STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295036	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Las Vegas Care Center	3215 E. Cheyenne Ave. 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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review and document review, the facility failed to ensure residents were not confined to a room and barricaded bed, for 2 of 6 sampled residents (Resident 2 and 3). The deficient practice resulted in residents being confined to bed without consent, placing the residents at risk of psychosocial harm, loss of dignity, and compromised resident rights.Findings include:Resident 2 (R2) was admitted on [DATE] and readmitted on [DATE] with diagnoses including bipolar disorder and history of falling.Resident 3 (R3) was admitted on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, intellectual disabilities, and contractures.A review of facility reports revealed on 12/13/2025 at 4:00 AM, the Activities Director entered the building as the manager on duty and during initial rounds noted two residents were barricaded in bed. The report documented the residents had permission to have beds against the wall with one side open. The side of the bed which was supposed to remain open was blocked by a mattress held up by Geri chair locked in place.On 01/07/2026 at 11:00 AM, the Activities Director indicated entering the building through a side entrance. The Activities Director was conducting an observation of hallways and noticed a mattress against beds with a Geri-chair holding it in place. The Activities found the nurse assigned to the hallways in question. The nurse was questioned about mattress and indicated it was done for safety. After discussing with nurse, the Director of Nursing was notified. On 01/07/2026 at 10:00 AM, R2 indicated remembering the incident and at the time felt it was not appropriate to be confined to bed. R2 verbalized feeling safe in the facility now and was happy with the outcome of investigation and the steps the facility took.On 01/07/2026 at 10:35 AM, a Certified Nursing Assistant (CNA) verbalized understanding of the facility's protocol for allegations of abuse. The CNA explained the immediate supervisor and abuse coordinator would have been notified of the allegations. The CNA recalled having several in-service training courses throughout the year including abuse training within two days of incident involving involuntary seclusion of the two residents. The CNA confirmed part of the training included education on ensuring if there was a concern staff had with the care of residents it is brought to the attention of leadership.On 01/07/2026 at 10:40 AM, a Licensed Practical Nurse who served as the facility's Education Director verbalized being familiar with the incident regarding the involuntary seclusion of the two residents. The Education Director explained during the investigation there was a training plan developed which included the normal yearly abuse training and added elements found during the investigation thought to be helpful including training on staff reporting any out of the ordinary events or concerns. The Education Director referred to the additional training as if you see something, say something.On 01/07/2026 at 10:45 AM, a Unit Manager indicated being familiar with the incident and verbalized all staff training took place beginning 12/15/2025 approximately two days after the incident occurred. The Unit Manager confirmed part of the training included ensuring staff members notified (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	leadership if any concerns were identified.On 01/07/2026 in the morning, the Director of Nursing (DON) indicated all three identified staff members were suspended pending investigation. The DON verbalized both residents were negative for any signs of abuse during the assessment. The investigation found residents were deliberately barricaded in bed. When staff were questioned, the staff stated, it was for safety. Two staff members who had knowledge of the seclusion and participated were terminated; the third staff member was given a written warning. Inservice was completed on 12/15/2025. The staff were reported to the Board of Nursing. The facility policy titled Abuse, Neglect, Exploitation, or Mistreatment, revised 10/23/2019, documented the facility leadership prohibited neglect, mental, physical and or verbal abuse, use of physical and/or chemical restraint not required to treat a medical condition, involuntary seclusion, corporal punishment and misappropriation of resident property. The facility maintained all allegations of abuse, neglect, and misappropriation of property were thoroughly investigated and appropriate actions taken. Investigations included but were not limited to the identification and removal of alleged perpetrator, identification of alleged victim, type of allegation, where and when the incident occurred, written summaries of interviews, a resolution, measures taken to prevent future incidents. The facility was confirmed to be in substantial compliance as of 12/18/25, after staff member interviews confirmed education on abuse and abuse reporting, termination of both the Licensed Practical Nurse and the CNAs employment, review of the in-service training completed on 12/15/2025, and review of documentation confirming the facility report to the State Board of Nursing.