STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295090	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health Care of Las Vegas	5840 W Sunset Rd Las Vegas, NV 89118

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 - Minimal harm or potential for actual harm 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 observation, interview, and record review, the facility failed to ensure a physician's order for 1:1 meal assistance was followed for 1 of 12 residents (Resident 30). The deficient practice had the potential to put the resident at risk for weight loss and aspiration.Findings include:Resident 30 (R30)R30 was admitted on [DATE], with diagnoses including encephalopathy, dementia, sepsis, and urinary tract infection.On 01/13/2026 at 9:19 AM, R30 was observed sitting upright in bed with a sign posted on the wall above the bed that read 1:1 ASSIST WITH FEEDING. On 01/13/2026 at 12:20 PM, R30 was observed lying supine in bed, eyes closed with lunch tray on the bedside table.On 01/13/2026 at 2:05 PM, R30 was observed lying supine in bed, lunch tray was observed on the bedside table with approximately 30% meal gone.On 01/14/2026 at 12:54 PM, R30 was observed sitting upright in a wheelchair in front of an overbed table. The overbed table had a lunch tray with about 10% of the meal consumed. R30 stated no one helped with feeding and was able to feed self.A physician diet order dated 01/09/2026, documented1:1 assist; encourage meal intake. Special instructions: aspiration precaution: one-to-one assist, small bites/sips, eat/feed slowly with all meals, remain upright while feeding and 20-30 minutes after meals and oral care after feeding. R30's meal tray tickets dated 01/14/2026 and 01/15/2026, documented 1:1 assist for breakfast, lunch and dinner.R30's Point of Care charting for activities of daily living lacked documented evidence staff support was provided for eating from 01/09/2026 - 01/13/2026.On 01/14/2026 at 1:02 PM, a Certified Nursing Assistant (CNA1) stated R30 was considered set -up level for feeding but could feed self without verbal cues. CNA1 indicated R30 ate 50% of breakfast this morning. CNA1 explained meal assistance level was discussed during shift handoff and endorsed between off going and oncoming shift CNAs and R30 was reported as requiring set up level assistance. CNA1 explained they checked the tray ticket for instructions, then set up meals for the residents. CNA1 observed the sign on wall behind R30 which read; 1:1 ASSIST WITH FEEDING. The CNA1 explained 1:1 assistance meant the CNA needed to assist physically feed the resident. The sign meant R30 was supposed to be fed by staff. CNA1 stated the breakfast tray was set up and R30 was not assisted with feeding that morning. On 01/14/2026 at 1:14 PM, a Certified Nursing Assistant (CNA2), explained the Registered Nurse (RN) advised CNAs if a resident required 1:1 feeding assistance with meals. CNA2 stated 1:1 meal assistance meant the resident sat upright, and staff stayed with and physically fed the resident. Set up assistance meant setting up the tray and cutting up food if requested. CNA2 stated R30 had been refusing meal assistance and was not eating at all.On 01/14/2026 at 1:23 PM, a Registered Nurse (RN), explained R30 was alert and oriented with some forgetfulness and was set up assistance for feeding. The RN explained R30 was not eating, and the speech therapy department placed a sign indicating 1:1 ASSIST WITH FEEDING on the wall above the bed to encourage nutritional intake. R30 remained set up only for meal assistance. The RN stated R30 was set up only, not 1:1 meal assistance feeding. On 01/14/2026 at 4:11 PM, a Registered Nurse (RN) indicated depending on who wrote the order, the RN was responsible for ensuring the physician, speech therapy and dietitian were aware of the change. Typically, the clinical manager wrote the order, which was printed and given to the floor nurse. The RN then notified the kitchen staff and CNAs of the new diet order. The RN confirmed the diet order for (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R30 dated 01/09/2026 required 1:1 feeding assistance for each meal. The RN explained R30 sometimes refused 1:1 assistance and staff encouraged or cued eating. Staff were expected to document refusals and notify the physician. The RN confirmed no refusals or physician notifications were documented in R30s medical record and acknowledged the physician's order was not followed. On 01/14/2026 at 4:21 PM, a Certified Nursing Assistant (CNA3), stated R30 was provided with 1:1 assistance with feedings. CNA3 explained level of assistance R30 required during feeding was not documented in the medical record, only the percentage of meals eaten and liquids given were documented.On 01/15/2026 at 7:47 AM, Director of Nursing (DON), indicated nurses were expected to communicate the diet order to CNA's and confirmed staff should follow the diet order and provide 1:1 assistance when ordered. CNAs were expected to physically assist with feeding and provide encouragement and cues. The DON clarified 1:1 feeding assistance was different from set up assistance required the CNAs remained with the resident through the entire feeding activity. The DON acknowledged there was no documented evidence on the level of assistance provided to R30 during meal feedings.On 01/15/2026 at 10:20 AM, the Physical Therapy Rehabilitation Service Manager explained R30 was not on the speech therapy caseload and had no speech therapy services ordered at the facility. The manager indicated 1:1 meal assistance feeding was not a skilled therapy need and R30 had no functional deficit but required cues due to sleepiness.

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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 food items were labeled and dated once removed from original packaging, food items were labeled with acceptable discard dates, damaged items were not mixed in with the stock items, and spray bottles containing chemicals were labeled. The deficient practice had the potential for exposing residents to expired perishable food items and compromise safety of residents and staff.Findings include:On 07/13/2026 at 7:41 AM, during a tour of the kitchen with the Registered Dietitian (RD) the following issues were observed: Two clear plastic bags in the walk-in freezer contained unknown food items without labels to identify contents or indicate the date placed in bag.In the refrigerator, a container of marinara sauce was labeled with an open date of 01/06/2026 and use by date of 06/26/2026. In the cleaning supply room, an unlabeled spray bottle of blue colored liquid.In the dry storage room, a dented can of cranberry sauce with undamaged cans. On 01/13/2026 at 8:05 AM, the RD explained the food items should have been labeled and dated once removed from the original container. The RD indicated the marinara sauce had a use by date well past the accepted use date. The RD confirmed any chemicals used in spray bottles should have been labeled.On 01/14/2026 at 12:15 PM, the Dietary Manager verbalized food items needed to have a label with a received or open date so the staff would know when to discard them. The Dietary Manager indicated staff should have discarded the unlabeled food items and any liquids in spray bottle should have been identified.The facility policy titled Food Storage documented sufficient storage facilities were to be provided to keep food safe, wholesome, and appetizing. Chemicals were required to be clearly labeled, kept in original containers when possible and stored in designated areas away from food. Food was to be dated as it was placed on the shelves, and food items removed from original packaging marked with use by date. Leftover food was to have a use by date within 7 days or discarded.