STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295017	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Horizon Health and Rehabilitation Center	660 Martin Luther King Blvd Las Vegas, NV 89106

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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 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** 40131 Based on observation, interview, record review, and document review, the facility failed to ensure the signs and symptoms (s/s) of bleeding for a resident on anticoagulants were monitored for 1 of 25 sampled residents (Resident 2). This deficient practice had the potential to result in hemorrhage, an increased risk of severe anemia, and harm to the resident. Findings include: Resident 2 (R2) R2 was admitted on [DATE], with diagnoses including anoxic brain damage and iron deficiency anemia. A physician order dated 06/10/2024, documented Heparin Solution 5,000 units/milliliters (ml) to be administered subcutaneously every 12 hours for deep vein prophylaxis. The Medication Administration Record (MAR) from June to July 2024, documented the Heparin solution injections were administered as ordered. R2's medical records lacked documented evidence the s/s for bleeding were monitored until 07/11/2024. On 07/09/2024 at 9:34 AM, R2 was in bed, awake, non-verbal and obtunded. The family was at the bedside. A Licensed Practical Nurse (LPN) indicated R2 was bed-bound and totally dependent in activities of daily living. On 07/11/2024 at 3:12 PM, R2 was lying in bed, and the lower quadrant of the abdomen had minimal bleeding and bruising. The LPN confirmed there was minimal bleeding in the lower abdomen. The LPN confirmed R2 was taking an anticoagulant. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/11/2024 at 3:15 PM, the Assistant Director of Nursing (ADON) explained the resident who was receiving anticoagulant medication should have been monitored for bruising, hematuria (blood in urine), bloody stool, nausea and vomiting, and coffee ground emesis. The ADON indicated the monitoring would be incorporated with the order to give prompts to the Licensed Nurses or ensure continuity of care. The ADON explained the admission nurse or the Licensed Nurses were responsible for obtaining and transcribing the monitoring orders, and the ADONs would review the chart following the resident's admission. The ADON confirmed monitoring orders had not been obtained and transcribed until 07/11/2024. On 07/12/2024 at 1:07 PM, the Director of Nursing (DON) indicated the residents receiving anticoagulant medications should have been monitored for signs and symptoms of bleeding, and an order should have been required. A facility policy titled Anticoagulation Monitoring Program revised May 5, 2024, documented the anticoagulant administration was based on an individualized management program to reduce the likelihood of harm. Steps to minimize adverse effects included improving communication, implementing close prescriber oversight, and enhancing resident and family education.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41903 Based on observation, interview, record review, and document review, the facility failed to provide care to prevent a stage 4 pressure ulcer for 1 of 25 sampled residents (Resident 72). The deficient practice caused a wound to develop and not be identified until it had progressed into a stage 4 pressure ulcer. Findings include: Resident 72 (R72) R72 was admitted on [DATE], and readmitted on [DATE], with diagnosis including unspecified injury level of cervical spinal cord, paraplegia, muscle wasting and atrophy. Braden Scale for Predicting Pressure Sore Risk dated 01/15/2024, documented total Braden Scale score of 15, which determined R72 was at risk for pressure ulcers. A Skin Risk Analysis and Interventions dated 01/15/2024, documented skin was to be inspected daily, especially bony prominences, repositioned at least every hour and increased frequency of turning. A Wound Information Observation History dated 02/27/2024, documented an unstageable (the stage of the wound was unclear) right buttock ulcer was identified on 02/27/2024, not present on admission/re-entry. An Observation Report dated 01/26/2024, documented weekly skin observation was completed by a nurse. Observation details included no alterations in skin. The medical record lacked documented evidence skin evaluations by nursing were completed from 01/27/2024 until the wound was identified on 02/27/2024. A Point of Care History Report dated 01/20/2024 to 02/19/2024, documented turning/repositioning was done for R72 until 02/13/2024. The medical record lacked documented evidence R72 was assisted with turning/repositioning from 02/14/2024 until the wound was identified on 02/27/2024. On 07/11/2024 at 02:45 PM, The Director of Nursing (DON) reported Certified Nursing Assistants (CNAs) were to check skin daily and report to the nurses any changes or concerns. Nurses were to do weekly skin checks. On 07/11/2024 at 11:19 AM, the Wound Care Nurse, confirmed the facility acquired wound was identified during bedside care on 02/27/2024. The pressure ulcer was unstageable when identified and later staged as a stage 4 pressure ulcer. The Wound Nurse explained nursing staff was supposed to perform weekly skin assessments and well as skin checks with bedside care and stated skin assessments must have included a visual of the site. The Wound Nurse acknowledged if the wound would have been found earlier, more appropriate healing time would have been achieved, the wound would have been smaller and easier to have worked with. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/12/2024 at 09:42 AM, a Licensed Practical Nurse (LPN) reported scheduled weekly head to toe skin checks were to be done and also while repositioning R72. The LPN acknowledged the benefits of identifying the wound early included reduced pain and risk of sepsis and R72 would have resumed regular activities quicker. On 07/12/2024 at 09:56 AM, the Wound Care Nurse reported R72's wound was avoidable if the processes in place would have been followed. On 07/12/2024 at 09:57 AM, a CNA explained CNAs were to check resident's skin, chart in the system when completed and report any findings to a nurse. On 07/12/2024 at 12:00 PM, the Wound Physician confirmed R72 had a facility acquired, stage 4 sacral pressure sore. The Wound Physician explained due to R72's medical conditions, lack of feeling in the area and nutritional status, R72 could have developed the wound in a very short period of time, even 24 hours. The Wound Physician explained the wound was unavoidable based on R72's condition, however, the Wound Physician acknowledged R72's wound may have been avoided if the process of turning R72 was followed as well as skin checks done. On 07/12/2024 at 12:28 PM, the DON explained nursing skin assessments were to be done weekly and repositioning R72 was supposed to happen or be offered assistance with repositioning, every two hours. On 07/12/2024 at 02:36 PM, the DON reported repositioning was an expectation that should have been done as standards of practice. The DON explained the Point of Care (POC) system where CNAs charted, did not display the option of repositioning after 02/13/2024 and reported not knowing how the option dropped off the POC system. The DON explained staff should have continued repositioning R72 even though the POC system did not show it as an option and acknowledged the medical record lacked documented evidence repositioning was done from 02/14/2024 until the wound was identified on 02/27/2024. The DON further acknowledged the medical record lacked documented evidence nursing skin assessments were done from 01/27/2024 until the wound was identified on 02/27/2024. The DON reported the nurse assigned to the side of the building where R72 resided, admitted had not performed skin assessments due to not knowing skin assessments needed to be done for residents. A policy titled Wound Care Policies and Procedures revised 06/01/2015, documented weekly skin checks should have been performed and documented by licensed staff on all patients/residents. Assessment of a resident's skin condition helped define prevention strategies.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interview, record review, and document review, the facility failed to ensure a physician order for splint application was obtained and implemented to treat a resident's contracture for 2 of 35 sampled residents (Residents 2 and R77), and the care plan was updated following the resident's readmission for 1 of 35 sampled resident (Resident 77). The deficient practice could potentially lead to worsening contractures, decreased mobility, increased pain, and a reduced quality of life for the affected residents. Findings include: R2 was admitted on [DATE], with diagnoses including contracture of the left and right hands and atrophy. The Joint Mobility Screen dated 06/10/2024, documented the inability of R2 to flex and extend the fingers. The Restorative Nursing Care Plan dated 06/10/2024, documented R2's goal of maintaining the current level of function with the use of bilateral upper extremities palm protection or a hand roll for 3-6 hours per day. The Minimum Data Set with R2's functional status dated 06/24/2024, documented R2's upper and lower extremities were impaired. A Care Plan revised 06/24/2024, documented R2 was receiving splinting due to an increased risk of contracture in both upper extremities. The approach involved using palm protector splint/rolls on both hands to prevent contracture. R2's medical records lacked documented evidence a physician order for R2's palm protector splint or hand roll to manage R2's contracture was obtained and implemented. On 07/09/2024 at 9:38 AM, R2 was in bed, obtunded, and contracted in all four extremities. R2's fingers were digging into the palms. R2's family was at the bedside, and applied rolled towels to both hands. When interviewed, R2's family could not communicate in the common language. On 07/11/2024 at 3:15 PM, the Director of Rehabilitation Services (DORS) indicated a screening performed on 06/10/2024, showed no recent changes from the previous admission, and R2 remained totally dependent in all care. The DORS explained R2 was referred to restorative nursing for range of motion exercises. The recommendation was for both upper and lower extremities to receive passive range of motion exercises. The DORS explained for upper extremity contractures, hand rolls or palm protectors were recommended to prevent further contractures. The DORS indicated the nursing staff were responsible for obtaining physician orders, transcribing, and implementing the splint. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/11/2024 at 4:16 PM, the lead Restorative Nursing Assistant (RNA) indicated after R2 was screened, the Restorative Nursing Care Plan (RNCP) would be formulated and endorsed by the rehabilitation department to the RNA department. The lead RNA indicated after receiving the RNCP, the recommendations would be reviewed and endorsed to the nursing department for order transcription. The lead RNA explained the paperwork for splinting should have been processed within 24 hours on weekdays, and, if received on weekends, by the following Monday. The lead RNA explained the ADONs were responsible for obtaining and transcribing the order, while the RNA was responsible for implementing the splinting. The lead RNA acknowledged obtaining and transcribing orders in a timely manner was challenging, which led to delayed implementation. On 07/12/2024 at 1:32 PM, the Assistant Director of Nursing (ADON) confirmed the order had not been obtained and transcribed per recommendation. The ADON explained following the resident's readmission, the care plan should have been updated, and there should have been an order to treat the resident's contractures. Resident 77 (R77) R77 was admitted on [DATE], with diagnoses including hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) affecting the right dominant side, muscle weakness, and right hand contracture. On 07/09/2024 at 9:22 AM, R77 was in bed, awake and verbally responsive. R77 had a contracture on the right arm with a closed fist. No splint was in place. R77 indicated had right-sided weakness and could not lift the arm or open the fingers. R77 indicated had not been on rehabilitation services. On 07/11/2024 at 3:25 PM, the DORS indicated the most recent screening recommended rehabilitation services for R77's reduced upper and lower extremity functioning. The DORS indicated the services had ended on 06/20/2024, for a two-week maintenance therapy. The DORS indicated the evaluation included a right-hand splint for 4-6 hours, and R2 was expected to wear a resting hand splint for 4-6 hours following the transition. The DORS confirmed the implementation of the splinting was delayed. On 07/12/2024 at 1:32 PM, the ADON confirmed there was no updated care plan for R77's contractures and there was a delay in order transcription. The ADON verbalized the importance of having an order in place and ensuring timely implementation of splinting to manage R77's contracture. On 07/12/2024 at 2:20 PM, the Director of Nursing (DON) indicated the staff were expected to have better communication to ensure the prompt implementation of the resident's splinting to prevent further contracture or injury. A facility policy titled Joint Mobility/Range of Motion Program and Splinting revised 02/29/2024, documented a restorative program would be implemented through the care plan to increase, maintain or prevent deterioration of joint mobility, to maximize physical function when referral to therapy was not indicated or upon transition, and assistive devices would be provided if indicated. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Restorative Nursing dated 02/29/2024, documented the facility was committed to providing quality care and services to all residents. The restorative program, an integral component of nursing practice, contributed to achieving this goal. The plan of care included the program's approaches and interventions, and documented the interventions and results.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interview, record review, and document review, the facility failed to ensure: 1) the nutritional assessment for a resident on percutaneous endoscopic gastrostomy (PEG) was completed upon readmission per policy for 1 of 25 sampled residents (Resident 2), and 2) care orders to manage the PEG tube were obtained and transcribed for 1 of 25 sampled residents (Resident 2). The deficient practice could have the potential to compromise resident safety and well-being, leading to inadequate nutritional support and an increased risk of complications related to PEG tube management. Findings include: Resident 2 (R2) R2 was admitted on [DATE] and readmitted on [DATE], with diagnoses including anoxic brain injury, dysphagia (difficulty swallowing) and gastrostomy. 1) On 07/09/2024 at 9:34 AM, R2 was in bed, awake, non-verbal, and obtunded. Tube feeding (TF) Jevity 1. 2 was hanging by the bedside and not infusing. The label on the TF bag dated 07/08/2024, indicated a flow rate of 70 milliliters per hour (ml/hr.). The water bag's label indicated a flow rate of 70 ml/hr. R2's medical records lacked documented evidence the nutritional assessment was completed following R2's readmission. On 07/10/2024 at 3:44 PM, a Licensed Practical Nurse (LPN) indicated R2 was PEG tube dependent, was discharged and readmitted on [DATE]. The Licensed Practical Nurse (LPN) verified and confirmed the incompleteness of the nutritional assessment for R2's PEG tube. The LPN indicated the assessment should have been completed upon the resident's admission or readmission by the Registered Dietitian. The LPN indicated the nutritional assessment in the medical record was outdated from R2's previous stay. The Observation Detail List Report completed on 07/11/2024, documented R2 was nothing per Orem (NPO) or nothing by mouth, as per information obtained from medical record review. R2 received Jevity 1.2 at 65 ml/hr. for 18 hours, with a weight of 146.2 kilograms. The intervention plan included continuing Jevity 1.2 at 65 ml/hr. for 18 hours and continuing water flushing at 125 ml every 6 hours. On 07/11/2024 in the afternoon, the Assistant Director (ADON) confirmed the nutritional assessment had not been completed in a timely manner, and indicated the Registered Dietitian (RD) was responsible for completing it upon R2's admission. The ADON verbalized the importance of the nutritional assessment in meeting the nutritional needs of residents receiving nutrition through a PEG tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/11/2024 at 2:22 PM, the Registered Dietitian (RD) confirmed the nutritional assessment had not been completed upon R2's admission until 07/11/2024. The RD explained the standard process was to complete the resident's assessment following admission or readmission and annually thereafter, or as needed in case of a change in condition. The RD explained there had been no significant weight change for R2, and the goal was to maintain the current weight. A facility policy titled Nutritional Assessment/Evaluation, revised on June 20, 2024, documented the RD would complete a comprehensive assessment upon the resident's admission, annually, and whenever a significant change in status occurred. The medical record retained the original nutritional assessments until its closure. A new nutritional assessment should have been completed upon the resident's readmission. 2) The hospital transfer summary dated 06/08/2024, documented R2 presented to the emergency department from the facility with symptoms including bilious emesis and fever. R2's course was complicated by a clogged PEG tube, which was resolved with flushing. The Minimum Data Set, dated dated dated [DATE], documented R2 had a PEG tube. On 07/09/2024 at 9:34 AM, R2 was in bed, awake, non-verbal, and obtunded. TF Jevity 1.2 was hanging by the bedside and not infusing. The label for the TF bag dated 07/08/2024, with a flow rate of 70 ml/hr. The water bag was not infusing and labeled a flow rate of 70 ml/hour. R2's family was at bedside and showed R2's bloated stomach and tapped the abdomen with fingers, creating a dull sound. R2's medical records lacked documented evidence the care orders to manage R2's PEG tube were obtained and transcribed, such as verification of PEG tube placement, elevating the head of the bed and monitoring, changing the PEG tube when obstructed or dislodged, and water flushing before and after medications. On 07/10/2024 at 3:22 PM, the Wound Care Certified Nurse (WCCN) indicated the care orders should have been obtained. Normal saline to cleanse the PEG tube insertion area and gauze application for which the wound team was responsible, and the care orders such as feeding, flushing, changing the PEG tube for obstruction or dislodgement, placement verification, and monitoring would have been obtained and implemented by the assigned Licensed Nurses. During verification at bedside, the WCCN confirmed R2 was bloated and should have R2's normal state documented and indicated the Licensed Nurses were responsible for the assessment and monitoring. On 07/10/2024 at 3:44 PM, a Licensed Practical Nurse (LPN) indicated the admission nurse or the assigned licensed nurse should have completed the PEG tube assessment upon R2's readmission and transcribed the care orders. The LPN indicated was familiar with the care of R2, as resident had been PEG tube dependent for a long time. The LPN verbalized care orders to manage R2's PEG tube should have been obtained and transcribed upon readmission. On 07/10/2024 at 4:03 PM, the Director of Nursing (DON) indicated, on admission the Licensed Nurses or admission nurses, were responsible for obtaining and transcribing the orders. The DON indicated the care orders should have been in place upon R2's readmission. The DON indicated it was the staff's responsibility to obtain and transcribe the care orders to manage residents' PEG tubes. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Enteral and Parenteral Feedings, revised on June 20, 2024, documented physician orders were to be obtained for all enteral feedings. Problems and complications, such as gastric distention and aspiration, were monitored and reported to the physician and nutrition services.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 37718 Based on observation, interview, and document review the facility failed to post daily staffing information in a place accessible to residents and visitors. The deficient practice had the potential to result in a lack of awareness for residents and visitors regarding the type and number of staff on duty on any given day. Findings include: On 07/12/2024 at 8:10 AM, a tour of the facility was conducted with the Director of Nursing (DON). Licensed nurses and Certified Nurse Assistant assignments were posted on an 8 and 1/2 by 11-inch sized paper near each of the two nursing stations, affixed to the corridor wall about four or five feet above floor level. The posting verbiage was in approximately size-14 font, difficult to read unless close up, and room assignments were hand-written. The staffing documents lacked the total Patient Per Day (PPD) hours information for the facility. The DON verbalized the staffing posting as observed was what the facility customarily posted daily. On 07/12/2024 at 8:20 AM, the Administrator, verbalized knowledge of the requirement to post daily staffing information in a prominent place accessible to residents and visitors. The Administrator verbalized the staffing posting should have been in the front lobby areas of the facility. The Administrator verbalized the document should have been in a fairly large font for ease of review. The Administrator verbalized the PPD information should have been included in the staffing posting.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interview, record review, and document review, the facility failed to ensure their medication error rate was below five (5) percent (%) when two errors were identified with 30 opportunities observed, calculating an error rate of 6.67%. Failure to follow physician orders and timely administer medications posed a potential risk of injury or harm to the resident. Findings include: Resident 55 (R55) R55 was admitted on [DATE], with diagnoses including muscle weakness and spasms. On 07/11/2024 at 8:26 AM, a Licensed Practical Nurse (LPN) prepared R55's eight medications except B12 and the Refresh eye drop. A Physician order dated 04/19/2024, documented B12 tablets, chewable daily, at 9:00 AM. A Physician order dated 05/13/2024, documented Refresh Classic, one drop in both eyes four times daily. The Medication Administration Record (MAR) dated 07/11/2024, documented R55 refused the B12 and the eye drops. On 07/12/2024 at 11:26 PM, R55 indicated the vitamin B12 and the eye drops had not been refused on 07/11/2024, and the LPN did not explain or ask R55 as to why the medications were not administered. R55 expressed a desire to receive the medications as ordered, particularly the eye drops to ease eye dryness. On 07/12/2024 at 11:28 AM, the LPN confirmed the vitamin B12 and eye drops had not been administered. The LPN indicated the medications were missed and documented R55 as having been refused. The LPN confirmed R55 had not been asked nor refused the medication. The LPN explained if a resident refused medication, it would be reoffered, and the physician would be notified and the refusal documented. The LPN confirmed the physician had not been notified, and there was no documentation of R55's refusal. The LPN indicated the medications were missed and not administered within the time frame as ordered. On 07/12/2024 at 11:40 AM, the Director of Nursing (DON) indicated the staff were expected to accurately document if the medications were administered, missed, or had an actual refusal. A facility policy titled Medication Management revised 04/17/2024, documented medication error rates were not five percent or greater. The staff and practitioners should strive to minimize the potential for medication error by following eight (8) rights for administering medication, including the right time and right charting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295017	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Horizon Health and Rehabilitation Center	660 Martin Luther King Blvd Las Vegas, NV 89106

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 29141 Based on observation, interview, and document review, the facility failed to 1) procure a clean food preparation environment and 2) ensure food products that needed to be refrigerated were kept in a safe temperature range by accurately monitoring the temperature of the walk-in refrigerator. The deficient practice could potentially expose residents to foodborne illnesses. Findings included: On 07/09/24 in the morning, an inspection was conducted with the kitchen manager in the kitchen area. The following issues were identified: 1) Cleanliness: - The exhaust hood over the stove was greasy and visibly dusty outside. - The oven was visibly soiled with greasy matter and dust outside and greasy with food debris inside. - Food debris was observed on the floor behind the oven, stove, and pressure cook. - The floor in the room preparation area was visibly soiled with food debris. A fan was on the floor, blowing air to the table where hamburger patties were being prepared. - The air conditioning (AC) vents were visibly dusty. - An AC vent in the dishwashing area was visibly corroded, with the paint peeling apart. On 07/09/2024 at 9:30 AM, the kitchen manager indicated the oven and the exhaust hood were cleaned monthly but should be cleaned more often. The kitchen manager acknowledged that fans could not be used in the kitchen, and food exposed to the air blown by the fan would be discarded. 2) Walk-in Refrigerator: At 9:40 AM, the temperature reading in the external thermometer of the walk-in refrigerator indicated 44 degrees Fahrenheit (F). The temperature log located at the door of the walk-in refrigerator documented a temperature of 40 F was obtained in the morning. The two thermometers situated inside the refrigerator read 58 F each. The kitchen manager indicated that the door of the walk-in refrigerator was opened several times during meal preparation, which could be the reason the temperature dropped. It was suggested the temperature be checked in one hour. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295017	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Horizon Health and Rehabilitation Center	660 Martin Luther King Blvd Las Vegas, NV 89106

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/09/2024 at 11:09 AM, the temperature of the walk-in refrigerator was rechecked. The two internal thermometers read 54 F. The kitchen manager confirmed the observation and verbalized the temperature should have been between 38 and 40 F and the food products should have been relocated to another refrigerator. The kitchen manager stated a report would be submitted to the maintenance department. On 07/09/2024 at 12:30 PM, the walk-in refrigerator was checked again. The temperature in the internal thermometers continued at 54 F. Temperatures were obtained from food products, including a milk carton and a bag of smoked sausages. The temperature was 56 F, confirmed by the kitchen manager, who indicated the food products would be relocated to another refrigerator. The kitchen manager indicated some products were received in the morning such as the orange juice that needed to be keep frozen and dairy products including milk. On 07/10/2024 at 7:35 AM, a follow-up inspection of the walk-in refrigerator was performed. The temperature in the internal thermometers continued at 56 F. The temperature was 56 F. There were food products at dangerous temperatures, including three boxes of oranges with labels indicating to keep them frozen. The orange juices in the boxes were not frozen. Additionally, some condiments needed to be refrigerated, including mayonnaise, cheese, two boxes of buttery spread, vegetables, a soy sauce container, whipped topping, sandwiches, sliced ham, sliced turkey, health shake, raw and boiled egg, yogurt, sour cream, and some vegetables. The kitchen manager disposed of the items and acknowledged that the food was in a dangerous zone temperature. The kitchen manager indicated staff did not check the two thermometers inside the refrigerators; instead had used the outside thermometer and documented that temperature. The facility policy titled Food Safety in Receiving and Storage, dated 06/20/2023, documented a thermometer should be kept in each refrigerator and that the refrigerator's ambient temperature should be maintained between 34 and 40 F.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295017	A. Building B. Wing	07/12/2024

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 29141 Based on observation, interview, and document review, the facility failed to ensure a walk-in refrigerator was maintained in working condition to keep refrigerated food products in a safe range of temperature. The deficient practice could potentially endanger the safety of the food, exposing residents to foodborne illnesses. Findings included: On 07/09/24 at 9:40 AM, the temperature reading in the external thermometer of the walk-in refrigerator indicated 44 degrees Fahrenheit (F). The temperature log located at the door of the walk-in refrigerator documented a temperature of 40 F was obtained in the morning. The two thermometers situated inside the refrigerator read 58 F each. The kitchen manager indicated that the door of the walk-in refrigerator was opened several times during meal preparation, which could be the reason the temperature dropped. It was suggested the temperature be checked in one hour. On 07/09/2024 at 11:09 AM, the temperature of the walk-in refrigerator was rechecked. The two internal thermometers read 54 F. The kitchen manager confirmed the observation and verbalized the temperature should have been between 38 and 40 F and the food products should have been relocated to another refrigerator. The kitchen manager stated a report would be submitted to the maintenance department. On 07/09/2024 at 12:30 PM, the walk-in refrigerator was checked again. The temperature in the internal thermometers continued at 54 F. Temperatures were obtained from food products, including a milk carton and a bag of smoked sausages. The temperatures were 56 F, confirmed by the kitchen manager, who indicated the food products would be relocated to another refrigerator. The kitchen manager indicated some products were received in the morning such as the orange juice that needed to be keep frozen and dairy products including milk. On 07/10/2024 at 7:35 AM, a follow-up inspection of the walk-in refrigerator was performed. The temperature in the internal thermometers continued at 56 F. The temperature was 56 F. There were food products at dangerous temperatures, including three boxes of oranges with labels indicating to keep them frozen. The orange juices in the boxes were not frozen. Additionally, some condiments needed to be refrigerated, including mayonnaise, cheese, two boxes of buttery spread, vegetables, a soy sauce container, whipped topping, sandwiches, sliced ham, sliced turkey, health shake, raw and boiled egg, yogurt, sour cream, and some vegetables. The kitchen manager disposed of the items and acknowledged that the food was in a dangerous zone temperature. On 07/10/2024 in the morning, the Maintenance Director explained they had not received a report the walk-in refrigerator was malfunctioning, and the last report received from the kitchen happened on 07/08/2024 for an unrelated issue. A facility's form titled Engineering Repair Request lacked documented evidence of the kitchen staff reported the concerns related to the walk-in refrigerator on 07/09/2024. The maintenance records revealed the last monthly preventive maintenance of the walking refrigerator was performed on 07/08/2024 and no issues were identified.