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	04/02/2026

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 interviews, record review, and document review, the facility failed to maintain professional boundaries and protect a resident from verbal abuse for 1 of 3 sampled residents (Resident 1). This deficient practice had the potential for residents to experience emotional and physical harm.Findings include:Resident 1 (R1) was admitted on [DATE] and discharged on 03/13/2026 with diagnoses of quadriplegia, immunodeficiencies, protein-calorie malnutrition, and difficulty walking.The Quarterly Minimum Data Set (MDS) dated [DATE] documented R1 had a BIMS score of 15 indicating R1 was cognitively intact.A nurse's progress note dated 01/16/2026, documenting events from 01/15/2026, indicated R1 went to the Director of Nursing's (DON) office with the Director of Staff Development and a certified nursing assistant (CNA) present. R1 expressed concerns regarding an argument with CNA1. R1 reported becoming frustrated due to waiting times and began yelling and using foul language toward CNA1. CNA1 responded in a similar manner and then exited the room.A physical therapy assistant (PTA) present during the incident was interviewed. R1 was informed an investigation would be initiated and that appropriate reporting procedures would be followed. R1 apologized for the behavior and indicated they were simply frustrated.The DON offered a psychiatric consultation, which R1 accepted. The primary provider was notified and ordered a psychiatric referral. A psychiatric nurse practitioner who was on-site evaluated R1. R1 expressed appreciation for the facility's response.A physician encounter note dated 01/17/2026 documented the nurse reported R1 had a verbal altercation with CNA1. The incident was reported to DON and Assistant Director of Nursing (ADON). The physician noted R1 had a history of behavioral issues and a pattern of being non-cooperative with nursing staff.On 04/02/2026 at 9:25 AM, a Licensed Practical Nurse (LPN) reported R1, did not want to be at the facility, frequently became upset and used profane language toward staff. The LPN recalled an incident in which the resident was yelling at a staff member. When the LPN entered the room to assess the situation, the resident yelled, I have gotten one staff fired; do you want to get fired also? The LPN noted the resident later apologized for the behavior.On 04/02/2026 at 10:45 AM, a Physical Therapy Assistant (PTA) recalled going to R1's room to determine whether the resident was ready for their scheduled therapy session. The PTA indicated, upon entering the room, R1 appeared agitated. CNA1, whose name was unknown, entered the room shortly afterward, and R1 began exchanging words with staff, using profane language, including repeated use of the F word.The PTA immediately reported the incident to the DON. The PTA observed R1 had gone to the DON to report the issue as well.On 04/02/2026 at 11:50 AM, CNA2 reported hearing noise coming from R1's room and went to check what was happening. Upon entering, CNA2 observed R1 yelling, CNA1 then entered the room, and a verbal exchange occurred between the R1 and CNA1. During this exchange, both R1 and the CNA1 used profane language. CNA1 subsequently exited the room.On 04/02/2026 at 12:45 PM, the Director of Nursing (DON) explained the facility's procedures when an allegation of abuse was reported. The DON explained upon receiving an allegation, the facility immediately initiated an investigation. This process included interviewing the residents involved, followed by interviews with other residents and staff members who might have had relevant information.The DON explained (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	team meeting would be held, which included the Assistant Director of Nursing (ADON) and Social Services, to develop appropriate, tailored to the individual needs and goals of each resident.If the allegation involved staff-to-resident abuse, the employee would be suspended pending the outcome of the investigation. If the allegation was not substantiated, the staff member would be permitted to return to work but required to complete one-on-one retraining regarding abuse prevention and appropriate conduct. If the allegation was substantiated, the employee would be terminated, and the incident reported to the Board of Nursing.The DON indicated being informed of an incident between R1 and CNA1 in which profane language was exchanged by both parties. The DON interviewed CNA1 involving in the incident, and CNA1 admitted responding to the resident using profanity out of frustration. The DON suspended the CNA1 pending further investigation.The DON indicated other staff members, who were present during the incident, were interviewed and confirmed the verbal exchange between R1 and the CNA1 had occurred. After gathering all interviews from staff, residents, and the CNA1 involved, the Interdisciplinary Team (IDT) concluded the incident was verified. Based on the findings, CNA1 was terminated on and reported to the State Board of Nursing. Education and training on abuse prevention and reporting policies and procedures were provided for all staff, and the family members and physician were notified.During the onsite investigation on 04/02/2026, the facility's correction of the past non-compliance as evidenced by:Observation of staff and resident interactions were professional and courteous.The DON interviewed the staff who were present during the incident and verified that the incident had occurred between Resident 1 (R1) and the Certified Nursing Assistant (CNA1).ADON interviewed alert and oriented residents in the area where the CNA had worked; no additional complaints were noted or observed.R1 was seen by the psychiatric nurse practitioner following the incident to assess psychosocial well-being.R1 remained stable, and no acute changes were observed.Documentation of education was provided to the CNA1 on 01/15/2026 including training on abuse and prior customer service, termination was carried out on 01/21/2026, and the CNA was reported to the State Board of Nursing regarding the incident. Documentation of staff in-services and education on abuse and neglect were provided from 01/16/2026 through 01/20/2026.FRI #2720791