STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295094	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spanish Hills Wellness Suites	5351 Montessouri Street Las Vegas, NV 89113

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 facility failed to ensure the hand sink in the kitchen foodˆpreparation area dispensed hot water; kitchen equipment was free of greasy buildup and food debris; floors were maintained free of heavy food debris and spillage; the ventilationˆhood filter was free of visible dust and grease buildup; and food items were properly stored in the freezer.The deficient practices had the potential to compromise food safety, increase the risk of foodborne illness, and create conditions conducive to pest infestation and physical hazards, placing residents, staff, and visitors at risk.Findings include:On 02/24/2026 at approximately 8:30 AM, during the initial kitchen tour following concerns were observed:-In the food preparation area, a designated handwashing sink did not dispense hot water due to a malfunctioning hotˆwater handle, preventing appropriate handwashing and sanitation practices. -Heavy grease build-up and food debris were present on the sides of the fryer. -The ventilation hood filter located on the cook line was visibly dusty and greasy.-Heavy food debris and dried food spillage were observed on floors beneath multiple pieces of kitchen equipment, including the stove, fryer, oven, toaster, cookˆline table, trayˆline steam table, dishwasher, walkˆin refrigerator, and dryˆstorage shelving. -The oven contained visible residue from old, burned food and grease. -The dishwasher machine exhaust was visibly soiled with grease and dust. -The toaster was heavily soiled with food debris. -Multiple frozen food items, including milkshakes, luncheon loaf, cheese omelets (15 lbs.), buttermilk pancakes (12 lbs.), and pork sausage (six 10ˆlb boxes), were stored in the walkˆin refrigerator instead of the freezer, contrary to manufacturer instructions requiring frozen storage.On 02/24/2026 at 8:45 AM, a cook reported the kitchen and equipment were required to be cleaned weekly and acknowledged the unsanitary conditions observed. The cook confirmed the food items requiring frozen storage should have been stored in the freezer rather than the walkˆin refrigerator.On 02/25/2026 at 10:00 AM, the Dietary Manager explained the kitchen should have been cleaned daily to maintain a safe food service environment. The Manager acknowledged that items requiring frozen storage should have been stored as per the manufacturer's recommendation.The facility's policy titled Sanitation and Food Safety in Food and Nutrition Services dated 10/15/2025, documented the Dietary Manager had the responsibility for the food safety and sanitation of the kitchen and should provided a cleaning schedule for each area and piece of equipment.The facility's policy titled Cleaning the Toaster, indicated the toaster was maintained in a clean and sanitary condition by emptying the crumb tray, washing, rinsing, and sanitizing the crumb tray in the 3-compartment sink daily.The facility policy titled Cleaning Ovens, dated 10/15/2025, indicated the oven was cleaned for spills as they occur, baked-on food debris as needed, and the interior cleaned with fresh water daily. The policy provided directions for a weekly oven cleaning, including removing and cleaning the racks, loosening baked-on grease or carbonized food with a brush or scraper, removing loosened soil, rinsing with water, and allowing them to dry.

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations, interviews, and document review, the facility failed to follow effective sanitation practices in the kitchen area and did not implement the pest control service's recommendations to prevent the proliferation of insects in the kitchen area. This deficient practice had contributed to the ongoing pest activity, increasing the risk of food contamination and compromising the safety and sanitation of the food service environment.Findings include:On 02/24/2026 at approximately 8:30 AM, during the initial kitchen tour following concerns were observed:Heavy food debris and dried food spillage were observed on floors beneath multiple pieces of kitchen equipment, including the stove, fryer, oven, toaster, cookˆline table, trayˆline steam table, dishwasher, walkˆin refrigerator, and dryˆstorage shelving.The oven contained visible residue from old, burned food and grease.The toaster was heavily soiled with food debris.During the kitchen inspection, three live cockroaches were observed in food service areas: one on the floor in the dishwashing area, one in the floor drainage under a sink at the cook line, and one at the door of the walkˆin refrigerator. Pest control reports dated 01/15/2026, 01/22/2026, 01/30/2026, 02/12/2026, and 02/19/2026, revealed cockroach activity had been consistent on each service visit, and a recommendation to clean regularly was provided.On 02/24/2026, the maintenance Director explained the pest control contractor provided services every other week and as needed. The Maintenance Director confirmed pest control interventions could be ineffective if the kitchen staff did not maintain proper cleaning in the area.The facility policy titled Pest Control dated 10/15/2026, documented the proper sanitation would be maintained, and clutter would be reduced to prevent food and harborage for pests.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review, the facility failed to ensure a copy of the discharge notice was sent to the Office of the State Long-Term Care (LTC) Ombudsman for 1 of 42 sampled residents (Resident 150). This failure had the potential to lead to resident rights not being advocated for improper discharges.Findings include:Resident 150 (R150) was admitted on [DATE] with diagnoses including unspecified diastolic congestive heart failure, chest pain, and atrial fibrillation. R150 was discharged on 01/08/2026.R150's medical record lacked documented evidence of notification to the State LTC Ombudsman.On 02/26/2026 at 2:37 PM, the Director of Case Management explained the process for reporting to the LTC Ombudsman was to generate a list of discharged residents at the end of each month and send it by facsimile to the LTC Ombudsman. The Director of Case Management reviewed R150's medical record and confirmed the LTC Ombudsman was notified regarding the discharge. The Director of Case Management stated there was no proof, tracking or documentation kept to confirming the LTC Ombudsman was notified of any resident discharges.On 02/27/2026 at 1:54 PM, the Director of Nursing (DON) stated the expectation for reporting resident discharges to the LTC Ombudsman was the responsibility of case management. The DON explained at the end of each month, case management sent a list of discharges to the LTC Ombudsman for notification. The DON was unaware of how case management tracked the LTC Ombudsman notifications.The facility policy titled Discharge notification, revised on 05/09/2025, documented the Social Services Staff/or designee was charged with ensuring that systems were in place to provide written notification of transfer or discharge to the LTC Ombudsman. The notifications were documented in the resident's medical record.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, interview, and document review, the facility failed to ensure a care plan was developed for the care of extensive skin dryness in the lower extremities for 1 of 42 sampled residents (Resident 119). This deficient practice had the potential to worsen skin dryness and compromise skin integrity.Findings include:Resident 119 (R119) was admitted on [DATE] with diagnoses including bilateral lower extremity pain, onychomycosis, cellulitis of the right big toe, and morbid obesity.On 02/24/2026 at 11:00 AM, an observation revealed extensive flaky skin dryness with visible scaling of R119's bilateral lower extremities.A physician order dated 01/12/2020, documented instructions to apply antifungal cream to the bilateral lower extremities daily and as needed for dryness.The medical record lacked documented evidence a care plan was developed and implemented to address the resident's dry skin condition.On 02/27/2026 at 10:30 AM, the Director of Nursing (DON) confirmed the antifungal medication could have been administered at any time between 6:00 AM and 6:00 PM, as ordered by the physician. The DON indicated a corresponding care plan should have been developed to ensure the care of R119's skin condition.The facility's policy titled Person-Centered Care Plan dated 06/09/2023, documented a person-centered care plan was created to guide staff in the provision of treatment, care and services necessary for residents to obtain and maintain the highest physical, mental and psychosocial well-being.

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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, medical record review, interview, and document review, the facility failed to ensure 1) prescribed splints were applied as ordered for 1 of 42 residents (Resident 17), and 2) a staff member did not document an antifungal ointment as administered when it was not available in the medication cart and not applied to the resident for 1 of 42 sampled residents (Resident 119). This deficient practice had the potential to result in worsening contractures due to the lack of consistent joint positioning, and to result in untreated skin dryness, worsening skin breakdown, and missed medication doses.Findings include:Resident 17 (R17) was admitted on [DATE] with diagnoses including cerebrovascular accident with leftˆside weakness, atrial fibrillation, and hypertension.A physician order dated 12/02/2025 documented the use of splints as follows: a waffle boot to the left lower extremity and a carrot orthosis to the left hand for 6 hours or as tolerated.A physical therapy evaluation dated 07/23/2025 documented R17 could safely wear an orthotic on the left foot for up to 4 hours.On 02/24/2026 at 9:40 AM, R17 was observed in bed with a contracture of the right hand and paralysis of the left side of the body. The waffle boot and carrot orthosis were not observed to be applied as ordered.On 02/25/2026 at 9:00 AM, R17 was observed in bed. The prescribed splints were not observed to be applied.On 02/25/2026 at 10:00 AM, review of the Medication Administration Record (MAR) revealed a nurse had signed at 9:00 AM, indicating the splints had been applied.On 02/25/2026 at 11:30 AM, R17 was observed in bed. The prescribed splints were not observed to be appliedOn 02/25/2026 at 11:40 AM, a Registered Nurse (RN) assigned to care for R17 confirmed the resident was not wearing the prescribed splints. The RN acknowledged the MAR had been signed to indicate the splints were applied but the application had not yet occurred because they had been busy. The RN checked R17's room and was unable to locate the splints.A care plan dated 12/30/2025, documented R17 required a waffle boot on the left lower extremity and a carrot orthosis on the left hand to prevent further contracture. The care plan indicated R17 refused the splints, and approaches included encouraging residents to comply with wearing or placing splints as ordered.2) Resident R119 was admitted on [DATE] with diagnoses including bilateral lower extremity pain, onychomycosis, cellulitis of the right big toe, and morbid obesity.On 02/24/2026 at 11:00 AM, an observation revealed extensive flaky skin dryness with visible scaling of R119's bilateral lower extremities.A physician order dated 01/12/2020 documented instructions to apply antifungal cream to the bilateral lower extremities daily and as needed for dryness.The medical record lacked documented evidence a care plan was developed and implemented to address the resident's dry skin condition.On 02/27/2026 at 9:00 AM, the treatment administration record (TAR) revealed the antifungal medication was signed as administered in the spot corresponding to that day.On 02/27/2026 at 10:15 AM, a Registered Nurse (RN) assigned to care for R119 stated the resident received antifungal ointment daily for skin dryness to the bilateral lower extremities. Upon request to review the medication, the RN confirmed the antifungal ointment was not available in the medication cart and a new container had to be retrieved from the supply room. The RN acknowledged the medication had not been applied but had been documented as administered on the MAR. The RN verbalized medication should not have been charted as given if it was not available.On 02/27/2026 at 10:30 AM, the Director of Nursing (DON) confirmed the antifungal medication could have been administered at any time between 6:00 AM and 6:00 PM, as ordered by the physician. The DON acknowledged the antifungal medication should not have been documented as administered when it was not available, as this created the potential for a missed dose. The DON indicated the resident's skin condition should have been accurately documented on the weekly skin assessments, and a corresponding care plan should have been developed.The facility's policy titled Medication Management Program last revised on 01/15/2025, documented the authorized staff member should return to the medication cart immediately after the administration of the medication to document the administration by signing with initials on the MAR. The policy indicated that if the medication was not given, a rationale should be documented.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure dietary orders were followed for a resident receiving a chopped diet for 1 of 42 sampled residents (Resident 16). The deficient practice created potential for choking, aspiration and/or compromised nutritional status of the resident.Findings include:Resident 16 (R16) was admitted on [DATE] with diagnoses including spinal stenosis, anorexia, morbid obesity, history of stroke, dysphagia, and altered mental status.A physician diet order dated 01/23/2026 documented no added salt, consistency chopped.On 02/25/2026 at 12:50 PM, R16 was lying in bed with head of bed elevated eating lunch. R16's meal ticket documented no added salt-chopped and included the following items: -Three chicken tenders with one portion of dipping sauce-Oneˆhalf cup mashed potatoes with 2 ounces of gravy-Oneˆhalf cup chopped steamed cabbage-One serving of chopped lemon meringue pieR16's meal tray consisted of a chicken patty on bun cut into four quarters, French fries, green beans, chocolate cream pie. R16 explained the chicken patty on bun had been cut into four quarters by a Certified Nursing Assistant (CNA).R16's meal tray did not reflect the items listed on the meal ticket.When comparing the meal ticket to the food on the tray, R16 explained did not have any of those foods on the tray. R16 began eating the chicken sandwich and started coughing. R16 explained items on meal tray were usually chopped in smaller pieces.On 02/25/2026 at 1:30 PM, CNA3 confirmed R16's food items on the plate did not match the meal ticket.On 02/25/2026 at 1:35 PM, a Licensed Practical Nurse (LPN), explained food was chopped in the kitchen for chopped diet orders prior to being delivered to the residents. The LPN stated if food items on the meal tray do not match the meal ticket, the CNA was to notify the kitchen prior to serving the meal.On 02/25/2026 at 3:36 PM, CNA4 explained when passing meal trays, the process was to ensure the meal tickets matched food on tray and came from the kitchen as ordered. If the meal tray and ticket did not match, the meal was brought to the kitchen and switched for the proper meal. CNA4 delivered R16s meal tray and did not pay attention to the diet order. CNA4 acknowledged the tray was incorrect and the food was not chopped. CNA4 explained residents consuming incorrect textured foods were at risk for choking.R16's nutritional care plan approach edited 01/23/2026 documented interventions to include diet as ordered by physician: No Added Salt, Chopped.On 02/26/2026 at 1:30 PM, a Speech Therapist explained R16 was followed by speech services and required a chopped diet to prevent them from taking too big of bites of food, due to impulsivity and to prevent choking. On 02/27/2026 at 1:41 PM, the Director of Nursing (DON), explained staff were expected to ensure residents were provided with the appropriate diet consistency when distributing meal trays. The DON explained the process started in the kitchen, where staff were responsible for checking and preparing the meal tray to the appropriate order. When staff set up the meal tray, they were expected to review the meal ticket. If there was a discrepancy, staff brought the tray back to the kitchen or to the attention of kitchen staff to get the appropriate meal. The DON confirmed a chicken sandwich cut in four quarters did not constitute a chopped diet order. The DON explained the tray should have been the correct consistency before leaving the kitchen and the CNA should have alerted the kitchen when the tray was discovered to not be accurate. The facility policy titled Therapeutic diets revised on 10/15/2025, documented to prepare and serve all therapeutic and mechanically altered diets as planned, and to check all trays for accuracy before they were served to the patient/resident.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure expired food items were discarded from two resident refrigerators. The deficient practice had the potential for expired foods to be consumed, which could lead to foodborne illness. Findings include:On 02/24/2026 at 11:26 AM, the refrigerator in resident room [ROOM NUMBER] contained:- one unopened container of yogurt, expired 12/18/2025- two unopened bottles of Starbucks Vanilla Frappuccino, expired 12/15/2025- two slices of blueberry pie, each in a clamshell container not datedOn 02/24/2026 at 11:36 AM, a Certified Nursing Assistant (CNA1), confirmed the findings in the refrigerator in resident room [ROOM NUMBER]. CNA1 explained CNA staff were responsible for cleaning the refrigerators and removing expired food items as part of daily duties when cleaning resident rooms. CNA1 stated expired items should have been discarded to prevent residents from consuming and getting sick.On 02/24/2026 at 11:56 AM, a Registered Nurse (RN), stated the resident refrigerators were checked daily and nurses and CNAs were responsible to monitor them and expired items discarded. The RN explained expired items would need to be removed to prevent residents from consuming and possibly developing stomach issues such as pain or diarrhea. On 02/24/2026 at 12:06 PM, the refrigerator in resident room [ROOM NUMBER] contained a ham and cheese sandwich, wrapped in cellophane, with a handwritten date on it. The date was written in black ink, 02/2026 was legible, however, the numerical day of the month was smeared and could not be determined. A resident who occupied room [ROOM NUMBER], stated the ham and cheese sandwich had, been in there a while.On 02/24/2026 at 12:16 PM, CNA2, confirmed the ham and cheese sandwich in the refrigerator for room [ROOM NUMBER], and declared the date on the cellophane wrapper was 02/01/2026. CNA2 placed ham and cheese sandwich back into the refrigerator and stated, in case the resident wants to eat it later.On 02/24/2026 at 12:19 PM, a Registered Nurse (RN), confirmed the ham and cheese sandwich in the refrigerator for room [ROOM NUMBER] and stated the writing for the date was unclear. The RN indicated would discard the item and stated food items should be in refrigerator less than 3 days.On 02/27/2026 at 1:46 PM, the Director of Nursing (DON) explained the resident refrigerators should not contain expired food items. The expectation was the night shift staff checked the refrigerators weekly and removed and discarded expired items right away. The DON indicated regardless of food items being opened, if date was expired, it should have been disposed of. The DON explained residents who consumed expired food were at risk for illness or infection. The facility policy titled Food from outside sources, safe handling of, revised on 06/20/2023, documented foods were labeled to identify the resident's name, container contents, and the date it was prepared. Items were stored for three days. Expired and unlabeled items would be discarded.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and document review, the facility failed to maintain proper waste management practices by allowing 3 of 3 outdoor waste dumpsters to remain uncovered. This deficient practice had the potential to attract pests and create unsanitary conditions in the wasteˆhandling area.Findings include:On 02/24/2026 at 8:40 AM, three outdoor garbage dumpsters were observed uncovered and overfilled, creating conditions that could attract pests and result in unsanitary wasteˆhandling practices.On 02/24/2026 at 9:30 AM, the Maintenance Director confirmed the observation and stated the garbage service company picked up waste weekly. The Maintenance Director acknowledged the dumpsters should have been kept covered at all times to prevent pest activity and odors.The facility's policy titled Waste Disposal, dated 10/16/2025, documented that waste would be disposed of in a manner that prevents transmission of disease, nuisances, or breeding areas for insects and feeding areas for animals such as rodents. The policy further indicated staff should ensure waste containers and dumpsters remain covered.