STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295092	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health Care of Summerlin	2860 N Tenaya Way Las Vegas, NV 89128

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295092	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health Care of Summerlin	2860 N Tenaya Way Las Vegas, NV 89128

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review, the facility failed to ensure an allegation of abuse was thoroughly investigated for 1 of 4 sampled residents (Resident 1). The deficient practice had the potential for failure to ensure the resident's safety and prevent further abuse from occurring. Findings include:Resident 1 (R1) was admitted on [DATE] and discharged on 05/27/2025, with diagnoses including intervertebral disc degeneration, morbid obesity, and long term use of opiate analgesic. The Nurse's Notes (progress notes) dated 05/18/2025 at 4:10 PM, documented (Name of R1) complained that a few nights ago, three nurses came in to reposition me at night, They pulled my arm and as a result, I developed bruises on my left arm and the inner side of my elbow. 2 spots around 3 cm dark decolorization noticed. No s/sx of infection or pain. Pt couldn't remember the exact date. DON reported. There was no documented evidence of the facility's investigation regarding R1's allegation. On 09/24/2025 at 11:38 AM, Registered Nurse 1 (RN1) explained an allegation of abuse from a resident, family, or staff, should have been reported immediately to the Administrator. RN1 would have initiated the investigation right away by interviewing the staff, residents, and family about the allegation. RN1 explained notifying the Director of Nursing (DON) and Administrator about the details and results of the initial investigation conducted. RN1 would also notify the resident's physician. RN1 indicated documenting the reported allegations of abuse in the progress notes and the actions taken to address the allegation. RN1 confirmed reporting to the DON the allegation made by R1 as documented in the nurse's notes dated 05/18/2025 at 4:10 PM. RN1 requested to review the notes and R1's medical record to verify the actions taken regarding the resident's reported allegation of abuse. On 09/24/2025 at 11:48 AM, RN2 revealed R1's complaint documented in the nurse's notes dated 05/18/2025 at 4:10 PM was an allegation of abuse and should have been reported and investigated right away. RN2 explained if such complaint was received from a resident or staff, RN2 would have reported the allegation to the Administrator. RN2 would have initiated the investigation right away. RN2 explained the reported allegation and actions taken should have been documented in the nurse's notes. On 09/24/2025 at 11:55 AM, RN1 revealed working as a Charge Nurse on 05/18/2025, Sunday. RN1 confirmed R1 reported an allegation of abuse as documented in the nurse's notes and notifying the DON about the allegation. RN1 explained not knowing the staff involved because R1 reported the incident happened few nights ago. RN1 indicated an investigation of the allegation of abuse was not initiated because RN1 did not know which staff to interview or suspend. On 09/24/2025 at 12:07 PM, a Charge Nurse explained if an allegation of abuse was received from a resident, similar to the allegations made by R1, the Charge Nurse would have completed a head-to-toe skin assessment, interviewed the resident, and notified the physician, DON and Administrator. The Charge Nurse would have documented the assessment in the nurse's notes including the allegation and actions taken by the Charge Nurse to address the allegation. The Charge Nurse would have initiated an investigation immediately or right after the resident reported the allegation. On 09/24/2025 at 1:01 PM, a Certified Nursing Assistant (CNA) indicated being assigned to R1 when the resident was still at the facility. R1 required two to three person assist and maximum assistance in turning and repositioning. The CNA revealed on two occasions while the CNA was changing the resident in bed with another CNA, R1 requested the CNA to be gentle because the resident was in a lot of pain. R1 claimed other people, especially on night shift, were rough with the resident. R1 was always in pain and complained when being turned and repositioned. On 09/24/2025 at 1:26 PM, the DON explained the staff were expected to notify the DON or the Administrator right away for an allegation of abuse, even if it was a hearsay. The DON and the Administrator would have initiated an investigation immediately which included interviewing the residents and staff or possible witnesses. The alleged perpetrator, if a staff member, would have been suspended pending investigation. The facility would ensure the resident's safety. The Administrator would have reported the incident to the State. The DON explained a head-to-toe skin assessment would have been completed for an allegation of physical abuse and documented the assessment in the progress notes. The DON confirmed not being aware of the alleged incident documented in the nurse's notes dated 05/18/2025 at 4:10 PM. The DON acknowledged R1's allegation was not reported to the DON. The DON revealed there was no documentation in the progress notes about the follow-up made regarding the R1's allegation. The DON indicated RN1 was the supervisor on 05/18/2025 and should have done an investigation such as determining the staff involved and reported to the DON. The DON confirmed the allegation was not followed through and investigated