STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295110	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Valley Health and Wellness Suites	2965 Wigwam Parkway Henderson, NV 89074

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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
	295110	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Valley Health and Wellness Suites	2965 Wigwam Parkway Henderson, NV 89074

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 0627 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 a resident was not involuntarily discharged without a valid reason, when a resident returned to the facility after a therapeutic leave and was not allowed to reenter the facility, for one of two sampled residents (Resident 2). The deficient practice had the potential to cause residents to experience adverse effect such as mental distress and unmet medical needs. Findings include:The facility policy titled Against Medical Advice (AMA) -Day Outing/Therapeutic Leaves of Absence indicated a resident may leave for a day outing or therapeutic leave of absence (LOA) with family and friends at any time during their stay with written permission from their physician. If the physician denied permission, then the patient may elect the right to sign out against medical advice. The facility policy titled Discharge /Transfer, dated 10/23/2019, indicated for involuntary discharge, the facility would develop a safe discharge plan, including but not limited to securing an alternate location, and have the discharge plan approved by the resident or guardian, obtain a physician order for discharge, complete and provide a written notice of transfer/discharge to the resident and the Office of the State Long-Term Care Ombudsman. Resident 2 (R2) was admitted on [DATE] with diagnoses including congestive heart disease and muscle weakness. The resident was discharged on 07/02/2025. The type of discharge was listed as against medical advice (AMA). R2's admission Minimum Data Set (MDS), dated [DATE], indicated R2 had good memory function and no behaviors. The MDS indicated the resident was able to transfer and ambulate independently. A Physician Order dated 06/20/2025 indicated the resident may go on pass on their own risk for up to four hours at a time. The order indicated the resident should inform staff with as much advance notice as reasonably possible. A Discharge Summary Note, dated 07/02/2025, entered as a late entry on 07/12/2025, indicated the resident was discharged AMA. The Discharge Summary indicated R2 left on pass. The Discharge Summary indicated R2 was discharged AMA due to facility policy for noncompliance to 4-hour pass rule.A Voluntary Discharge Notification Against Medical Advice and Release of Liability Form, dated 07/02/2025, indicated the form lacked a diagnosis. The form indicated R2 was in violation of a four-hour pass per provider order and facility policy. The form indicated Pt didn't sign. A Nursing Progress Note dated 07/02/2025, and documented at 9:30 PM, indicated the AMA form was not signed by R2. The note indicated the resident violated a four-hour pass order from the provider and had violated facility policy. The note indicated R2 had left with the person that drives him when he goes out on pass with belongings in hand.A Nursing Noted dated 07/02/2025, and documented at 8:34 PM, indicated the Assistant Director of Nursing (ADON) had called the writer and asked if R2 was in the building back from the four-hour pass. The note indicated R2 had not returned to the facility. The ADON instructed the writer not to let the patient back into the building except to give the resident their belongings and if resident refused to leave and became a problem to call the police. The note indicated R2 returned at 9:15 PM. The note indicated R2 was given belongings and informed the resident could not stay at the facility any longer because the resident had abused the four-hour pass. The note indicated R2 was unhappy and stated it was not right that the facility was kicking the resident out. The note indicated R2 called someone and asked to be picked back up because of being told that the resident could not stay at the facility anymore. The note indicated the person arrived and R2 left with this person at 9:30 PM.On 09/18/2025 at 9:52 AM, the Assistant Director on Nursing (ADON), verbalized R2 had been discharged from the facility on 07/02/2025. The ADON reported the facility had experienced an ongoing problem with R2 going out on a four-hour pass and not returning on time. The ADON reported R2 would leave the facility without telling anyone. The ADON verbalized on 07/02/20254, R2 went out for pass in the morning, and was supposed to return around noon. The ADON reported R2 returned to the facility about 9:30 PM. The ADON reported when finding out the resident had not returned timely, the ADON instructed staff to pack the resident's belongings and put them in the lobby, and not to let the resident come back into the facility. The ADON instructed staff that when R2 arrived, they were to hand the resident the belongings and not to allow the resident to come into the building. The ADON indicated staff informed the resident because the ADON verbalized the facility policy and procedure directed if a resident was not back from a four-hour pass within four hours, it was to be considered an AMA discharge. The ADON revealed a resident wanting to leave against medical advice would be asked to sign a form before leaving the facility. The ADON revealed R2 did not sign the AMA form. On 09/18/2025, at 10:32 AM, the Case Manager, revealed on admission R2 was going to be long term. The Case Manager verbalized R2 was a long-term