

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29E037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Mission Pines Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2860 E. Cheyenne Avenue North Las Vegas, NV 89030	
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 observation, interview, record review and document review, the facility failed to ensure a resident was free from abuse for 1 of 7 sampled residents (Resident 1). The deficient practice had the potential to result in physical injury, pain, emotional distress, fear, and psychosocial harm to the resident as a result of resident-to-resident physical aggression. Findings include: Resident 1 (R1) was admitted on [DATE] and readmitted on [DATE], with diagnoses including dementia, schizophrenia, and anxiety disorder. The Brief Interview of Mental Status dated 05/08/20206, documented a score of 11/15, indicating R1's cognitive status was moderately impaired. Resident 2 (R2) was admitted on [DATE] and readmitted on [DATE], with diagnoses including dementia, post-traumatic stress disorder, anxiety disorder, bipolar disorder, and hemiplegia (complete paralysis of one side of the body) and hemiparesis (weakness or partial loss of strength on one side of the body). The Brief Interview of Mental Status dated 05/08/20206, documented a score of 15/15, indicating R2's cognitive status was intact. A facility report dated 05/08/2026, documented residents had a verbal altercation which escalated to a physical altercation. R1 made physical contact with open palm to the right arm of R2. No physical aggression received in return. Both residents involved were immediately separated by staff. A Nursing Progress Note dated 05/07/2026, documented R2 was in the dining room waiting for a scheduled smoke break when R2 became involved in a verbal altercation with R1 and called out to staff for assistance. Staff immediately intervened, separated both residents, and placed them on one-to-one observation. A skin assessment was completed, which revealed no injuries, redness, or bruising. R2 denied pain. The physician and family were notified of the incident. Physician orders were obtained for monitoring and a psychiatric evaluation. A Physical Aggression Report dated 05/07/2026 at 11:00 AM, documented R1 was involved in a verbal altercation with R2 while seated in the south dining room. The report indicated R1 was alert and oriented to person, place, time, and situation. Following the verbal altercation, R1 initiated physical contact with R2, resulting in resident-to-resident physical aggression. The Employee (Receptionist) Statement dated 05/07/2026 documented R1 and R2 were involved in a verbal altercation in the south dining hall. The receptionist reported hearing the residents arguing and, upon looking toward the area, observed R1 strike R2 on the right arm. The receptionist documented R1 made a comment about being first; however, the receptionist was unable to determine the exact nature or context of the dispute. On 06/17/2026 at 9:35 AM, a Certified Nursing Assistant (CNA) indicated R1 could engage in conversation but frequently demonstrated impaired recall. The CNA described R1 as verbally aggressive at times, could become angry and curse at staff. The CNA reported not witnessing the resident-to-resident altercation involving R1 and R2 on 05/07/2026, but was informed the incident occurred during the transition to smoke break. The CNA indicated R1 and R2 were roommates at the time of the incident and frequently spent time together. The CNA indicated that following the altercation, the residents were immediately separated, no longer permitted to sit together, relocated to separate rooms on opposite sides of the unit, and placed on increased monitoring. On 06/17/2026 at approximately 11:10 AM, a Licensed Practical Nurse (LPN) who was the assigned nurse during R1 and R2's altercation on 05/07/2026. (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	The LPN indicated was assigned to the unit at the time of the incident but did not witness the actual altercation. The LPN reported both residents were in the dining room preparing to line up for a scheduled smoke break. According to information reported to the LPN by staff and residents, R1 and R2 engaged in a verbal disagreement regarding who would be first in line for the smoke break. The LPN indicated R1 became upset with R2's response and made physical contact with R2 occurred in the south dining room. The LPN indicated was familiar with R1 prior to the incident and described R1 as having fluctuating moods and behaviors. The LPN indicated that one moment R1 could be pleasant and cooperative, while at other times R1 could become angry if something occurred that R1 did not like. The LPN reported R1 was known to become upset when redirected, including when staff limited smoking privileges due to safety concerns. The LPN indicated staff received abuse prevention education routinely and had received recent abuse training approximately one month prior to the incident. On 06/18/2026 at 8:52 AM, during a telephone interview, R2 indicated while seated in the hallway outside the dining room she asked R1 ([NAME]) to move slightly to allow room. R2 reported R1 became upset, accused R2 of attempting to take R1's spot, and intentionally struck R2 on the arm. R2 denied any prior altercations with R1 and reported experiencing temporary pain but no bruising or injury. R2 stated there were no staff members physically present in the immediate area when the incident occurred. R2 expressed the incident was a significant concern because physical aggression occurred without provocation or reason and no resident should be struck by another resident. On 06/18/2026 at 9:16 AM, during a telephone interview, the Receptionist indicated witnessing R1 and R2's physical aggression. The Receptionist indicated being stationed at the reception desk and hearing a verbal altercation coming from the dining room area. Upon looking toward the area, the Receptionist observed R1 strike R2 on the arm. The Receptionist explained approximately six residents were present in the dining area at the time of the incident. The Receptionist indicated no staff members were physically present in the dining room or immediate area and confirmed residents were not being directly monitored at the time of the altercation. The Receptionist reported being the only staff member who witnessed the incident and the first staff member to respond. The Receptionist indicated residents frequently gathered in the area while waiting for smoke breaks and there was no designated staff assignment to supervise residents in the hallway or dining area except of mealtimes or smoking times. The Receptionist indicated resident supervision was not a direct responsibility of the receptionist position due to other assigned duties at the reception desk; however, resident activity remained within view of the reception area. The Receptionist reported attention was drawn to the incident after hearing the residents arguing and immediately responded upon observing physical contact. On 06/18/2026 at 9:31 AM, during a telephone interview, the Director of Nursing (DON) believed the residents were preparing for a scheduled smoke break at the time of the incident and were arguing regarding the smoking line. The DON acknowledged residents preparing for smoke breaks should have been monitored and indicated residents were discouraged from lining up early for smoke breaks because conflicts could occur. The DON reported residents were expected to be supervised during mealtimes, activities, and smoking-related activities. The DON indicated staff were generally present during meals, activity staff supervised organized activities, and residents preparing for smoke breaks were expected to be monitored. The DON indicated the altercation may have been prevented had a staff member been physically present with the residents during the smoking line-up. The DON acknowledged the incident could have been prevented through staff intervention, including having a staff member present and separating the residents once the verbal escalation began. The DON indicated R2 was frustrated but did not sustain any observed injury and there were no indications of trauma following the incident. A facility policy titled Resident Rights (undated), indicated a resident is entitled to be free from mental and physical abuse. A facility policy titled Abuse, Neglect, Exploitation, and Misappropriation Prevention Program revised 04/2021, documented residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. FRI 3009520		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure a comprehensive care plan was updated to include interventions surrounding supervised visitation by a specific family member with criminal history for 1 of 7 sampled residents (Resident 4). The deficient practice had the potential to compromise the safety of the resident and violate the privacy of other residents in the secured unit. Findings include: Resident 4 (R4) was admitted on [DATE], with a diagnoses including unspecified dementia, anxiety and schizophrenia. On 06/17/2026 at 8:25 AM, R4 was seated in the common lounge located at the center of the secured unit. There was a total of 13 residents in the lounge seated near one another. Upon the survey team's request, R4 was assisted to the room by a staff member for an interview. On 06/17/2026 at 8:31 AM, R4 was pleasant, cooperative and able to respond to questions with moments of confusion noted. R4 indicated being a resident at the facility for about four years and was satisfied with the care provided by nursing staff in the unit. On 06/17/2026 at 8:43 AM, a Certified Nursing Assistant (CNA) steadily assigned to the secured unit was familiar with R4 and indicated R4 was under public guardianship but there was one family member who visited R4 mostly on weekends. On 06/17/2026 at 9:00 AM, the charge nurse steadily assigned in the secured unit indicated being very familiar with R4 who a resident at the facility for about four years had been and was in the secured unit due to dementia. The nurse indicated R4 was under public guardianship and did not get any family visits until a biological child was released from prison after a 20-year sentence. The charge nurse emphasized the family member was on supervised visits due to taking unauthorized photos of R4 and to prevent unauthorized photography of other residents in the unit. The medical record lacked documented evidence R4's comprehensive care plan was updated to include safety measures which would be put in place to ensure R4 and other residents' rights were respected and honored during visits by the family member with a criminal history. On 06/17/2026 at 11:43 AM, a representative from the public guardian's office confirmed R4 had a family member who surfaced after serving a long prison sentence and the facility informed the public guardian's office that visitation for this family member would be supervised due to making false allegations and unauthorized photography. On 06/17/2026 at 1:30 PM, the Director of Nursing (DON) indicated receiving a report from a nurse regarding unauthorized photography by R4's family member. The DON indicated speaking with R4's family member who maintained only photos of R4 were taken and not of the other residents. The DON indicated the incident occurred in the common lounge where the residents in the secured unit would often be seated close to each other. The DON indicated visits were not to occur outside the secured unit under observation by staff. On 06/17/2026 at 2:39 AM, the Administrator and DON indicated R4's care plan for public guardianship initiated on 03/17/2023 should have been updated to include observed visitation by R4's family member and monitoring R4 for signs and symptoms of psychosocial distress. On 06/18/2026 in the morning, the Administrator clarified visitation by R4's family member who had a criminal history should be supervised due to reports of possible unauthorized photography. Visitations would be conducted outside the secured unit, in other areas of the facility such as the dining area, patio or any available areas with consideration to the residents' preference. The Administrator indicated R4's care plan should have been updated to reflect said intervention related to visitations by R4's family member. The Comprehensive Care Plan policy revised March 2022, documented assessments of residents were ongoing, and care plans were revised as information about the residents changed. FRI 2790348 FRI 2971681		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review, the facility failed to ensure the medical record contained complete information for 1 of 7 sampled residents (Resident 4). The deficient practice had the potential to negatively impact on the resident's quality of care. Findings include: The Charting and Documentation policy revised July 2017 documented all services provided to residents and any changes in the residents' psychosocial condition shall be documented in the resident's medical record. The medical record should facilitate communication between the inter-disciplinary team (IDT). Documentation would include events and incidents involving the residents and documentation must be objective, complete, and accurate. Resident 4 (R4) was admitted on [DATE], with a diagnoses including unspecified dementia, anxiety and schizophrenia. On 06/17/2026 at 9:00 AM, the charge nurse steadily assigned in the secured unit indicated being very familiar with R4 who a resident at the facility for about four years had been and was in the secured unit due to dementia. The nurse indicated R4 was under public guardianship and did not get any family visits until a biological child was released from prison after a 20-year sentence. The charge nurse emphasized the family member was on supervised visits due to taking unauthorized photos of R4 and to prevent unauthorized photography of other residents in the unit. The medical record lacked documented evidence the facility addressed, discussed, care planned and communicated to the interdisciplinary team (IDT) the change in R4's situation, specifically, the reappearance of R4's biological child who had a significant criminal history after the family member's release from prison. On 06/17/2026 at 11:43 AM, a representative of the office of the public guardian confirmed R4 was a protective ward and conveyed a note dated 05/20/2026 which read, R4's family member had been placed on supervised visits due to making false allegations and taking unauthorized photography. The medical record lacked documented evidence the information made to or received from the office of the public guardian regarding supervised visits for R4's family member was discussed by the IDT, communicated to the physician and included in R4's care plan. On 06/17/2026 at 1:30 PM, the Director of Nursing (DON) recalled receiving a report from a nurse regarding R4's family member taking unauthorized photography in the common lounge of the secured unit. The DON indicated speaking with R4's family member regarding facility rules and explained visits would be outside the secured unit and observed by staff members moving forwards. The medical record lacked documented evidence of the aforementioned incident by the DON. On 06/17/2026 at 2:39 PM, the Abuse Coordinator indicated extensive conversations with the public guardian regarding R4's family member should have been documented. The Visitation Sign-In form revealed R4's family member visited the resident on 11/30/2025, 03/20/2026, 04/05/2026, 04/18/2026, 05/06/2026, 05/25/2026 and 06/05/2026. A behavior note dated 06/05/2026, revealed R4's family member visited and the nurse took R4 to the conference room. The medical record lacked documented evidence visits occurred outside of the secured unit with staff supervision on 11/30/2025, 03/20/2026, 04/05/2026, 04/18/2026, 05/06/2026, and 05/25/2026. On 06/17/2026 at 4:04 PM, the DON confirmed there was no documentation visits were supervised when R4's family member came to the facility on [DATE], 03/20/2026, 04/05/2026, 04/18/2026, 05/06/2026, and 05/25/2026. The DON could not speak to whether the safety of R4 was compromised since the DON did not know the extent of the family member's criminal history. On 06/18/2026 at 7:45 AM, the supervisor of R4's public guardian (PG) indicated R4 had been under guardianship since 10/05/2021. The PG supervisor confirmed R4 had a biological child who was released after serving a 20-year prison sentence in 2025. The PG supervisor confirmed R4 and the family member had been out of touch and the family member was able to locate R4 with the help of a police detective. According to the PF supervisor, visitation by this family member should be allowed unless there was a court order to discontinue visits. On 06/18/2026 at 7:57 AM, the PG supervisor indicated a facility nurse notified (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the PG regarding R4's family member videotaping other residents in the unit on 04/27/2026 which resulted in future visits being supervised. The PG supervisor indicated taking photographs of protective wards were permitted only for medical purposes such as taking photos of wounds or a photo for a face sheet. PGs were careful with allowing photographs of protective wards even by family members because these photos may circulate in social media or inappropriately used. The medical record lacked documented evidence of the nurse's observation of R4's family member videotaping other residents in the secured unit, reporting the incident to the DON, and notification to the public guardian was documented in R4's medical record. On 06/18/2026 at 9:46 AM, the DON indicated not being informed by any nurse regarding R4's daughter videotaping other residents in the secured unit on 04/27/2026. The DON indicated this incident should have been reported to the DON and documented in R4's medical record. According to the DON, this should have also been included and addressed in the resident's care plan. The facility permitted residents to receive visitors subject to the protection of rights of other residents in the facility. The facility reserved the right to change the location of a visit if such visit infringes upon the rights of other residents in the facility. FRI 2790348FRI 2971681		