

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 05/27/2026
NAME OF PROVIDER OR SUPPLIER Life Care Center of South Las Vegas		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review, the facility failed to ensure 1) blood glucose (BG) levels were obtained on admission, 2) discharge summary recommendations for diabetes management were discussed or clarified with the attending physician, and orders for BG monitoring and Insulin sliding scale were obtained for a resident with type one diabetes mellitus, 3) BG levels were obtained during a change of condition, and 4) the facility had a clear diabetes management process or protocol for 1 of 40 sampled residents (Resident 161). The deficient practice potentially resulted in diabetic-related complication requiring hospitalization. Findings include: Resident 161 (R161) was admitted on [DATE], with diagnoses including type one diabetes mellitus, and encounter for surgical amputation of right toe due to gangrene. 1) On [DATE] at 3:35 PM, a Registered Nurse (RN) recalled admitting R161 on the evening of [DATE]. The RN explained when residents with diabetes were admitted, a baseline blood glucose would be obtained. According to the RN, this value would be communicated to the physician and would guide the physician on whether to place the resident on a low sliding scale or the regular sliding scale unless the resident was not Insulin-dependent. The RN indicated the resident's baseline blood glucose value would also guide the physician on the frequency of BG monitoring orders for the resident. The RN acknowledged a BG check was not obtained when R161 was admitted due to an oversight on the part of the RN. On [DATE] at 10:38 AM, the medical records director confirmed there was no record a BG was obtained when R161 was admitted on [DATE] in the evening. The first BG check for the R161 was recorded on [DATE] at 9:10 AM with a result of 209 milligrams (mg) per deciliter (dl) (Reference range: 70 mg/dl to 99 mg/dl when fasting or under 140 mg/dl two hours after a meal). 2) A review of the hospital Discharge summary dated [DATE], revealed R161 underwent amputation of the right third toe on [DATE]. R161 was receiving Insulin Glargine (long-acting) twice a day (BID) and Insulin Humalog (fast-acting) before meals (AC) and at bedtime (HS) following a sliding scale. R161's BG was monitored twice a day with the Insulin Glargine administration and before meals and at hour of sleep for the Insulin Humalog administration. The hospital discharge medication reconciliation dated [DATE], included Insulin Glargine (Lantus injection) 100 units/milliliter (ml) vial, 50 units subcutaneously daily. A free text med rec notes read please consider sliding scale insulin while at rehab facility. Please also consider splitting long-acting Insulin to twice daily. The medical record lacked documented evidence discharge recommendations to put R161 on an Insulin sliding scale and splitting the long-acting Insulin twice daily were communicated to the physician. The medical record lacked documented evidence the admitting nurse clarified, obtained and transcribed orders for BG checks for R161 and the frequency thereof. On [DATE] at 3:35 PM, the RN who admitted R161 on the evening of [DATE] explained the facility did not have an admissions nurse but all nurses were trained in the admission process. The RN indicated hospital discharge summaries were thoroughly reviewed for all newly admitted residents (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 0711 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review, the facility failed to ensure the attending physician conducted an independent, thorough review of a hospital discharge summary for a resident admitted with Type one diabetes mellitus for 1 of 40 sampled residents (Resident 161). The deficient practice resulted in the resident experiencing diabetic-related complications which required rehospitalization. Findings include: Resident 161 (R161) was admitted on [DATE], with diagnoses including type one diabetes mellitus, and encounter for surgical amputation of right toe due to gangrene. The hospital Discharge summary dated [DATE], revealed R161 underwent amputation of the right third toe on [DATE]. R161 was receiving Insulin Glargine (long-acting) twice a day (BID) and Insulin Humalog (fast-acting) before meals (AC) and at bedtime (HS) following a sliding scale. R161's BG was monitored twice a day with the Insulin Glargine administration and before meals and at hour of sleep for the Insulin Humalog administration. The hospital discharge medication reconciliation dated [DATE], included Insulin Glargine (Lantus injection) 100 units/milliliter (ml) vial, 50 units subcutaneously daily. A free text med rec notes read please consider sliding scale insulin while at rehab facility. Please also consider splitting long-acting Insulin to twice daily. The medical record lacked documented evidence discharge recommendations to put R161 on an Insulin sliding scale and splitting the long-acting Insulin twice daily were reviewed and addressed by the attending physician. On [DATE] at 11:51 AM, R161's attending physician indicated expecting the admitting nurses to communicate hospital recommendations for an Insulin sliding scale. The physician indicated they would have agreed to follow hospital recommendations for an Insulin sliding scale and to divide the resident's long-acting Insulin into two administrations. The physician verbalized being under the impression the facility protocol was to perform BG checks at least three times a day for residents being admitted with a diagnosis of diabetes. A health status note dated [DATE] (5:32 AM), documented R161 was being sent out to the hospital due to a change in condition. Specifically, R161's heart rate was 32 beats per minute, hands were cold, Oxygen saturation was 82 % (normal 95% to 100%) on room air, deep rapid respirations, unable to speak due to catching breath and was lethargic. Physician called. A hospital Discharge summary dated [DATE], revealed R161 was admitted to the hospital on [DATE] with acute encephalopathy likely metabolic in the setting of DKA and stress hyperglycemia. R161 was started on an Insulin drip, placed on a DKA protocol and moved to the ICU for further assessment and management. R161 was intubated due to altered mentation and respiratory failure. Palliative care was discussed and R161 was discharged to hospice care on [DATE]. A report received by the State Agency on [DATE], revealed R161 expired on [DATE] under hospice care. On [DATE] in the morning, the Regional Director of Clinical Services and the Clinical Quality Coordinator indicated physicians had an obligation to conduct a thorough independent review of the hospital discharge summary to include discharge medications, treatment services received at the hospital and free text recommendations and not merely rely on nurses. The facility's Physician Services policy reviewed [DATE], revealed each resident was supervised by a licensed physician to provide quality medical care, routine scheduled physician visits, monitor resident care and make changes as needed. Physician services include but are not limited to resident evaluation - physicians complete, sign and date comprehensive assessment history and physician within 72 hours within 24 hours prior to all admissions to the facility. Complaint 2992873		

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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, record review and document review, the facility failed to ensure resident rooms and bathrooms were in good repair for 9 of 72 resident rooms. The deficient practice had the potential to negatively impact on the residents' quality of life. Findings include: On 05/20/2026 in the afternoon, an observation tour of the facility with a life safety code (LSC) inspector revealed the following: -room [ROOM NUMBER] had a broken doorknob with handle easily removed.- room [ROOM NUMBER] had a loose toilet that moved from left to right, and the toilet base was not sealed and secured to floor. - room [ROOM NUMBER] had damage to flooring underneath toilet with missing tiles. The toilet paper holder was missing from wall exposing a sharp edge.- room [ROOM NUMBER] had scraped drywall with paint coming off at the head of bed releasing scraps and powder-like substance accumulating on floor.- room [ROOM NUMBER] had a broken bathroom door, and a broken ceiling tile which had the potential to fall on the resident, as it was directly above the toilet area. - room [ROOM NUMBER] had a loose toilet.- room [ROOM NUMBER] had a loose toilet.- room [ROOM NUMBER] had a loose toilet.- room [ROOM NUMBER] had a loose toilet. On 05/20/2026 at 1:30 PM, the Executive Director indicated being informed of the LSC survey findings with the physical environment. The Administrator verbalized expecting the entire team (clinical and non-clinical) to complete a work order for all broken or damaged areas in the facility to enable maintenance staff to fix the issues in a timely manner. The Administrator stated every resident was entitled to a safe, homelike environment. The facility's Home Like Environment policy reviewed 04/01/2026, documented the facility would provide a safe, clean, comfortable and homelike environment for each resident. The facility's Keeping a Resident's Room in Order policy reviewed 04/02/2026, documented it is the responsibility of all staff to create a homelike environment and promptly address any cleaning needs to keep rooms orderly. Housekeeping and maintenance services would be provided to maintain sanitary, orderly and comfortable interior.		

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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 observation, interview, record review and document review, the facility failed to ensure care and management of a resident's intravenous line (IV) were included in the resident's baseline care plan for 1 of 40 sampled residents (Resident 171). The deficient practice placed the resident at risk for infection. Findings include: Resident 171 (R171) was admitted on [DATE], with diagnoses including traumatic subdural hemorrhage and unspecified dementia. On 05/18/2026 at 10:38 AM, R171 laid supine in bed and appeared to be nonverbal. A midline with single lumen and purple port was observed on R171's left upper arm with dressing dated 05/08/2026. There was no IV pole or pump observed in the room. The medical record lacked documented evidence a baseline care plan was developed for R171's IV line. On 05/20/2026 at 12:15 PM, the Director of Nursing (DON) indicated R171's IV line should have been included in the resident's care plan, but this was not done. The facility's Baseline Care Plan policy dated 08/28/2017, documented the facility must develop and implement a baseline care plan for each resident which includes instructions needed to provide effective and person-centered care of the resident. The care plan would be developed within 48 hours of admission and contain minimum healthcare information necessary to properly care for the residents.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **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 for an indwelling catheter for 1 of 40 sampled residents (Resident 2). The deficient practice placed the resident at risk for a urinary tract infection (UTI). Findings include: Resident 2 (R2) was admitted on [DATE], with diagnoses including paraplegia, obstructive uropathy and urine retention. On 05/18/2026 in the morning, R2 was rolled to right side while the wound care nurse provided treatment to a sacral wound. A covered urinary bag was observed hanging on the right side of the bed. A physician order dated 04/07/2026, documented indwelling catheter to straight drainage. Size: 18 French Bulb: 10 cubic centimeters. Change for infection, obstruction or when the closed system was compromised as needed for stage four sacral wound. A physician order dated 04/07/2026, documented to perform catheter care every shift. On 05/21/2026 at 9:35 AM, the Unit Manager explained R2 was a paraplegic with an infected sacral pressure ulcer requiring use of a Foley catheter. The Unit Manager reviewed R2's medical record and indicated there was no documentation the Foley catheter had been replaced since admission. The Unit Manager entered R2's room and indicated needing to obtain information from the resident. On 05/21/2026 at 11:54 AM, the Unit Manager indicated R2 had a 16 French Foley catheter with orange port. R2 informed the Unit Manager the catheter was exchanged last week per resident's request and R2 themselves requested staff to use a 16 French Foley catheter. The medical record lacked documented evidence of the resident's request for a Foley catheter exchange using a 16 French Foley was recorded and a physician order was obtained for insertion of a 16 French catheter. The medical record lacked documentation catheter care was being provided every shift. On 05/21/2026 in the afternoon, the Unit Manager acknowledged physician orders were not followed when R2 was observed to have a 16 French catheter while the order was for a size 18 French. The Unit Manager could not speak as to why orders for catheter care every shift were not transmitted to the residents' medication administration record (MAR) so there was no documentation this was being provided routinely every shift. On 05/21/2026 at 10:31 AM, the Director of Nursing (DON) confirmed physician order were not followed based on the Unit Manager's direct observation of R2 having a 16 French Foley catheter. The DON confirmed there was no documentation of the resident's Foley catheter removal and insertion as well as routine catheter care. The DON explained documentation of catheter care did not transmit to the MAR because of an error in entering the batch order which stated, no documentation requirements. According to the DON, the resident was placed at risk for a urinary tract infection (UTI) and other catheter-related complications. The facility's Indwelling Urinary Catheter Foley Management reviewed 09/04/2025, documented based on comprehensive assessment of a resident, the facility must ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive care plan and resident's choices. Refer to [NAME] Procedural Guidance on routine care. The Lippincott procedure: Indwelling Urinary Catheter Removal and Insertion policies (undated), outlined documentation requirements to include, indication for use, assessment findings, date and time of procedure, urine characteristics, any complications, size and type of catheter and amount of sterile water in the catheter balloon.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure care and management orders were entered for a resident who was admitted with an intravenous (IV) line for 1 of 40 sampled residents (Resident 171). The deficient practice placed the resident at risk for infection. Findings include: Resident 171 (R171) was admitted on [DATE], with diagnoses including traumatic subdural hemorrhage and unspecified dementia. On 05/18/2026 at 10:38 AM, a midline with single lumen and purple port was observed on R171's left upper arm with dressing dated 05/08/2026. There was no IV pole or pump observed in the room. The medical record lacked documented evidence R171's IV line was identified by the admission nurse, clarification orders were obtained from the physician, and care orders were transcribed into the medical record. On 05/18/2026 at 10:40 AM, the Licensed Practical Nurse (LPN) confirmed R171 had a left upper arm midline dated 05/08/2026. The LPN indicated the resident was admitted to the facility on [DATE] which meant the IV line was inserted at the hospital. The LPN reviewed R171's electronic health record (EHR) and confirmed the admitting nurse failed to identify the resident's IV line, obtain clarification from the physician on whether to keep or remove the line and care and maintenance orders of the IV line would be removed. The LPN indicated consequences of midline with no care orders was infection. On 05/19/2026 at 10:30 AM, the Infection Preventionist (IP) explained when a resident was admitted with a peripheral line, the admitting nurse should remove the line since they were meant for short term use. If the resident was admitted with a midline, the nurse would obtain clarification orders from the physician on whether to maintain or remove the line. If the order was to keep the midline, care orders to include site assessment every shift, weekly dressing changes and flushing must be entered into EHR. The IP stated consequences of not following facility policy for IV lines placed residents at risk for infection. On 05/20/2026 at 12:15 PM, the Director of Nursing (DON) corroborated the IP's explanation peripheral lines were meant for short term use and would have to be removed on admission [DATE] if it was inserted in the hospital on [DATE]. If it was midline, the admitting nurse would have to seek clarification from the physician on whether to remove or maintain. If ordered to maintain, care orders such as site assessment, flushing and dressing changes should be entered and carried out. The DON confirmed the admission nurse failed to identify the resident's IV line in the admission assessment and there was no documented evidence clarification and care orders were obtained from a physician and transcribed into the EHR. The facility's Infusion Therapy - Intravenous Fluids policy revised 01/06/2026, revealed the facility would need to assess the resident for continued use of an IV line and contact physician for orders to discontinue or remove when no longer necessary. Dressing changes were performed every seven days or when soiled, loosened or dislodged. Documentation requirements included: indication for dressing change, date and time, appearance of catheter site, patient's response to procedure and any complications.		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and document review, the facility failed to ensure an annual performance evaluation for 2 of 2 Certified Nurse Aides (CNA1 and CNA2) was completed at least once every 12 months. The deficient practice had the potential to limit the facility's ability to evaluate competency, identify training needs and allow performance deficits to go unaddressed. Findings include:CNA 1 was hired on 02/15/2005.CNA 2 was hired on 01/09/2008.A review of information gathered from the Payroll Coordinator revealed the annual performance evaluations were not available for CNA1 and CNA2.On 05/20/2026 at 9:28 AM, the Payroll Coordinator explained certified nurse aides completed training and a competency evaluation prior to hire and received a performance review annually.On 05/20/2026 at 12:13 PM, the Payroll Coordinator could not verify if an annual performance review had been completed, or when the last evaluation was conducted for CNA1 and CNA2 since the date of hire.On 05/21/2026 at 8:19 AM, the Director of Staff Development (DSD), explained CNA performance evaluations were conducted annually.On 05/21/2026 at 9:34 AM, the Executive Director (ED), stated the expectation was to have the DSD and the payroll coordinator work together to be sure the facility was in compliance with state and federal regulations with all facility training and onboarding. The ED explained the staff evaluation expectation was that evaluations were done routinely and time was spent with the employees reviewing their performance over the prior year, and as needed.The facility policy titled Area of Focus: Performance Evaluations, dated 12/04/2025, documented annual performance reviews were given to all associates.The facility's policy titled Employment File Guidelines, dated 10/20/2025, documented a list of employment documents and signed policies that should be found in a typical associate personnel file. The list included performance evaluations.		

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 05/27/2026
NAME OF PROVIDER OR SUPPLIER Life Care Center of South Las Vegas		STREET ADDRESS, CITY, STATE, ZIP CODE 2325 E. Harmon Ave. Las Vegas, NV 89119	
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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review, the facility failed to ensure 1) indication for use for psychotropic medications were appropriate 2) side effect and behavior monitoring was in place 3) an informed consent was obtained for psychotropic medication use and 4) an Abnormal Involuntary Movement Scale (AIMS) Assessment was conducted for 1 of 40 sampled residents (R174). The deficient practiced placed the resident at risk of unnecessary medication use and potential adverse side effects. Findings include: Resident 174 (R174) was admitted on [DATE] with diagnoses including unspecified dementia without behavioral disturbance, personal history of traumatic brain injury, and history of transient ischemic attack. Physician orders dated 05/17/2026 documented Buspirone Hydrochloride (a medication used to treat anxiety) 5 milligrams (MG) by mouth two times a day for altered mental status, and Quetiapine Fumarate (an atypical antipsychotic used to treat schizophrenia, bipolar disorder, and major depression) 25 MG one tablet by mouth two times a day for anxiety. R174's medical record lacked documented evidence of psychotic medication monitoring for behaviors or side effects related to the use of Buspirone Hydrochloride and Quetiapine Fumarate. R174's medical record lacked signed consents for the use of Buspirone Hydrochloride and Quetiapine Fumarate. R174's medical record lacked an AIMS Assessment. On 05/21/2026 at 12:38 PM, a Licensed Practical Nurse (LPN) explained when a resident admits to the facility with psychotropic medications the nurse would obtain a consent with signature. residents receiving psychotropic medications would have side effects and behavioral monitoring orders for each shift. The LPN explained residents receiving anti-psychotic medication would not have an AIMS assessment however the nurse would monitor the resident for shaking, dyskinesia (uncontrollable and involuntary movements), eyes twitching and mouth movements that may be abnormal and not related to a diagnosis the resident already presented with. On 05/21/2026 at 12:48 PM, the Director of Nursing (DON) explained the expectation for residents admitting to the facility with psychotropic medication would be for the nurse to obtain signed consent upon admission. The DON expressed nurses would enter psychotropic medication monitoring for side effects and behaviors which were required for each shift. If a resident had an anti-psychotic medication an Abnormal Involuntary Movement Scale (AIMS) Assessment would be conducted the following day. On 05/21/2026 at 12:52 PM, The DON reviewed R174's medical record and confirmed the documented indication of altered mental status for Buspirone Hydrochloride and anxiety for Quetiapine Fumarate were not appropriate, the record lacked side effects and behavior monitoring, informed consent was not obtained upon admission, and an AIMS assessment had not been completed. The facility policy titled Psychotropic Medication Management, reviewed 12/02/2025, documented the following: -The resident medical record must show documentation of adequate indications for the medication's use and the diagnosed condition for which a medication was prescribed. -A consent was required for each medication-Evaluation of a resident's physical, behavioral, mental, and psychosocial signs and symptoms, in order to identify the underlying cause, including adverse consequences of medications: Abnormal Involuntary Movement Scale (AIMS) Assessment tools would be used for all antipsychotic medications. -Monitoring of medications for efficacy and adverse consequences.		

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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 the kitchen was maintained in a sanitary manner. The deficient practice placed residents at risk for foodborne illness. Findings include: On 05/18/2026 at 7:35AM, a kitchen tour was conducted with the Dietary Manager. Food debris and spillage were present on floor throughout the kitchen area specifically under the steam table, under the three-compartment sink, in the dry food storage area, and floor of walk-in freezer and refrigerator. The Dietary Manager acknowledged the debris and spillage and explained the floors needed to be cleaned. On 05/19/2026 at 1:51 PM, the Dietary Manager explained cleaning of the kitchen floors occurred at change of shift and again at night for closing of the kitchen. The cleaning of the kitchen floors consisted of sweeping and no rinse mopping. The Dietary Manager acknowledged there was lot of miscellaneous buildup, debris and spillage on the kitchen floors. The facility policy titled Prevention of Cross Contamination, reviewed 05/01/2025, documented all floor surfaces must be mopped daily and as needed using a bucket with water and appropriate floor cleaner. The facility policy Cleaning Schedule, revised 04/30/2025, documented the Director of Food and Nutrition Services shall develop a routine cleaning schedule to ensure the Food and Nutrition Services department was maintained in a clean and sanitary manner.		

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure orders for physical therapy (PT) and occupational therapy (OT) were followed for 3 of 40 sampled residents(Residents 63, 73 and 169) and speech therapy (ST) for 1 of 40 sampled residents (Resident 48). The deficient practice placed the residents at a potential for slower progression towards goals.Findings include: Resident 63 (R63) was admitted on [DATE], with diagnoses including morbid obesity, acute respiratory failure with hypoxia and osteoarthritis. On 05/18/2026 in the morning, R63 reported missing two PT sessions on 04/10/2026 and 04/28/2026. According to the resident, the session for 04/28/2026 was rescheduled for 05/02/2026 but no staff member showed up. On 05/20/2026 in the morning, the Director of Rehabilitation services (DOR) explained R63 was evaluated for PT and OT on 04/06/2026 and was scheduled to receive five PT and five OT sessions per week. The DOR confirmed R63 missed two PT sessions on 04/10/2026 and 04/28/2026. The second session was rescheduled for 05/02/2026 but no one showed up due to short staffing. Resident 73 (R73) was admitted on [DATE], with diagnoses including chronic obstructive pulmonary disease and age-related osteoporosis. On 05/18/2026 at 9:14 AM, R73 reported having issues with therapy not being provided as scheduled. On 05/20/2026 in the morning, the DOR indicated R73 was admitted on [DATE] and was evaluated for PT and OT on 05/02/2026. R73 was scheduled to receive five PT and three OT sessions per week. The DOR confirmed a PT session was missed on 05/05/2026 due to short staffing and R73 refused a PT session of 05/08/2026. Resident 169 (R169) was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease. On 05/18/2026 in the morning, R169 reported not getting therapy services. On 05/20/2026 in the morning, the DOR indicated R169 was admitted on [DATE] and was evaluated for PT and OT on 05/14/2026. According to the DOR, R169 was scheduled to receive five PT sessions and three OT sessions per week. The DOR confirmed missed a PT session on 05/17/2026 due to low staffing on weekends. On 05/20/2026 at 11:43 AM, the DOR explained the facility had 109 residents on the census and there were 97 residents on the therapy case load. The DOR indicated the Rehab team was down a full-time OT, a full-time PT assistant, and a full-time OT assistant. The DOR acknowledged the rehab staff were challenged with current case load and delivering therapy prescriptions. (continued on next page)		

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/20/2026 at 11:51 AM, the DOR verbalized consequence of residents missing therapy impaired the resident's rehabilitation process and placed the residents at risk for slower progress towards goals. The facility's Rehabilitation Orders policy revised 12/23/2025, documented rehabilitation services were delivered per physician's orders. Resident 48 (R48) was admitted to the facility on [DATE] with diagnoses including encounter for surgical aftercare, malignant neoplasm of tongue, dysphagia, and malnutrition. A speech therapy (ST) encounter note dated 05/05/2026 documented an evaluation was completed and a plan of treatment was developed with a recommendation for two ST sessions per week. On 05/18/2026 at 9:34 AM, R48 indicated they had not received ST as ordered. R48 explained therapy was needed to be able to eat orally. A May 2026 schedule log for therapy services documented R48 was scheduled for ST on 05/05/2026, 05/07/2026, 05/14/2026 and 05/15/2026. A service log matrix dated from 05/01/2026 to 05/31/2026 documented R48 received ST on 05/05/2026 and on 05/07/2026. ST was not performed on 05/14/2026 and 05/15/2026. On 05/20/2026 at 10:56 AM, the Director of Rehabilitation (DOR) explained upon evaluation, ST was determined based on the resident diagnosis. During evaluation a plan of care would be determined and discussed. The DOR indicated R48 was evaluated and ST ordered for two times per week and to have puree meals with speech therapist assistance. The DOR R48 was seen twice in the first week but due to a staffing issue the full-time speech therapist and the two PRN speech therapists were unavailable to work. The DOR acknowledged the current rehab staff was challenged with current case load and delivering therapy prescriptions. The DOR verbalized the consequence of residents missing therapy was impaired results and risk for slower progress towards goals.		