Printed: 04/08/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295076	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of South Las Vegas	2325 E. Harmon Ave. Las Vegas, NV 89119

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review, the facility failed to ensure an incident of resident elopement was reported to the State Agency (SA) within the required timeframe for 1 of 24 sampled residents (Resident 84). The deficient practice had the potential to place residents at risk for further incidents and to not be adequately protected. Findings include: Resident 84 (R84) R84 was admitted on [DATE] with diagnoses including dementia, and displaced fracture of left tibia. On 06/09/2025 the State Agency received an anonymous complaint alleging the facility had a resident elopement from the facility which was not reported as required. On 06/12/2025 at 1:00 PM a Certified Nursing Assistant (CNA) verbalized during shift change, the CNA would walk down hall with previous CNA and updates were given regarding residents. The CNA explained the front inside automatic door was always locked and would have to be buzzed out or press button on wall adjacent to the front door prior to doors opening. The CNA indicated wander guards was a device used to alert staff of a resident walking near the exit doors and an audible alarm would go off when the resident wearing a wrist or ankle bracelet was within a few feet of exit and generally would be used for confused residents and not residents with intact cognitive awareness. The CNA revealed residents at risk for elopement or residents with wandering or exit seeking behaviors were given a wander guard. The CNA verbalized the wander guard was a single use band as it would have to be cut off to be removed, the nurse would apply the wander guard. Once a resident was fitted with a wander guard the information would be put in a binder and kept at the nursing station. If a resident were to leave the facility without notifying a staff member it would be considered an elopement and code pink would be called overhead and staff would begin searching for resident. On 06/12/2025 at 1:13 PM, the Unit Manager indicated rounds were conducted as often as possible, generally every 30 minutes residents were at least observed between the CNA and nurses overlapping rounds. The Unit Manager verbalized the only exit from the building was at the front where there were two automatic doors. The interior door was always locked, and a staff member was at the front desk to buzz people in and out until 8:00 PM. After 8:00 PM anyone entering would have to ring the bell and nursing staff had a monitor of camera view of the front door and could buzz person inside. (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: 295076	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2025
NAME OF PROVIDER OR SUPPLIER Life Care Center of South Las Vegas		STREET ADDRESS, CITY, STATE, ZIP CODE 2325 E. Harmon Ave. Las Vegas, NV 89119	

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The unit manger explained wander guards were used for residents who were difficult to redirect, had exit seeking behaviors, and were impulsive with decision making. Wander guards required a physician order to be applied. The wander guard could not be pulled off or unsnapped once applied, it had to be cut off. The Unit Manager explained there was an elopement binder at the nursing station and front desk which includes a photo of residents who have wander guard in place. R84 did not speak English and would require staff to call interpreter or use staff who spoke Korean in order to adequately communicate with resident. The Unit Manager explained R84 would frequently walk in secured courtyard however one day went outside when the front door was open. The Unit Manager verbalized the resident did not leave the property however the resident was given a wander guard after incident. The Unit Manager verbalized resident was frequently considered confused in assessments due to language barrier however when speaking in native language R84 was alert and oriented to person, place, time, and events. R84 had plan to be discharged on 06/06/2025 and wanted the wander guard removed the previous night. The Unit Manager explained there was no discharge order yet primarily because the facility needed to wait until R84's friend came to building to pick up R84 in order to get details of where R84 was going. The Unit Manager indicated sometime after 9:00 or 10:00 PM resident was noted to be missing, and code pink was called for elopement, the executive director was notified, and the police were contacted. The resident was never found and was discharged from facility system. On 06/12/2025 at 1:47 PM, the Social Worker explained a cognitive assessment was conducted after admission using a translator. On 06/12/2025 at 2:07 PM, a Case Manager indicated R84 was Korean speaking and did not understand English and would use language service to communicate with resident. The CM explained the discharge plan was for R84 to discharge with friend however had to wait until day of discharge to speak with R84's friend to get details on where the resident would be living. The CM explained a different CM was primarily handling case with R84 and had previously spoke to R84's friend. The CM verbalized all communication with family or friends regarding discharge should be documented in the medical record however there were no notes regarding any communication with friend. There was no discharge order entered as the facility was waiting until day of discharge to discuss with R84's friend. The CM confirmed resident leaving the facility would not be considered a discharge and if it was a case of leaving against medical advice (AMA) it would generally still give the facility an opportunity to discuss risks associated and was not the case with R84. On 06/12/2025 at 2:27 PM, Unit Manager indicated being able to speak Korean and was occasionally used to interpret for R84. The Unit Manager explained being able to communicate well with resident in Korean and English however it appeared as though resident could understand English and would need to respond in Korean in order to be fully understood. On 06/13/25 at 11:00 AM, the Director of Nursing (DON) explained R84 should have interpreter with all staff not able to communicate in Korean. The DON indicated the facility would not usually give resident wander guard for alert and oriented and should not have been given wander guard and felt it was an overreaction from nurse due to previous incident with another resident eloping from facility. The DON confirmed the process for obtaining a wander guard would be to get order from physician, monitor every shift the wander guard was in place. and add in the care plan. The DON acknowledged there (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295076	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2025
NAME OF PROVIDER OR SUPPLIER: Life Care Center of South Las Vegas		STREET ADDRESS, CITY, STATE, ZIP CODE: 2325 E. Harmon Ave. Las Vegas, NV 89119	

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was no order for wander guard however there was a note in the electronic health record notifying the physician. On 06/13/2025 in the afternoon, the Executive Director (ED) indicated the resident was officially discharged since R84 was scheduled to be discharged the following day and did not consider it an elopement. The ED explained the police were notified because all contact information for R84 did not produce any results. The ED verbalized understanding the resident did not have discharge order or any evidence the resident was considered leaving against medical advice. The ED indicated had spoken to member from corporate team and it was determined it did not meet the facility reporting standards however was not able to say if incident was considered a safe discharge, leaving against medical advice, or an elopement. There was no record the State Agency was notified of elopement from facility for R84. The facility policy titled Elopement (revised 11/19/2024) documented elopement occurs when a resident leaves the premises or a safe area without authorization such as an order for discharge. Complaint NV00074431

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295076	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2025
NAME OF PROVIDER OR SUPPLIER Life Care Center of South Las Vegas		STREET ADDRESS, CITY, STATE, ZIP CODE 2325 E. Harmon Ave. Las Vegas, NV 89119	

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to ensure incontinent care was provided to a dependent resident who was soiled, wet, and had requested assistance for 1 of 24 sampled residents (Resident 111). This deficient practice had the potential to result in skin breakdown, infections, discomfort, and a diminished quality of life. Resident 111 (R111) R111 was admitted on [DATE] and discharged on 04/02/2025 with diagnoses including multiple sclerosis, difficulty walking, and need for assistance with personal care. On 06/04/2025 the State Agency received a report detailing concerns related to R111. The report alleged R111 had been left in a soiled incontinence brief for several hours on 03/17/2025 while at the facility. An admission minimum data set (MDS) assessment dated [DATE] documented R111: - no mobility devices - dependent on toileting - dependent with lower body dressing - dependent with mobility On 06/13/2025 at 10:00 AM, the Unit Manager indicated being familiar with incident involving R111. The Unit Manager revealed R111 had incontinence brief changed at 11:30 AM on 03/17/2025 with assistance from certified nursing assistant (CNA). At approximately 5:00 PM on 03/17/2025 the night shift CNA indicated R111 had complained of not having brief changed since the morning and had been requesting assistance. The Unit Manager explained the brief was immediately changed and it was discovered the day shift CNA had left the building for transport with another resident and did not notify the other CNAs in the building, only notifying the nurse for the unit. The Unit Manager indicated speaking with the nurse and was advised the nurse had seen the resident earlier in day for medication pass and then answered the call light later. The nurse verbalized R111 had requested assistance with changing brief and nurse obtained assistance from a CNA but did not follow up with CNA to ensure service was provided. On 06/13/2025 at 11:22 AM, the Director of Nursing (DON) acknowledged incident and verbalized it did occur. The DON explained the day shift CNA went with another resident to medical appointment and did not notify the other CNAs in the facility only the nurse on unit. The DON indicated the expectation for staff when answering call lights was for staff to provide needed services or ensure it was completed and verbalized the nurse can follow up or change resident and does not necessarily always fall on the CNA to complete. The DON further explained it was normal for nurse to turn off call light after checking on resident and notify the CNA of what was needed, however it was important the nurse return to CNA to ensure task was completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295076	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of South Las Vegas	2325 E. Harmon Ave. Las Vegas, NV 89119

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Resident Rights (revised 09/10/2024) documented residents have a right to dignified existence with access to persons and services inside and outside the facility. The facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment which promotes maintenance or enhancement of the quality of life. Complaint NV00074387 Facility Reported Incident NV00073739

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295076	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2025
NAME OF PROVIDER OR SUPPLIER: Life Care Center of South Las Vegas		STREET ADDRESS, CITY, STATE, ZIP CODE: 2325 E. Harmon Ave. Las Vegas, NV 89119	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to obtain physician orders for 2 of 24 sampled residents (Resident 84 and Resident 51) and schedule a follow-up appointment as recommended for 1of 24 sampled residents (Resident 51). The deficient practice had the potential for inappropriate discharge and to delay treatment and healing of a fracture. Findings include: Resident 84 (R84) R84 was admitted on [DATE] with diagnoses including dementia, and displaced fracture of left tibia. The medical record lacked documented evidence of a physician order to discharge for R84. The medical record lacked documented evidence of a physician order for use and monitoring of a wander guard for R84. On 06/12/2025 at 1:13 PM, the unit manger explained wander guards were used for residents who were difficult to redirect, had exit seeking behaviors, and were impulsive with decision making. Wander guards required a physician order to be applied. The wander guard could not be pulled off or unsnapped, once applied, it had to be cut off. The Unit Manager verbalized there was an elopement binder at the nursing station and front desk which includes a photo of residents who have a wander guard in place. The Unit Manager explained R84 would frequently walk in secured courtyard however one day went outside when the front door was open. The Unit Manager verbalized the resident did not leave the property however the resident was given a wander guard after incident. The Unit Manager verbalized resident was frequently considered confused in assessments due to language barrier, however when speaking in native language R84 was alert and oriented to person, place, time, and events. R84 had plan to be discharged on 06/06/2025 and wanted wander guard removed the previous night. The Unit Manager explained there was no discharge order yet primarily because the facility needed to wait until R84's friend came to building to pick up R84 in order to get details of where R84 was going. The Unit Manager indicated sometime after 9:00 or 10:00 PM, resident was noted to be missing, and code was called for elopement, the executive director was notified, and the police were contacted. The resident was never found and was discharged from facility. On 06/12/2025 at 2:07 PM, a Case Manager (CM) explained the discharge plan was for R84 to discharge with friend however had to wait until day of discharge in order to speak with R84's friend to get details on where the resident would be living. The CM explained a different CM was primarily handling case with R84 and had previously spoke to R84's friend. The CM verbalized all communication with family or friends regarding discharge should be documented in the medical record, however there were no notes regarding any communication with friend. There was no discharge order entered into computer as the facility was waiting until day of discharge to discuss with R84's friend. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295076	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2025
NAME OF PROVIDER OR SUPPLIER Life Care Center of South Las Vegas		STREET ADDRESS, CITY, STATE, ZIP CODE 2325 E. Harmon Ave. Las Vegas, NV 89119	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/13/25 at 11:00 AM, the Director of Nursing (DON) indicated the facility would not usually give resident a wander guard for alert/oriented residents and R84 should not have been given wander guard and felt it was an overreaction from nurse due to previous incident with another resident eloping from facility. The DON confirmed the process for obtaining a wander guard would be to get order from physician, monitor every shift the wander guard was in place. and add in the care plan. The DON acknowledged there was no order for wander guard however there was a note in the electronic health record notifying the physician. On 06/13/2025 in the afternoon, the Executive Director (ED) indicated the resident was officially discharged since R84 was scheduled to be discharged the following day and did not consider elopement. The ED verbalized understanding the resident did not have discharge order or any evidence the resident was considered leaving against medical advice. The ED was not able to say if incident was considered a safe discharge, leaving against medical advice, or an elopement. Complaint NV00074431 Resident 51 (R51) R51 was initially admitted on [DATE] and re-admitted on [DATE] with diagnoses including dysphagia, muscle weakness, and displaced fracture of surgical neck of right humerus. On 06/10/2025 at 10:32 AM, R51 explained having had a fall several months ago resulting in a fracture of the right arm and needing a sling. R51 stated never had follow- up appointments or x-ray, and the sling was gone. A Nursing progress note dated 12/07/2024 documented R51 had a witnessed fall. The CNA reported to the nurse R51 was on the floor. A Nursing progress note dated 12/07/2024 documented upon follow-up, R51 had pain localized to the right shoulder and arm. R51 was receiving pain medication. A Physician progress note dated 12/09/2024 documented R51 reported to have a fall during the weekend, Xray of right shoulders ordered, and R51 to be sent out to emergency room if Xray reports humeral fracture. An imaging report for the right upper shoulder dated 12/09/2024 documented impression of acute comminuted (bone broken into three or more pieces) and displaced fracture of the neck of the humerus. A Hospital Emergency Provider report dated 12/09/2024 documented diagnosis shoulder dislocation, humerus fracture right shoulder non-custom immobilization sling. A Physician progress note dated 12/10/2024 documented R51 returned from emergency room with recommendation of right shoulder and right upper extremity immobilization. R51 was to follow up with Orthopedics. An imaging report of the right humerus dated 01/14/2025 documented impression of humeral fracture. An Orthopedic consult note dated 01/16/2025, documented R51 to remain in the sling, follow up in four to six weeks with updated x-rays of right shoulder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295076	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of South Las Vegas	2325 E. Harmon Ave. Las Vegas, NV 89119

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nursing progress note dated 01/16/2025 documented R51 returned from orthopedic consult appointment for right shoulder fracture with orders to continue sling and follow up in four- six weeks. Transportation made aware. R51's medical record lacked a physician order for right shoulder sling. On 06/11/2025 at 11:50 AM, a Licensed Practical Nurse (LPN) explained when orders or requests for appointments were made an appointment request form was completed and given to case management for scheduling. Once the appointment was made the facility would transport the resident. On 06/11/2025 at 11:58 AM, a Case Management staff member explained long term care resident's appointments were coordinated with the social service department. On 06/11/2025 at 12:03 PM, the Social Services Director (SSD) explained remembering the orthopedic consult appointment for R51 and it being non-surgical interventions. The SSD reviewed the notes from R51's orthopedic appointment on 01/16/2025 and confirmed the recommendation was to follow up in four to six weeks. The DSS explained needing to review information to verify if an appointment was made. On 06/12/2025 at 8:19 AM, R51's Nurse Practitioner (NP) explained R51 was sent to another hospital for an orthopedic visit. The NP stated the fracture was not operable. The NP stated R51 wore a sling for a while and explained being unaware there was no physician order for the sling. The NP confirmed an order should have been entered for R51's sling use and an order should have been written for when the sling was discontinued. The NP was unable to explain when the sling use was discontinued and what provider instructed R51 to no longer wear the sling. On 06/12/2025 at 10:56 AM, the LPN confirmed R51's medical record lacked physicians orders for the right arm sling. On 06/13/2025 at 8:42 AM, The Unit Manager (UM) for R51's unit confirmed R51 would require an order for the sling, and it should have been entered upon return from the hospital. On 06/13/2025 at 9:10 AM, the Director of Nursing (DON), explained the expectation for a resident returning from the emergency room or hospital was for orders to be reviewed with the resident's attending physician. The orders would then be entered in the resident's medical record. The DON explained R51 would require orders for use of the sling. The DON explained residents who return with recommendations for appointments required the nurse to relay the recommendations to resident's physician and enter the orders. The DON explained for transportation arrangement the appointment form was to be completed and processed. The DON explained having reviewed R51's medical record and confirmed orders were not obtained for the use of the right arm sling and no orders were obtained to discontinue the use of the sling. The DON also confirmed the recommendation for the follow up appointment was not completed. The facility policy titled Transportation Coordination and Services, with review date 05/15/2025, documented the facility would assist residents in making necessary appointments for services not provided in the facility and arranging for transportation to and from such appointments. The facility policy titled admission Policy- Nevada Facilities, revised 01/07/2025, documented a physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295076	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of South Las Vegas	2325 E. Harmon Ave. Las Vegas, NV 89119

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for the resident's immediate care and needs.