STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295095	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandstone Spring Valley	5650 South Rainbow Blvd 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review the facility failed to ensure a resident was kept safe from abuse for 1 of 6 sampled residents (Resident 1). The deficient practice had the potential for the resident to experience emotional distress and physical harm. Findings include: Resident 1 (R1) R1 was re-admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus, chronic obstructive pulmonary disease, end stage renal disease, and heart failure. The facility reported incident (FRI) dated 02/03/2024 documented the following: -On 02/01/2025 in the PM, R1 reported to the Nurse that on Saturday 2/1/2025, a Certified Nursing Assistant (CNA) took R1's room phone away because the resident kept calling the desk. - Employee 1 (E1) was interviewed and admitted to taking the phone away from the resident because the resident had kept calling the front desk. -Conclusion: The allegation of abuse by E1 against R1 was substantiated. The facility investigation documented R1 was upset with E1 due to E1 unplugging the phone in the room and putting it on the dresser across the room where R1 could not get to it and telling R1 to stop calling downstairs. E1 was suspended pending the investigation results. E1 was terminated on 02/06/2025 for abuse as the facility documented the employee willfully inflicted punishment to the resident which resulted in R1's mental anguish. The facility also reported E1 to the Board of Nursing on 02/06/2025. The Social Services Coordinator's (SSC) investigative notes documented R1 thought E1 was upset with R1. R1 also stated E1 had been bossy and had given R1 attitude because E1 said R1 was putting the call light on too much and was calling downstairs constantly asking for things. R1 stated E1 unplugged the phone in the room and put it on the dresser across the room where R1 could not get to it and told R1 to stop calling downstairs. The SSC also documented R1 still had their cell phone and call light with them during this event. (continued on next page)

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
	295095	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandstone Spring Valley	5650 South Rainbow Blvd 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A behavioral Care Plan revised 02/28/2025 documented R1 was demonstrating behavioral distress related to feeling powerless or out of control and utilizing ineffective coping mechanisms. Interventions included praising calm communication, walking to quiet areas, and staff to professionally and calmly communicate to the resident. A behavioral Care Plan implemented on 02/28/2025 documented R1 was displaying behavioral symptoms of yelling and screaming out due to difficulty in adjusting to life in a Long-Term Care facility due to ineffective coping skills. Interventions were updated to include staff intervening when inappropriate behaviors were observed by using creative refocusing to alter the resident's behavior patterns. On 06/05/2025 at 10:45 AM, R1 stated this incident happened a while ago. R1 said nothing like this had happened before or after this incident. R1 reported no psychosocial harm from the incident and reported also not experiencing any emotional distress from the incident. R1 stated felt safe and fine at this facility. The facility policy titled Resident Rights, Abuse and Neglect, adopted 05/01/2024, documented it is the policy of this facility to provide professional care and services in an environment free from any type of abuse, corporal punishment, involuntary seclusion, and misappropriation of property, exploitation, neglect, or mistreatment. During the onsite investigation on 06/05/2025, the facility's correction of the past non-compliance related to the incident occurred as evidenced by: -Observation of resident interactions were respectful and courteous. -Interviews with residents revealed they were happy with staff and were treated in a polite manner. -E1 was terminated and reported to the Board of Nursing on 02/06/2025. Facility Reported Incident #NV00073489 Complaint #NV00073457

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295095	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandstone Spring Valley	5650 South Rainbow Blvd 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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and document review the facility failed to ensure abuse policies and procedures were implemented for 1 of 6 sampled residents (Resident 1). The deficient practice had the potential to put residents at risk of physical or psychosocial harm. Findings include: Resident 1 (R1) R1 was re-admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus, chronic obstructive pulmonary disease, end stage renal disease, and heart failure. The facility reported incident (FRI) dated 02/03/2024 documented the following: -On 02/01/2025 in the PM, R1 reported to the nurse that on Saturday 2/1/2025, a Certified Nursing Assistant (CNA) took the resident's room phone away because the resident kept calling the desk. - Employee 1 (E1) was interviewed and admitted to taking the phone away from the resident because the resident had kept calling the front desk. The facility investigation documented the allegation of abuse by E1 against R1 was substantiated. The investigation also documented R1 was upset with E1 due to E1 unplugging the phone in the room and putting it on the dresser across the room where R1 could not get to it and telling R1 to stop calling downstairs. E1 was suspended pending the results of the investigation. E1 was terminated on 02/06/2025 for abuse as the facility documented the employee willfully inflicted punishment to the resident which resulted in R1's mental anguish. The facility also reported E1 to the Board of Nursing on 02/06/2025. On 06/05/2025 at 1:37 PM, a CNA indicated staff have their trainings on the computer. The CNA stated thought had completed the Abuse and Neglect Annual Training last week. On 06/05/2025 at 10:15 AM, a Licensed Practical Nurse (LPN) verbalized could not remember the last time the facility had training on resident abuse and neglect. On 06/05/2025 in the afternoon, the Director of Nursing (DON) indicated ongoing abuse training should occur with an abuse allegation event. The DON stated would have expected staff education on abuse like they provide at hire and annually. Employee training records indicated staff had not received additional abuse training related to the abuse event. The facility policy titled Resident Rights, Abuse and Neglect, adopted 05/01/2024, documented ongoing training sessions were one of the seven steps for the prevention of abuse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295095	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandstone Spring Valley	5650 South Rainbow Blvd 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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/05/2025 at 3:07 PM, the Administrator acknowledged their policy and procedures bullet pointed steps which should be taken to prevent a future occurrence of the abuse. The administrator indicated abuse training related to the identified abuse, which was investigated, should have been a part of their action steps taken to prevent future occurrences. The Administrator stated an allegation of abuse should have initiated this type of ongoing abuse training. FRI #NV00073349