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	06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Ridge Post Acute	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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to maintain a safe and comfortable room temperature for 1 of 8 sampled residents (Resident 1). The deficient practice had the potential to cause discomfort, dehydration, heat-related illness, and reduce the quality of life for the residents. Findings include: On 05/15/2026 at approximately 1:30 PM - 2:00 PM, observations and temperature measurements were conducted on the first-floor resident rooms located within the Lake [NAME] and Mt. [NAME] residential hallways. Room temperature measurements were obtained using a battery-operated temperature gun. Temperatures were taken along the forward-facing wall directly in front of the resident's bed in each room. Great care was taken to avoid obtaining temperature readings from windows, exterior walls exposed to direct sunlight, reflective surfaces, or other heat-producing sources in order to maintain a consistent and reliable method for assessing room temperatures. The observations and temperature measurements were conducted in the presence of facility maintenance staff, who acknowledged the conditions observed. The following resident room temperatures were recorded: room [ROOM NUMBER] – 81.6 degrees F room [ROOM NUMBER] – 84.9 degrees F room [ROOM NUMBER] – 85.4 degrees F room [ROOM NUMBER] – 86.1 degrees F room [ROOM NUMBER] – 81 degrees F room [ROOM NUMBER] – 81. degrees F room [ROOM NUMBER] – 85.1 degrees F During an interview, the Maintenance Director (MD) stated that portions of the facility's aged HVAC system were not operational. The MD further indicated that fans and portable interior air-conditioning units were being deployed throughout the facility in an attempt to mitigate elevated temperatures. During an additional interview, the facility's newly contracted HVAC vendor stated that the facility's (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	HVAC system was aged out and was under contract for complete replacement. The vendor stated that the replacement project would be completed in four phases, with each phase expected to last approximately one to one-and-one-half months. The vendor further stated that phases one and two would focus on areas of the facility with HVAC systems that were completely inoperable, with subsequent phases addressing the remaining units until full replacement of the HVAC system was completed. A resident complaint involved the air conditioning system not keeping the residents comfortable. The acceptable temperature range was 71 degrees to 81 degrees. At the time of the survey the resident of concern room temperature was measured at 85 degrees, which is four degrees greater than the maximum 81 degrees. The building has a first floor and a second floor, and each floor is divided into three major building sections. The three sections of the building were (1) Housing South; (2) Housing North; and (3) Central Middle for support services. Each of the housing sections further divided into three smoke compartments and are the same on both levels: North housing, three smoke compartments for each level to include: North (1200 & 2200) with 12 single resident rooms, nurse station and dining room. East (1300 & 2300) with 12 single resident rooms. South (1100 & 2100) with 4 single resident rooms and 6 double resident rooms (16 total residents). South housing North (1400 & 2400) with 4 single resident rooms and 6 double resident rooms (16 total residents). West (1600 & 2600) with 16 single resident rooms. South (1500 & 2500) with 12 resident rooms, nurse station and dining space Central support first floor. Large smoke compartment: lobby, multiple business offices, PT and OT, resident activity spaces, medical records storage spaces and dietary department. Small smoke compartment: stairs wand east elevators and storage rooms. Central support second floor Large smoke compartment with [NAME] elevators and stairs, Northeast freight. elevators and stairs, long corridor open to the lower floor, and mechanical rooms. Small smoke compartment for East stairs and elevators, plus storage rooms. 05/14/2026 Thursday High outside temperature (95 degrees) First floor: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Central smoke compartment, Lobby was hot (82 degrees) Delivery hall (82.5 degrees) North housing, East 1302 (82 degrees), 1311 (84 degrees) Nurse station (82.4 degrees) South 1108 (85 degrees), 1102-1108 corridor (84 degrees); re-temp 1108 (83.5 degrees AVG) Second floor: South housing, South 2508 (81.5 degrees), 2502 (86.5 degrees), West Dining (83.8 degrees) nurse station (81.5 degrees) North housing, South 2102 (87.9 degrees) East Nurse station (83.1 degrees), 2302 (84.9 degrees), 2304 (89.2 degrees), 2311 (89.6 degrees) 05/15/2026 Friday High outside temperature (99 degrees) First floor: North housing, East smoke compartment 1304 (85.1 degrees), 1311 (85.4 degrees) South housing South smoke compartment 1507 (81.6 degrees), 1508 (85 degrees) Second floor: North housing East smoke compartment 2-303 (87 degrees), 2304 (96 degrees) empty room, 2-306 (98 degrees) empty room, 2-308 (85 degrees), 2-309 (87 degrees), 2-310 (91 degrees), 2-311 (92 degrees), 2-312 (88 degrees) 05/21/2026 Thursday High outside temperature (97 degrees) South housing, (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ˆ South smoke compartment 1508 (82.9 degrees) The facility had eight air handling unit systems, one roughly for each resident smoke compartment (6) for both the first and second floor; and one for each half of the central support smoke compartment upstairs and downstairs. On the roof, each air handling system had a bank of three units, and each unit required some level of attention for repair. Interview with the heating, ventilation, and air conditioning (HVAC) vendor Field Supervisor occurred over all three days, revealed the HVAC system needed to be redesigned to function properly. All HVAC system components needed to be custom built for this facility. A mechanical engineer was involved in generating the necessary data to update the mechanical plan set in order to begin the installation of the new upgraded HVAC equipment. The HVAC contractor indicated repairs and replacement efforts are currently underway and are projected to occur in four phases over an estimated six-month period. Each phase is anticipated to take approximately 1 to 1.5 months. The contractor reports they will first address units that are completely inoperable and then transition into replacement of aging rooftop units. Resident 1 (R1) was admitted on [DATE] with diagnoses including acute osteomyelitis right ankle and foot, type 2 diabetes mellitus with hyperglycemia, hypertensive heart and chronic kidney disease with heart failure and stage 5 chronic kidney disease. R1 resided on the 1100 hallway of the facility. On 05/14/2026 at 2:20 PM, upon entry into the facility a white 8x11 paper with black typed lettering was taped on the door entering the facility and at the reception desk in lobby and documented the following: Attention! We apologize for any inconvenience. Upgrades to the AC system are currently in progress. If you have any concerns, please feel free to communicate with Management. Thank you for your patience and understanding. A portable air conditioning (AC) unit was located in the front lobby adjacent to the reception desk. Ambient temperature throughout the facility in hallways, common areas and resident rooms fluctuated from comfortable to stuffy and warm. The facility utilized a multiple variety of portable AC units, industrial floor fans, and household oscillating fans throughout the hallways and in individual resident rooms. On 05/14/2026 at 2:26 PM, upon entering the 1100 hallway three fans were noted to be on and in use within the hallway. On 05/14/2025 at 2:28 PM, the Director of Maintenance explained the facility was in the process of replacing the existing air conditioning units and temperature checks were conducted every four hours. On 05/14/2026 at 2:30 PM, R1 was lying in bed with a sheet covering R1's abdomen and R1's legs were out from under sheet. A portable fan was located in the corner of R1's room by the door upon entry into R1's room. A small fan was sitting on R1's overbed table. R1 explained had been in the facility for a few weeks, and stated it's hot in here, had to bring the fans in to help. R1 explained the room had been hot for a few days. On 05/14/2025 at 2:32PM, a Life Safety surveyor and the Director of Maintenance obtained the room temperature of R1's room which registered at 85 degrees Fahrenheit (ˆ). (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/14/2026 at 4:06PM, the Administrator 1 (A1) and Director of Maintenance explained periodic temperature checks were initiated when temperatures outside began to rise approximately two weeks ago. Temperature checks were conducted every four hours 24 hours a day seven days a week. The nursing staff assisted with obtaining temperature checks in the evening/night shift hours. On 05/14/2026 at 4:34PM, the A1 explained the facility Emergency Plan would be if unable to keep room temperatures below 81ˆ, staff would relocate residents to alternate facilities. The trigger or determination of the relocation would be if temperatures were not able to be reduced below 81ˆ within two hours of placing portable air conditioners/fans then measures would be taken. On 08/14/2026 in the afternoon, review of the facility temperature logs lacked documentation regarding specific areas where the temperatures were obtained. On 05/14/2026 at 5:15PM, R1's room temperature was 83.8 ˆ; a portable AC unit had been installed and was turned on operating. The facility policy titled Homelike Environment, revised 02/2021, documented Residents were provided with a safe, clean, comfortable, and homelike environment. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics included a comfortable and safe temperature (71 ˆ- 81 ˆ). Complaint #3014048

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to comply or establish compliance with all applicable Federal, State, and local laws, regulations, and codes, specifically concerning:(1) not being properly permitted for construction/electrical change activities within the building with the local building department;(2) not completing the change of ownership license application with the State Survey Agency;(3) by not completing the change of ownership license application with the State Survey Agency, the facility has prevented their Centers for Medicare Medicaid Services (CMS) certification change of ownership from proceeding to completion; and(4) not timely notifying the State Survey Agency with all Administrator changes at this facility. Findings include: On [DATE] the census was 147 out of 160 licensed beds. A subsequent site visit on [DATE] the census was 128 out of 160 licensed beds. The facility failed to:1) Obtain the proper local building department permit related to the electrical wiring;2) Complete the state licensing application for the change of ownership;3) Complete the federal certification application process for the change of ownership; and4) Establish that there was an Administrator at the facility at all times or that the listed Administrator was present and available at this facility at all times. 1) On [DATE], a call was placed to the [NAME] County Building Department to enquire about electrical permits. Spoke with a Manager of Code Enforcement who was available to answer my questions. Our recent complaint investigation revealed the temporary installation of two Spider Boxes, these devices are generally used at construction sites to add electrical capacity to the project. In this case the Spider Boxes were used to add capacity for the use of portable air conditioning units in resident rooms and hallways while a new heating, ventilation, and air conditioning (HVAC) system was being installed. The two devices were hard wired into electrical panels in an electrical room on the first and second floor of the north housing section (half of the beds). The question of an electrical permit issued by the county was brought up but could not be answered by the facility. According to the telephone conversation with the Manager of the local county building department, an electrical permit would be required for this type of work of modifying the electrical panels connections to the spider boxes. The Manager indicated that a permit is required whether or not the electrical changes are code compliant or not. The Manager then looked up the facility's permit status and found one permit (for the HVAC system), and no permit was on record for the electrical panels modifications with the Spider Boxes. The facility would need to provide evidence of a permit issued by the County building department for the electrical modifications with the connected Spider Boxes installations. 2) The facility's proposed new owners submitted a Change of Ownership (CHOW) state licensing application on [DATE]. The [NAME] of Sale date was [DATE]. As of the date of this writing of [DATE], the CHOW license application has not been completed. Note: The license is still under the previous licensee until the license application is completed and approved. The previous licensee is exposed to the new owner's actions past the CHOW license completion date. 3) The facility's proposed new owners submitted a Change of Ownership (CHOW) federal certification application on [DATE]. The [NAME] of Sale date was [DATE]. As of the date of this writing of [DATE], the CHOW federal certification cannot be completed pending the completion of the state licensing application. 4) Interview with Administrator B on the afternoon of [DATE], revealed that Administrator B was currently an acting Administrator for the absent Administrator C, prior to the arrival of Administrator D that started on Monday [DATE]. Subsequent contact with Nevada Administrator Board, and this Board provided Administrator licenses for this facility's Administrators which were found in violation with the facility licensing regulations (Nevada Administrative Code (NAC) 449.0114) and not accurate with the Board of Administrators (NAC 654) for this facility as described below: a) The previous and current facility (Sandstone Spring (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Valley) had an Administrator Change on [DATE], wherein a new administrator, Administrator A, was in charge at the time when the state CHOW application was filed on [DATE]. What is not known is when Administrator A had actually left the facility. The [NAME] of Sale date was [DATE]. On [DATE] the State Survey Agency (SSA) was investigating a temperature related complaint at the facility and Administrator A had left Sandstone Spring Valley at an undetermined date prior to the SSA arrival. Administrator A's departure was made known to this SSA. There was no 10-day notification that Administrator A had left and that a new Administrator (Administrator B) was now at the facility (See NAC 449.0114(4)). However, on [DATE], Administrator B was at the facility on [DATE] complaint investigation. Administrator B was covering both his facility and temporarily covering this facility (which is allowed per NAC 654), but Administrator B's temporary license for this facility did not go into effect until [DATE], (per his temporary license) while being in charge at Sandstone Spring Valley during the [DATE] complaint investigation. Administrator B temporary Administrator License at this facility was issued [DATE] and an expiration date of [DATE]. Administrator C was not present and Administrator C's where abouts were unknown at the time of the hot ambient air temperature survey that was conducted on dates of [DATE] and 15, 2026, even though Administrator C was the Administrator of record for the facility at that time. However, Administrator B was at the facility on those dates even though Administrator B's temporary facility (Sandstone) Administrator's license had expired on [DATE]. Administrator C's Administrator's license issued [DATE], with the new name of the unlicensed facility (Sunset Ridge Post Acute) had the expiration date of [DATE]. Administrator D's first workday was [DATE]. Administrator D's Administrator license was issued [DATE], with the new name of the unlicensed facility (Sunset Ridge Post Acute) and had the expiration date of [DATE]. Administrator D was onsite with the subsequent survey date of [DATE]. Note: Administrator D license indicated 168 beds, which was a typo. There were only 160 licensed beds for this facility. A review summary of the above concerning this facility's noncompliance includes:i)The facility not pulling proper building permits;ii) the new owners of the new facility not being licensed;iii) the new owners of the new facility not being certified;iv) the facility not reporting Administrator changes timely to this State Survey Agency (SSA). NOTE: It is important to keep this SSA informed of the current Administrators so that when emergent events occur the SSA can get ahold of the proper person to mitigate problems. Since the CHOW application has not been closed, the new owner must ensure that all Administrator associated documentation has been included in the application, along with dates of service.