manager and the facility case manager, the Director of Nursing (DON). R1 was under straight Humana who authorized her stay. On 04/13/2026 at 4:40 PM, the DON indicated physician orders were required plus therapy discharge notes to discharge a resident. The DON indicated the discharge planning process started on admission where discharge goals were identified including support systems, any DME needed, services such as wound care, etc. Physicians wrote the discharge summary, case managers were in touch with the insurance providers, and the facility was required to notify the Ombudsman on discharges for residents who were not competent to make their own decisions and had no support system. If residents were alert, self-responsible, had their own residence, and family support, the Ombudsman did not need to be notified. On 04/13/2026 at 4:50 PM, the DON and the SSA indicated R1's discharge was an insurance-driven discharge, Insurance Company's Name messed this up. The SSA explained R1's right to appeal and R1 insisted on going home. R1 was told the cost for private pay would have been $600 per day for room and board. R1 told the SSA they wanted to go home with wound services. The DON indicated unfortunately they call the shots.The medical record lacked documented evidence of the conversation regarding no home health acceptance with the resident or any refusal by resident to stay under private pay.On 04/13/2026 at 5:03 PM, the SSA indicated when a resident discharged , one of the discharge instructions was to contact the facility if home health or DME or any concerns were encountered. R1 called the insurance company, and the facility was notified R1 was declined home health services due to the insurance being out of network. The SSA indicated the facility usually did not do well calls for discharged residents, except for residents who left against medical advice. The social service department continued to search for home health agencies who could accept R1, but facility had not succeeded.The facility policy titled Discharge Planning Process (revised April 2025) documented the discharge planning process would address each resident and the discharge goals and needs including caregiver support and referrals to local contact agencies as appropriate. The discharge plan would identify the discharge destination and ensure it meets the health and safety needs as well as preferences. Complaint 2978689

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to ensure scheduled showers were provided for residents who were assessed to require assistance with showers for 3 of 5 sampled residents (Residents 3, 4 and 5). The deficient practice had the potential to negatively impact on the residents' quality of life.Findings include:Resident 3 (R3) was admitted on [DATE], with diagnoses including displaced fracture of lateral malleolus of right fibula, subsequent encounter for closed fracture with routine healing and sprain of the superior tibiofibular joint and ligament and right knee.The admission minimum data set (MDS) dated [DATE], revealed R3 had intact cognition and required substantial/maximal assistance for bathing.On 04/13/2026 at 7:55 AM, R3 lay in wheelchair wearing night gown and reported being told their shower days were scheduled for Wednesdays and Saturdays on day shift. R3 reported they had only been provided two showers since admission. R3 indicated looking forward to showers and would not refuse one nor would the resident allow a bed bath to replace a shower. The Shower schedule revealed R3's showers were scheduled for Wednesdays and Saturdays by day shift. On 04/13/2026 at 9:44 AM, the Unit Manager (UM) went through the resident's shower sheets and indicated R3 who was admitted on [DATE] had two documented showers on 04/04/2026 and 04/08/2026. The UM indicated R3 appeared to have refused a shower on 03/28/2026 and 04/11/2026 and received a bed bath on 04/01/2026, 04/02/2026 and 04/06/2026. The UM indicated if R3 stated they would not refuse a shower and would always opt for a shower versus a bed bath then the medical record would show R3 had only been provided with two showers on 04/04/2026 and 04/08/2026.On 04/13/2026 at 3:00 PM, the Director of Nursing (DON) reviewed R3's activities of daily living (ADL) bathing report which revealed R3 received showers on 04/04/2026 and 04/08/2026 and appeared to not have missed bathing since bed baths were given on 04/01/2026, 04/02/206 and 04/06/2026 and reflected R3 refused showers on 03/28/2026 and 04/11/2026.On 04/13/2026 at 3:22 PM, the DON was in R3's room when R3 verbalized looking forward to showers especially since there were only two showers scheduled every week. R3 indicated preferring a shower over a bed bath and pointed to bed and stated, I have never received a bath on this bed. R3 emphasized not refusing a shower on 03/28/2026 but acknowledged refusing one on 04/11/2026 since the certified nursing assistant (CNA) offered to shower the resident late in the day and the CNA was reaching end of shift.On 04/13/2026 at 3:26 PM, R3 listened as the DON confirmed a shower was documented as refused on 03/28/2026 but R3 denied being offered a shower at all on 03/28/2026. The DON indicated the ADL report showed R3 was provided with bed baths on 04/01/2026, 04/02/2025 and 04/03/2026, R3 interrupted and told the DON this was not true and reiterated the resident had not had a bath while in bed. The DON confirmed the resident's report of showers did not align with medical record.Resident 4 (R4) was admitted on [DATE] and readmitted on [DATE] with diagnoses including ischemic cardiomyopathy, atrial fibrillation and diabetes mellitus.The admission MDS dated [DATE], documented R4 had intact cognition and required partial/moderate assistance with bathing.On 04/13/2026 at 8:10 AM, R4 indicated missing showers.The Shower schedule revealed R4's showers were scheduled for Mondays and Thursdays on day shift. On 04/13/2026 at 9:51AM, the UM indicated R4 was admitted on [DATE] and readmitted [DATE]. The UM reviewed R4's ADL bathing report and indicated R4 missed a scheduled shower on 04/03/2026 with no documented evidence of refusal or re-offer.On 04/13/2026 at 3:01 PM, the DON confirmed R4 missed a scheduled shower on 04/03/2026.Resident 5 (R5)R5 was admitted on [DATE], with diagnoses including Parkinson's disease.The admission MDS dated [DATE], revealed R5 had moderately impaired cognition and was totally dependent on staff for showers.On 04/13/2026 at 8:20 AM, R5 sat up in bed with breakfast tray in front. R5 indicated being in the facility for two weeks and had not gotten a shower.The Shower schedule document revealed R5's showers were scheduled for Tuesdays and Fridays on day shift. On 04/13/2026 at 9:44AM, the UM reviewed R5's ADL bathing (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	report and confirmed R5 missed a scheduled shower on 04/07/2026 due to a room change and missed another shower on 04/10/2026 with no documented reason.On 04/13/2026 at 3:02 PM, the DON confirmed R5 had a missed shower 04/10/2026 but a bed bath was provided on 04/08/2026 after a scheduled shower was missed on 04/07/2026. The facility's ADL Service Assistance policy revised 08/25/2022, documented personal care would be provided to all residents according to findings from the move-in evaluation. Residents were to have a full shower/bath, according to their needs and preferences at least twice per week.Complaint 2712783

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review, the facility failed to ensure a physician order for computed tomography (CT) scan was carried out for 1 of 5 sampled residents (Resident 1). The deficient practice had the potential to delay or negatively impact the resident's plan of care.Findings include: Resident 1 (R1) was admitted on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.A physician order dated 12/10/2026, documented to have CT scan (a fast, non-invasive imaging procedure which uses X-rays to create detailed three-dimensional images of bones, organs and tissues) to exclude ascending aortic aneurysm.The medical record lacked documented evidence R1's CT scan was completed.On 04/13/2026 at 1:17 PM, the Unit Manager explained diagnostic procedures which could be done inside the facility including X-rays, kidney, ureter, bladder (KUB), and electrocardiogram (EKG). Procedures which could not be done in the facility and would need to be scheduled with an outside provider included CT scans, magnetic resonance imaging (MRI), and barium swallow tests. The Unit Manager explained once a physician order was obtained for a CT scan, a nurse would complete an appointment request form which would be handed over to case management be responsible for scheduling the procedure.On 04/13/2026 at 1:20 PM, the Unit Manager acknowledged personally entering R1's order for a CT scan into the resident's medical record but forgot to complete an appointment request form and this order was not communicated to case management. The Unit Manager confirmed the physician order for R1's CT scan dated 12/10/2025 was not carried out.On 04/13/2026 at 2:36 PM, the Director of Nursing (DON) confirmed the missed CT scan for R1 was an oversight.The facility's Diagnostic Services policy reviewed 09/23/2025, documented the facility would ensure diagnostic services would meet the needs of the residents and the facility would be responsible for quality and timeliness of services whether services were provided by the facility or an outside resource. The results would be reported timely to the ordering physician to address potential concerns, disease prevention, diagnosis and treatment.Complaint 2712783