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	06/13/2025

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure residents have a right to make choices about aspects of their life in the facility which are significant to the resident for 1 of 26 sampled residents (Resident 89) and 3 unsampled residents (Residents 29, 32, and 61). The failure to accommodate the residents' preferences and choices had the potential risk to cause psychosocial distress to the residents. Findings include: The facility is located off a major street close to the downtown areas and the parking lot is combined with the neighboring hospital. The facility had a secured covered patio in the back of the facility off the Activity Room. This patio area had a covered area which is complete with misters, lights, plants, and numerous park benches to sit and enjoy the quiet peaceful outdoor air. Resident 89 (R89) was admitted to the facility on [DATE] with diagnosis of paraplegia, cellulitis, and a puncture wound with a foreign body. R89 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. On 06/10/2025 in the afternoon, R89 stated would like one thing to be changed so residents would be allowed to go out and sit in the back patio area of the building. R89 asserted residents must be back in the facility by 6:00 PM or 7:00 PM. R89 affirmed during the summertime, this was when the sun was just starting to go down and the temperatures were also going down to where it was nice enough to be outside. However, the facility would not let residents stay outside past 7 PM because there was no one available after this time to chaperone the residents. During the Resident Council Meeting on 06/11/2025 in the afternoon, unsampled Resident 29 (R29) stated residents were not permitted to stay outside on the back patio of the building past 7:30 PM. Resident 32 and Resident 61 both confirmed this was in fact correct. R29 expressed the council was told residents had to go back inside the building at 7:30 PM due to a few residents using the back patio to smoke, and since smoking was not allowed in the facility, the patio was locked by 7:30 PM when Activity Staff went home. R23 asserted because of a few residents not following the rules, the rest of the residents were punished. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295017	A. Building B. Wing	06/13/2025

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/12/2025 at 12:59 PM, the Administrator stated given the facility's location, the facility recommended the residents come back in around 7:30 PM in the summer. For safety, when it gets dark, the facility staff had the residents come inside. There were no current outdoor places for the residents to go. The outdoor patio was closed at night because there were some residents who were trying to smoke on the patio at night. The Administrator stated was not aware the resident council was inquiring about the use of the patio after the curfew times. To the Administrator's knowledge, there was one resident who wanted to try to smoke in the patio area, so the facility decided to close the patio. The Administrator was unaware if the facility had tried alternatives to closing the patio. The Administrator asserted it was important the facility did not have smoking inside the building. The Administrator acknowledged was aware a resident had complained could not access outside fresh air which did not smell of cigarette smoke. On 06/12/2025 at 2:32 PM, the Activity Director (AD) stated the time the patio closed was at 8pm. The AD acknowledged had heard from the Resident Council, residents were upset because could not utilize the patio after 8pm. After 8pm was when the sun goes down and when it gets cooler so the residents can go out to enjoy the patio. The AD was not sure who the one person was, but there were a few residents who were caught smoking on the patio before the facility closed it. The AD also acknowledged no alternatives to locking the door to the patio were tried. The AD expressed it was not fair for the non-smokers who wanted to be able to get some fresh air when it starts to get cooler later in the day in the summer. On 06/12/2025 at 2:56 PM the Director of Nursing (DON) stated the patios are closed around 8 pm. The DON clarified the facility closed the patios at 8 PM because the facility did not have anyone to supervise the patios after 8pm. The DON further clarified the patios need to be monitored for safety. The DON also acknowledged the patio gates to the outside were always locked making it a secured patio. The DON stated there were a few residents caught smoking, and the facility had to close the patio. The DON acknowledged the non-smokers had let the facility know the residents wanted to use the outdoor spaces. The DON agreed the residents who did not smoke should not be penalized for those smokers who broke the rules. The DON also acknowledged the residents did not have the ability make their own life choices at this time regarding the patio availability. On 06/12/2025 a policy restricting the residents from going out to sit in the secured patio area after 8 PM was requested. The Administrator affirmed the facility did not have a policy relating to the patio restrictions. The facility's Resident Rights document (regarding self-determination and Participation), documented the resident had a right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the resident's choice of activities, schedules, healthcare and providers of healthcare services consistent with his/her interests, and assessments and plans of care. The resident had the right to make choices about aspects of his or her life in the facility that are significant to the resident.

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	06/13/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, document review and interview, the facility failed to ensure a resident was provided information about the right to formulate an advanced directive for 1 of 26 sampled residents (Resident #67). The deficient practice has the potential to deprive the resident of their right to determine their life status. Findings include: Resident #67 (R67) R67 was admitted to the facility on [DATE], with diagnoses including diffuse traumatic brain injury, bipolar disorder, anxiety disorder, and unspecified dementia. R67 had a Brief Interview for Mental Status (BIMS) score of three indicating severe cognitive impairment. A resident document titled Resident Face Sheet documented the resident was the responsible party and the daughter, sister, and brother-in-law were the emergency contacts. The facility was not able to provide any advanced directive documents such as: Power of Attorney paperwork, Guardian paperwork, a Physician Order for Life-Sustaining Treatment (POLST) form, or any other Advanced Directive paperwork for R67. The physician wrote an open-ended order dated 04/24/2023 with the description: Code Status: Full. On 06/10/2025 in the afternoon, an interview with R67 revealed the resident seemed confused. The resident thought was living in the Falls Housing Community off interstate five in California. On 06/11/2025 in the afternoon, the Director of Social Services (DSS) stated was not sure why the physician wrote an order for a full code for the resident when a full code is the default designation when no advanced directive is in place. The DSS affirmed a physician order is not considered a valid advanced directive. The DSS acknowledged since the resident had a low cognition (BIMS of three), there was no discussion with the resident on advanced directives since the resident lacked decisional capacity. This also meant the resident did not have the capacity to fill out the POLST form. The facility policy titled, Advance Directives, revised 06/09/2023, documented upon admission to the facility, the facility designee will determine the resident's decision-making capacity and identify the resident's primary decision maker and review the resident's existing choices with the resident or legal representative. The facility designee will also develop a care plan for all advanced directives; identifying, clarifying, and periodically reviewing, as part of the comprehensive care planning process, the existing care instructions and whether the resident or resident representative wishes to change or continue these instructions.

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	06/13/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **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's yelling and disruptive behaviors were addressed for 1 of 26 sampled residents (Resident 55). The deficient practice deprived other residents of the right to live in a peaceful environment with comfortable noise levels permitting for a restful night's sleep. Findings include: Resident 55 (R55) R55 was admitted on [DATE] and readmitted on [DATE], with diagnoses including insomnia, anxiety disorder and major depressive disorder. On 06/10/2025 at 9:45 AM, R55 was overheard from the hallway yelling, help! help! help! A Licensed Practical Nurse (LPN1) entered R55's room. Upon leaving R55's room, the LPN indicated R55 yelled all the time. On 06/10/2025 at 9:52 AM, R55 was seated in wheelchair and reported being unhappy in the facility due to not getting along with roommate and expressed was upset over being transported to the main dining room where R55 remained all night accompanied by a nurse. R55 indicated the nurse removed the resident from the unit to allow other residents to sleep because the resident yelled constantly. R55 acknowledged yelling constantly because the resident had difficulty sleeping and did not want to take any medications for sleep. On 06/10/2025 at 10:00 AM, R55's roommate Resident 109 (R109) sat in motorized wheelchair and indicated R55 yelled constantly day and night and cussed at staff which was disturbing to R109. On 06/12/2025 in the afternoon, R55 was observed asleep and unarousable in wheelchair by the front desk. On 06/13/2025 at 9:50 AM, R109 indicated R55 yelled day and night which disrupted R109's normal sleep patterns and R109 was able to sleep yesterday afternoon because staff brought R55 to the receptionist to allow R109 to rest. R109 confirmed the nurse had to bring R55 to the main dining room on the evening of 06/09/2025 to allow other residents in the unit to sleep. R109 indicated staff were fully aware of R55's behaviors but had run out of moves because nothing worked for R55. On 06/13/2025 at 11:06 AM, Resident 58 (R58) whose room was next to R55's room indicated being bothered by R55's constant yelling and stated, I am lucky to get three hours of sleep. On 06/13/2024 at 2:33 PM, Resident 122 (R122) who resided in the room directly across from R55's, was seated in walker on the front patio. R122 indicated being bothered by R55's constant yelling and had expressed this with the staff but the resident did not know what was being done for R55. (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	06/13/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/13/25 at 10:29 AM, LPN2 indicated being familiar with R55 and R109 who did not get along mostly due to R55's behaviors. According to LPN2, R109 was protective of staff and did not like it whenever R55 became verbally abusive towards staff. LPN2 indicated being aware Residents 109, 58 and 122 had expressed being bothered by R55's constant yelling and LPN2 was informed R55 needed to be removed from the room just to allow R109 to get some sleep. LPN2 indicated reporting R55's behaviors to the Assistant Director of Nursing (ADON1) and the DON but LPN2 was not aware of the leadership's plans for R55. LPN2 indicated all residents had the right to exist in a peaceful, homelike environment free from disruptive noise and R55's constant yelling was depriving other residents of peace and sleep. Review of medical record revealed R55's yelling behaviors were identified and documented by nursing staff almost daily. The medical record lacked documented evidence R55's yelling and disruptive behaviors were communicated to the psychiatric provider. On 06/13/2025 at 11:12 AM, ADON1 indicated being aware of R55's yelling behaviors which occurred frequently. ADON1 indicated being informed R55 had to be transported to the main dining room on the evening of 06/09/2025 to allow other residents to sleep. The ADON explained the facility tried room changes and one-on-one conversations but did not know what else could be done for the resident. The ADON indicated residents had the right to live in a peaceful homelike environment free from disruptive noise. On 06/13/25 at 11:32 AM, the Administrator indicated being aware of R55's yelling behaviors which affected other residents as evidenced by the night nurse needing to remove the resident from the unit on the evening of 06/09/2025 to allow other residents to sleep. According to the Administrator, the facility had tried room changes and separating R55 from other residents, but nothing seemed to work. The Administrator indicated residents had the right to live in a peaceful homelike environment free from disruptive noise. On 06/13/25 at 11:56 AM, the DON indicated being aware R55 had psychiatric diagnoses including major depressive disorder, insomnia and anxiety disorder and confirmed R55 was not on any psychotropic medications. The DON was familiar with R55's yelling and disruptive behaviors and was made aware R55's behaviors were affecting other residents particularly those who were near R55's room. The DON indicated all residents had the right to live in a peaceful, homelike environment free from disruptive noise and the DON acknowledged R55's behaviors were depriving other residents of peace and sleep. The Resident's Rights policy (undated) documented each resident had the right to a homelike atmosphere which is safe, clean with comfortable noise levels.

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	06/13/2025

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. (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	06/13/2025

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to review and follow up on a Preadmission Screening and Resident Review (PASRR) level 2, following a resident's psychiatric hospitalization for 1 of 26 sampled residents (Resident #57), and failed to ensure referrals for PASRR level 2 screening were completed for 4 of 26 sampled residents (Residents #121, 64, 55, and 67). The deficient practice had the potential to delay necessary specialized services and interventions for the residents, and could have impacted their placement, overall care and well-being.Findings include:A Preadmission Screening and Resident Review (PASRR) is a federally mandated process that ensures individuals with mental disorders or intellectual and developmental disabilities are not inappropriately placed in nursing facilities for long-term care, and it helps determine the most suitable and least restrictive setting, ensuring access to necessary services and supports. The facility's PASRR documentation policy dated 06/09/2023, indicated referrals were required for Level II residents or individuals with newly identified mental health or intellectual disabilities following a significant change in status. The policy documented the facility was expected to promptly notify the state-designated authority in such cases. Residents readmitted after psychiatric hospitalization or displaying new behavioral symptoms were to be referred for evaluation. Resident #57 (R57)R57 was originally admitted on [DATE], and re-admitted on [DATE], with diagnoses including intraparenchymal hemorrhage, status post craniotomy, anxiety, depression and agitation.The Minimum Data Set (MDS) quarterly assessment (MDS is a standardized assessment tool used in nursing homes and skilled nursing facilities to collect comprehensive information about residents' health and functional status) dated 02/04/2025, revealed neurological diagnoses included hemiplegia and seizure disorder, and psychiatric diagnoses included anxiety and bipolar disorder.In the MDS discharge assessment dated [DATE], neurological diagnoses included hemiplegia and seizure disorder, and psychiatric diagnoses included anxiety and bipolar disorder.A nursing progress note dated 04/08/2025, revealed R57 expressed feelings of depression, citing not seeing their children and their recent birthday as contributing factors. R57 communicated a desire to harm themself, which was reaffirmed upon subsequent assessment and redirection efforts were unsuccessful, leading to arrangements for hospital evaluation and treatment via legal hold (a situation where an individual is placed under involuntary psychiatric care due to concerns about their safety) for medical and psychiatric clearance.A hospital admission document dated 04/16/2024, revealed R57 was admitted to emergency department (ED) complaining of being suicidal with a plan to cut the wrists. Working diagnosis included suicidal ideation and schizoaffective disorder. The criteria for admission revealed behavioral health condition, symptom or finding for which observation care had failed, or was not considered appropriate. The hospital Discharge summary dated [DATE], documented R57's admission following an acute bipolar exacerbation, characterized by severe mood disturbances, suicidal ideation, and emotional distress. Prior to hospitalization, R57 reported feelings of hopelessness, expressed a plan for self-harm, and experienced worsening symptoms despite attempts at coping. The discharge summary indicated that due to the severity of their condition, R57 was medically cleared, placed on a legal hold, and admitted to the psychiatric unit for further treatment. Upon discharge, diagnoses included post-traumatic stress disorder. R57 was re-admitted to the facility on [DATE] at 11:30 PM, following hospitalization for an acute exacerbation of bipolar disorder and post-traumatic stress disorder, marked by suicidal ideation, depressed mood, racing thoughts, and flight of ideas. A Psychiatric evaluation dated 04/18/2025, documented R57 was recently hospitalized due to moderately worsening symptoms of severe depression and suicidal ideation with plan to self-inflict injuries. Baseline care plan dated 04/20/2025, documented R57 was re-admitted following an acute hospitalization due to depressed mood and suicidal ideation, resulting in a legal hold. Care approaches included implementation of PASRR recommendations to address mental health needs.The medical record lacked documented evidence a PASRR Level 2 evaluation was conducted after R57's return to the facility, despite R57's acute change in condition. The previous PASSR Level 1 screening dated 05/03/2021, determined R57 had no mental illness, intellectual disability, or related condition. This PASRRA 1 screening was no longer an accurate assessment for R57's current mental health conditions given their recent psychiatric hospitalization and legal hold. On 06/12/2025 at 1:00 PM, the MDS Coordinator explained the diagnoses documented in the MDS assessment were derived not only from the discharge summary but also from the attending physician's history, physical examination, medication administration records, and

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	06/13/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and document review, the facility failed to develop and implement a comprehensive care for post-traumatic stress disorder (PTSD) reflecting a resident's new mental health conditions and following a new Preadmission Screening and Resident Review (PASRR) Level 2 screening determination for 1 of 26 sampled residents (Resident #57). The deficient practice had the potential to compromise the resident's mental health management, leading to inadequate treatment, delayed interventions, and a lack of necessary support services. Findings include: A Preadmission Screening and Resident Review (PASRR) is a federally mandated process that ensures individuals with mental disorders or intellectual and developmental disabilities are not inappropriately placed in nursing facilities for long-term care, and it helps determine the most suitable and least restrictive setting, ensuring access to necessary services and supports. Resident #57 (R57) R57 was originally admitted on [DATE], and re-admitted on [DATE], with diagnoses including intraparenchymal hemorrhage, status post craniotomy, anxiety, depression and agitation. The Minimum Data Set (MDS) quarterly assessment (MDS is a standardized assessment tool used in nursing homes and skilled nursing facilities to collect comprehensive information about residents' health and functional status) dated 02/04/2025, revealed neurological diagnoses included hemiplegia and seizure disorder, and psychiatric diagnoses included anxiety and bipolar disorder. A nursing progress note dated 04/08/2025, revealed R57 expressed feelings of depression, citing not seeing their children and their recent birthday as contributing factors. R57 communicated a desire to harm themself, which was reaffirmed upon subsequent assessment and redirection efforts were unsuccessful, leading to arrangements for hospital evaluation and treatment via legal hold (a situation where an individual is placed under involuntary psychiatric care due to concerns about their safety) for medical and psychiatric clearance. In the MDS discharge assessment dated [DATE], neurological diagnoses included hemiplegia and seizure disorder, and psychiatric diagnoses included anxiety and bipolar disorder. A hospital admission document dated 04/16/2024, revealed R57 was admitted to emergency department (ED) complaining of being suicidal with a plan to cut the wrists. Working diagnosis included suicidal ideation and schizoaffective disorder. The criteria for admission revealed behavioral health condition, symptom, or finding for which observation care had failed, or was not considered appropriate. (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	06/13/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The hospital Discharge summary dated [DATE], documented R57's admission following an acute bipolar exacerbation, characterized by severe mood disturbances, suicidal ideation, and emotional distress. Prior to hospitalization, R57 reported feelings of hopelessness, expressed a plan for self-harm, and experienced worsening symptoms despite attempts at coping. The discharge summary indicated that due to the severity of their condition, R57 was medically cleared, placed on a legal hold, and admitted to the psychiatric unit for further treatment. Upon discharge, diagnoses included post-traumatic stress disorder (PTSD). R57 was re-admitted to the facility on [DATE] at 11:30 PM, following hospitalization for an acute exacerbation of bipolar disorder and post-traumatic stress disorder, marked by suicidal ideation, depressed mood, racing thoughts, and flight of ideas. A Psychiatric evaluation dated 04/18/2025, R57 was recently hospitalized due to moderately worsening symptoms of severe depression and suicidal ideation with plan to self-inflict injuries. Baseline care plan dated 04/20/2025, documented R57 was re-admitted following an acute hospitalization due to depressed mood and suicidal ideation, resulting in a legal hold. Care approaches included implementation of PASRR recommendations to address mental health needs. The medical record lacked documented evidence a comprehensive care plan to manage and care for PTSD was developed and implemented. The medical record lacked documented evidence a PASRR Level 2 evaluation was conducted after their return to the facility, despite R57's acute change in condition. The previous PASSR Level 1 screening dated 05/03/2021, determined R57 had no mental illness, intellectual disability, or related condition. This PASRRA 1 screening was no longer an accurate assessment for R57 current mental health conditions given their recent psychiatric hospitalization and legal hold. On 06/12/2025 at 1:00 PM, the MDS Coordinator explained the diagnoses documented in the MDS assessment were derived not only from the discharge summary but also from the attending physician's history, physical examination, medication administration records, and progress notes. The MDS Coordinator acknowledged unfamiliarity with the criteria for PASRR Level 2 screening, stating that such inquiries would typically be addressed by the Social Worker who was recently hired and could probably not be aware of the screening process for PASRR level 2. The MDS Coordinator confirmed the last quarterly MDS assessment did not include the new diagnoses of PTSD documented in the hospital discharge summary and the severe depression documented in the post hospitalization psychiatric evaluation conducted on 04/18/2025. Following a review of the agency's website responsible for conducting PASRR screenings, the MDS Coordinator identified a PASRR Level 2 determination dated 04/23/2025, which had been referred by the hospital on [DATE]. Upon verification, the MDS Coordinator confirmed this screening result was not incorporated into R57's medical records and affected the accuracy of the last MDS assessment, preventing the development of a comprehensive care plan to address R57's updated conditions. The PASRR screening level 2 dated 04/23/2025, revealed R57 met the criteria to be admitted in a nursing facility level of service and may be admitted if the facility was able to provide or arrange specialized services including individual and family psychotherapy, psychiatric follow ups, monitoring and advocacy services.

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	06/13/2025

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 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 ensure a new skin impairment was communicated to the wound care team in accordance with facility protocol for 1 of 26 sampled residents (Resident 118). This deficiency placed the resident at risk for wound complication. Findings include: Resident 118 (R118) R118 was admitted to the facility on [DATE], with diagnoses including acute and chronic respiratory failure with hypercapnia and ingrown nail. On 06/10/2025 at 8:38 AM, R118 laid in bed with feet exposed. A blackened area was observed on the tip of R118's right great toe. R118 explained the podiatrist had tried to remove R118's ingrown nail on 06/03/2025 but had to stop when R118 complained of pain. R118 indicated not knowing what the blackened area on the toe was and had communicated the concern to multiple staff but the resident had not heard back from anyone. A physician's order dated 03/28/2025 documented a consultation with Podiatry. A podiatry consult dated 06/03/2025, revealed R118 was seen by the podiatrist and was treated for thick, yellow toenails. Treatment included mycotic toenail debridement, trimming of long, thin, colorless nails, and simple nail trimming. On 06/12/2025 at 01:07 PM, the Wound Care Nurse reported being aware the podiatrist had attempted to remove the ingrown nail on the right great toe on 06/03/2025, but the provider had to stop when R118 expressed pain. The Wound Care Nurse reported evaluating R118's right great toe and described the blackened area as dried blood versus necrotic tissue which was painful when touched. The wound care nurse confirmed being told by R118 the concern had been communicated to multiple staff however no one had reported the skin issue to the wound care team. On 06/12/25 at 01:28 PM, R118 laid in bed with feet exposed. The Wound Care Nurse was present when R118 repeated having told multiple staff of the toe discoloration and pain, but no one had gotten back to R118 regarding the concern. The Wound Care Nurse indicated the toe discoloration and pain were considered abnormal findings and expected nursing staff to notify the wound care team of new skin impairment or complication immediately. On 06/12/2025 at 01:28 PM, the Certified Nursing Assistant (CNA) verbalized being assigned to R118 on 06/11/2025 and 06/12/2025. The CNA indicated noticing the blackened area on the right toe 06/11/2025 and reported it to the licensed Practical Nurse (LPN) on duty who said would check on it, but the CNA did not know if the LPN had done so. The CNA indicated expecting the nurse to contact the physician or the wound care team if R118 had a skin impairment. (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	06/13/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/12/2025 at 01:31 PM, the (LPN) indicated having been assigned to R118 last week, but LPN did not notice R118's discolored toe until today. The LPN reported attempting to apply socks on R118's right foot this morning, but R118 refused, stating the toes were tender. The LPN indicated the LPN to whom the CNAs reported the discolored toe on 06/11/2025 should have reported it to the wound care team. On 06/12/25 at 01:43 PM, the Wound Care Nurse indicated expecting nurses to report skin impairments immediately to avoid delays in appropriate interventions. The Wound Care Nurse stated it was difficult to determine how long the delay in reporting was and stated delay in communication meant a delay in proper interventions which placed R118 at risk for infection and worsening pain. On 06/12/25 at 01:49 PM, the Assistant Director of Nursing (ADON) indicated the CNAs' form called STOP and WATCH, the CNAs filled out whenever a change in condition was identified. According to the ADON, the purpose of the form was so CNAs could protect themselves in case the nurse they reported the abnormal finding to, forgot to address the reported change of condition. The ADON confirmed the CNA who identified R118's discolored toe with pain on 06/11/2025, failed to complete a Stop and Watch form for R118. The ADON indicated expecting CNAs to inform nurses of new skin impairments immediately, and nurses were expected to communicate with the wound care team for timely interventions. The ADON stated delays in communication translate to delays in intervention, which place the resident at risk for infection and pain. On 06/13/2025 at 10:39 AM, the wound care physician was inside R118's room and described the blackened area on R118's right great toe as hyper-granulation tissue or a scab and not dried blood. The physician indicated being aware the podiatrist performed an ingrown nail removal on 06/03/2025 wherein only a portion of the ingrown nail was removed due to R118's complaints of pain. The physician reported the wound care team was informed of R118's discoloration of the toe and reports of pain on 06/12/2025 and indicated expecting nurses to notify the wound care team sooner to prevent wound complications. The physician indicated after the wound care team was notified of R118's skin issues, infectious disease was involved, and prophylactic antibiotic had been ordered. The wound physician verbalized a delay in communication meant a delay in proper interventions and placed the resident at risk for complications such as infection and worsening pain. The facility policy titled Wound Care: Skin Checks, revised July 1, 2015, documented CNA would perform skin checks daily, as this allows for earlier identification and intervention. The facility policy titled Wound Care, Licensed Nurse Skin Checks, revised July 1, 2015, documented all residents will have a thorough weekly skin evaluation performed by a licensed nurse.

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	06/13/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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	06/13/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to ensure interventions were implemented to identify hazards and risks associated with smoking, and residents who smoked were adequately monitored or supervised for 2 of 16 sampled residents (Residents 91 and 99), and 1 unsampled resident (Resident 97), identified as smokers. This deficient practice had the potential to result in fire hazards and compromise the safety and well-being of the residents, staff, and others in the facility.Findings include:A facility policy titled Smoking Regulation, revised 11/01/2017, documented the facility was highly encouraged to maintain a smoke-free environment. If the facility chose not to remain smoke-free, facility leadership was required to establish an appropriate and safe environment for smoking to reduce the risk to residents who smoked, minimize exposure to secondhand smoke for others, and reduce the risk of fire. Smoking without direct supervision was not permitted. Possession of smoking materials (lighters, matches, cigarettes, etc.) in resident rooms or on the person was prohibited. When smoking was permitted during a resident stay, facility staff were required to receive and safeguard all smoking materials.Resident 91 (R91)R91 was admitted on [DATE], with diagnoses including chronic obstructive pulmonary disease and heart failure.On 06/10/2025 at 3:00 PM, R91 reported being a smoker and acknowledged keeping a lighter in a pants pocket while the roommate's Oxygen (O2) was on, in close proximity. R91 indicated being wheelchair-bound, able to propel self, smoked outside near a tree within the facility premises, did not require staff assistance, and was not supervised during smoking. R91 reported running out of cigarettes for a few days and indicated a sister would be bringing more.The Observation Detail List report dated 05/12/2025, documented R91 as a chain smoker.A document titled Smoking Residents, listed R91 as a smoker.A final written warning for violation of the no-smoking policy dated 05/202/2025, documented it was acknowledged and signed by R91.On 06/10/2025 at 3:15 PM, the Assistant Director of Nursing (DON) indicated R91 was alert, oriented, and identified as a smoker. The Assistant Director of Nursing (ADON) confirmed possession of a lighter in R91's pants pocket. The ADON retrieved the lighter and provided education regarding the non-smoking policy. The ADON indicated a smoking assessment was completed and a care plan developed. On 06/12/2025 at 11:01 AM, a Licensed Practical Nurse (LPN) explained a smoking assessment and inventory of smoking materials were completed upon admission of residents who smoked. The LPN was uncertain about the current smoking policy but indicated a transition was underway toward establishing a designated smoking area with assigned staff. The LPN acknowledged inconsistent enforcement of the non-smoking policy and indicated R91 was non-compliant despite repeated counseling. The LPN had not personally observed R91 smoking but confirmed frequent smoking behavior. The LPN expressed the physician notification and education attempts were made but hindered by unclear enforcement protocols regarding smoking.On 06/12/2025 at 11:20 AM, the ADON indicated assessments and inventories were completed at admission. The ADON indicated facility was identified as non-smoking, with plans to establish a designated smoking area and staff monitoring. The ADON reported R91 was non-compliant, continued smoking, and refused nicotine patches. The ADON indicated the physician and social services were aware, but discharge was delayed due to social worker turnover. The ADON explained the issue had been ongoing since having been discussed during Quality Assurance and Performance Improvement (QAPI) meetings and thirty-day discharge notices had been issued to non-compliant residents. The ADON indicated despite confiscation efforts, residents continued obtaining smoking supplies. The ADON described the issue as a daily challenge with ineffective interventions and inconsistent enforcement. The ADON confirmed the residents who smoked outside were not monitored.On 06/12/2025 at 11:39 AM, the Social Services Assistant (SSA) confirmed no active discharge plan for R91 related to non-compliance with smoking. The SSA indicated R91 had signed a no-smoking agreement upon admission and the leadership had discussed transitioning R91 to a smoking-permitted facility. The SSA explained additional personnel were assigned to redirect smokers, but monitoring and education efforts had not resolved the issue. The SSA indicated the residents were frequently observed smoking at the entrance with approximately 10 smokers daily on different times. The SSA indicated the issue had persisted since the previous year, and family members had voiced concerns regarding secondhand smoke exposure at the entrance. The SSA indicated despite consistent confiscation and patch offerings, residents refused interventions. On 06/12/2025 in the afternoon, a Certified Nursing Assistant (CNA) in Unit 2 indicated the facility was a non-smoking facility. The CNA indicated the residents continued

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	06/13/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to ensure the Foley catheter was assessed timely, the physician was notified of foul-smelling urine, the change in condition was documented, and the urinary drainage bag was changed as ordered for 1 of 26 sampled residents (Resident 104). This deficient practice had the potential to contribute to urinary tract infection, compromised skin integrity, and overall health status. Findings include: Resident 104 (R104) R104 was admitted on [DATE], with diagnoses including neoplasm of the kidney and obstructive and reflux uropathy. A Physician order dated 08/21/2024, documented to change Foley drainage bag weekly on Sunday. A Physician order dated 10/16/2024, documented an indwelling Foley catheter, 16 French, inflated with 10 cubic centimeters (cc), for benign prostatic hyperplasia (BPH). The order indicated the Foley catheter may be changed as needed for obstruction or dislodgement. A Physician order dated 10/16/2024, documented may irrigate Foley catheter with 60 cc sterile water as needed for sediments/obstruction as needed. A Care Plan dated 10/15/2024, documented R104 had an indwelling catheter related to BPH and recurrent urinary tract infections. Interventions included providing catheter care as ordered, monitor and document urinary output. The goal was for R104 to remain free from urinary tract infections for 90 days. On 06/10/25, at 9:59 AM, R104 was observed in bed with eyes closed. A urinary drainage bag, undated and in place, contained approximately 450 cc of dark yellow to amber-colored urine with visible sediment. On 06/11/25, at 1:49 PM, R104 was observed in bed, awake and verbally responsive. R104 verbalized the Foley catheter and urinary drainage bag had not been changed. R104 verbalized the diaper had been soaking wet and staff attributed the moisture to leakage from the insertion site, but the Foley had not been changed in over a month. R104 indicated had frequent urinary tract infections. On 06/11/25 at 1:51 PM, a Licensed Practical Nurse (LPN) verified the Foley catheter in place was a 16 French with a 10-cc water balloon. The LPN confirmed the urinary tubing contained sediment build-up, the urinary bag appeared old and discolored, and the urine was cloudy with a foul odor. The LPN indicated the Foley catheter should have been changed if leaking, the urinary bag should have been replaced as needed, and a physician's order should have been implemented and documented. (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	06/13/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R104's medical record lacked documented evidence the Foley catheter was assessed timely, the physician was notified of foul-smelling urine, the change in condition was documented, and the urinary drainage bag was changed as ordered. On 06/11/25 at 2:05 PM, the Assistant Director of Nursing (ADON) indicated a physician's order was required for residents with an indwelling Foley catheter, including justification, management, and ongoing assessment. Staff were expected to follow physician orders. The ADON confirmed R104 had concentrated amber-colored urine with a foul odor at the time of the catheter change, indicating a change in condition that should have been reported, with a Situation-Background-Assessment-Recommendation (SBAR) initiated and documented. No documentation was found of leakage, urinary tract infection symptoms, or SBAR initiation. The ADON stated the order directed weekly catheter changes, documented in the Treatment Administration Record (TAR); however, although recorded as changed on June 1 and 8, 2025, the catheter was not changed. The ADON explained changes were performed as needed, but the active order specified weekly changes and should have been clarified. The ADON confirmed the presence of foul-smelling urine, a tarnished and discolored drainage bag, and visible sediment. The urinary bag appeared old, and a reported change in condition should have prompted assessment and catheter replacement. The ADON indicated nursing staff were expected to notify the physician and document the change; however, this was not completed. On 06/12/25 at 11:31 AM, the Director of Nursing (DON) indicated residents with Foley catheters had diagnoses supporting continued use. Physician orders were required for catheter care, including maintaining cleanliness and discontinuing use when appropriate. Some residents had indwelling catheters due to underlying medical conditions. The DON stated the Foley catheter should have been flushed if occluded and changed if leaking. If foul-smelling urine was present, prompt assessment and physician notification were expected to obtain an order for urine collection, catheter change, and documentation. A facility policy titled Catheter-Urinary Catheter Cleaning and Maintenance - Lippincott Nursing Procedures, 9th Ed., pages 432-435, revised 05/05/2023, directed staff to monitor intake and output as ordered, observe for changes in urine volume and color, and notify the practitioner of abnormal findings. A facility policy titled Physician and Other Communication/Change of Condition, revised 05/05/2023, directed staff to complete a resident assessment, including any interventions provided. Staff were to complete a Situation-Background-Assessment-Recommendation (SBAR), notify the physician, and document all assessments and changes in the resident ' s condition in the medical record. Changes and new interventions were to be reflected in the individualized care plan. All attempts to notify physicians and family members or legal representatives were to be thoroughly documented in the medical record.

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	06/13/2025

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 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** Based on observation, interview, record review, and document review, the facility failed to ensure enteral feeding orders administered through the gastrostomy tube were followed as ordered, and total volume delivered was monitored and documented for 1 of 26 sampled residents (Resident 34). This deficient practice had the potential to result in inadequate nutritional and fluid intake, leading to malnutrition, dehydration, electrolyte imbalances, impaired wound healing and increased susceptibility to infections. Findings include: Resident 34 (R34) R34 was admitted on [DATE], with diagnoses including risk for malnutrition due to impaired food and fluid intake, diabetes mellitus, dementia and gastrostomy. On 06/10/2025 at 10:10 AM, R34 was observed in bed with the head of bed elevated 30 to 45 degrees. Nepro 1.8 (a liquid therapeutic nutritional supplement specifically designed to help meet nutritional needs) was hung on a pole, with the tube feeding (TF) bag approximately full at 1000 milliliters (mL). The bag was labeled 06/10/2025 at 4:40 AM, with an indicated rate of 35 mL/hour. The water bag was at approximately 1000 mL, labeled with the resident's name, but lacked an infusion rate and staff initials. TF was not flowing at the time of observation. A physician order dated 02/14/2025 documented Nepro 1.8 at 35 mL/hour for 15 hours daily or until a total volume of 525 mL was infused. Date and label each tubing, monitor for tolerance. On 06/10/2025 at 11:33 AM, TF remained connected to R34 but was not flowing at the time of observation. On 06/13/2025 in the morning, TF via enteral pump was observed turned off. A Licensed Practical Nurse (LPN) explained R34 was dependent on enteral feedings due to dysphagia (difficulty swallowing) and was receiving hospice services. The LPN indicated TF started at 2:00 PM and ended at 5:00 AM. The LPN confirmed the enteral feeding pump history showed a total feed volume of 1,452 mL over three days, reflecting a deficit of 123 mL. The 30-day total was 13,823 mL, reflecting a cumulative deficit of 1,927 mL. On 06/13/2025 at 10:13 AM, the Assistant Director of Nursing (ADON) explained if TF was initiated at 2:00 PM, it should have been administered for the prescribed duration or until the ordered volume was completed. The ADON clarified the ordered volume must be administered in full, regardless of interruptions. The ADON indicated inadequate delivery placed the resident at risk for weight loss and stated the current weight remained stable. A review of the June Medication Administration Record (MAR) revealed lacked documented evidence the total TF volume was consistently monitored or recorded. (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	06/13/2025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/13/2025 at 10:00 AM, the Registered Dietitian (RD) explained R34 was entirely dependent on tube feeding, with no oral intake. The current TF order was 35 mL per hour over 15 hours daily, totaling 525 mL/day or 15,750 mL over 30 days. The actual administered volume was 13,823 mL, reflecting a 1,927 mL deficit. The RD confirmed the deficit was clinically significant, particularly for a resident with no oral intake. The RD indicated the TF provided complete nutrition, including essential fatty acids, vitamins, and minerals. The RD indicated failure to deliver the full ordered volume placed the resident at risk for weight loss and nutritional deficiencies. The RD reported R34's TF met approximately 88.9% of daily caloric needs and 72.8% of protein needs. The RD identified protein intake as suboptimal and below the recommended goal. The RD recalled a request to nursing staff to begin documenting total volume delivered was made in November 2024, shortly after hire, but had not been implemented. The RD confirmed TF volume was not consistently monitored or documented in the MAR and expressed this failure placed the resident at risk for unintentional weight loss and unmet nutritional needs. On 06/13/2025 at 1:34 PM, the physician indicated it was essential to maintain nutritional status through consistent enteral feeding as ordered to support metabolic balance and reduce the risk of skin breakdown. The physician confirmed staff were expected to follow TF orders as prescribed. A facility policy titled Enteral Feeding - Documentation, revised 06/20/2023, documented licensed nursing staff would monitor residents receiving enteral nutrition daily and document according to facility guidelines, including recording intake and output amounts.

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	06/13/2025

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure 1) a resident's yelling and disruptive behaviors were communicated to the psychiatric provider and 2) the resident was referred to the behavioral services provider for psychotherapy services for 1 of 26 sampled residents (Resident 55). The deficient practice potentially had a negative impact on the resident of concern's overall well-being and deprived other residents of the right to live in a peaceful environment free from disruptive noise. Findings include: Resident 55 (R55) R55 was admitted on [DATE] and readmitted on [DATE], with diagnoses including insomnia, anxiety disorder and major depressive disorder. Psychiatric provider not informed On 06/10/2025 at 9:45 AM, R55 was overheard from the hallway yelling, help! help! help! A Licensed Practical Nurse (LPN1) entered R55's room. Upon leaving R55's room, the LPN indicated R55 yelled all the time. On 06/10/2025 at 9:52 AM, R55 was seated in wheelchair and reported being unhappy in the facility due to not getting along with roommate and expressed was upset over being transported to the main dining room where R55 remained all night accompanied by a nurse. R55 indicated the nurse removed the resident from the unit to allow other residents to sleep because the resident yelled constantly. R55 acknowledged yelling constantly because the resident had difficulty sleeping and did not take any medications for sleep. On 06/10/2025 at 10:00 AM, R55's roommate Resident 109 (R109), sat in motorized wheelchair and indicated R55 yelled constantly day and night and was verbally abusive towards staff which R109 found disturbing. On 06/12/2025 in the afternoon, R55 was observed asleep and unarousable in wheelchair in the lobby by the front desk. On 06/13/2025 at 9:50 AM, R109 indicated R55 yelled day and night which disrupted R109's normal sleep patterns. R109 reported being able to nap yesterday afternoon because staff brought R55 to the receptionist to allow R109 to rest. R109 confirmed the nurse had to bring R55 to the main dining room on the evening of 06/09/2025 to allow other residents in the unit to sleep. R109 indicated staff were fully aware of R55's behaviors but had run out of moves because nothing worked for R55. On 06/13/2025 at 11:06 AM, Resident 58 (R58) whose room was next to R55's room indicated being bothered by R55's constant yelling and stated, I am lucky to get three hours of sleep. (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	06/13/2025

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/13/2024 at 2:33 PM, Resident 122 (R122) who resided in the room directly across from R55's, was seated in walker on the front patio. R122 indicated being bothered by R55's constant yelling and had expressed this with the staff but the resident did not know what was being done for R55. On 06/13/25 at 10:29 AM, LPN2 indicated being familiar with R55 and R109 who did not get along mostly due to R55's behaviors. According to LPN2, R109 was protective of staff and did not like it whenever R55 became verbally abusive. LPN2 indicated being aware Residents 109, 58 and 122 had expressed being bothered by R55's constant yelling and LPN2 was informed R55 needed to be removed from the room just to allow R109 to get some sleep. LPN2 indicated reporting R55's behaviors to the Assistant Director of Nursing (ADON1) and the DON but LPN2 was not aware of the leadership's plans for R55. LPN2 indicated all residents had the right to exist in a peaceful, homelike environment free from disruptive noise and R55's constant yelling was depriving other residents of peace and sleep. A psychiatric consult report dated 12/17/2024, revealed R55 was seen by psychiatric provider due to refusing to go to dialysis treatments. The report documented R55 was currently not on any psychotropic medications and nursing was instructed to monitor R55's mood changes and consult psychiatry for any concerns. Review of medical record revealed R55's yelling behaviors were identified and documented by nursing staff almost daily. The medical record lacked documented evidence R55's yelling and disruptive behaviors were communicated to the psychiatric provider. On 06/13/2025 at 11:12 AM, ADON1 indicated being aware of R55's yelling behaviors which occurred frequently. ADON1 indicated being informed R55 had to be transported to the main dining room on the evening of 06/09/2025 to allow other residents to sleep. The ADON explained the facility tried room changes and one-on-one conversations but did not know what else could be done for the resident. On 06/13/25 at 11:32 AM, the Administrator indicated being aware of R55's yelling behaviors which affected other residents as evidenced by the night nurse needing to remove the resident from the unit on the evening of 06/09/2025 to allow other residents to sleep. According to the Administrator, the facility had tried non-pharmacological interventions such as room changes, separating R55 from other residents but the Administrator deferred to the DON regarding pharmacological interventions. On 06/13/2025 at 11:59 AM, the psychiatric nurse practitioner (NP) confirmed R55 was a patient whom the NP saw only one time on 12/17/2024 when R55 refused to go to dialysis treatments. The NP indicated not being aware of R55's yelling and disruptive behaviors since no one from the facility had communicated R55's behaviors with the NP. The provider indicated whenever mood or behavior changes were identified, the facility must request a psychiatric consult to allow the NP to re-evaluate R55 and provide education regarding appropriate interventions such as medications. (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	06/13/2025

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/13/25 at 11:56 AM, the DON indicated being aware R55 had psychiatric diagnoses including major depressive disorder, insomnia and anxiety disorder and confirmed R55 was not on any psychotropic medications. The DON was familiar with R55's yelling and disruptive behaviors and was made aware the night nurse had to take R55 to main dining room on the evening of 06/09/2025 so the other residents could sleep. The DON acknowledged non-pharmacological interventions which included room changes and separating R55 from other residents were ineffective. The DON indicated facility staff were fully aware of R55's disruptive behaviors and how it had negatively impacted other residents, but no one thought to refer R55 for a psychiatric consult which would have given the psychiatric provider the chance to discuss appropriate interventions sooner. Referral for Psychotherapy Services On 06/13/25 at 1:43 PM, ADON2 indicated R55 was a Tier one resident which were residents with yelling and disruptive behaviors. According to ADON2, the facility had contracted with a private vendor who had a government contract with Medicaid. The Behavioral Health Services (BHS) provider would place behavior residents in Tiers (one, two or three) based on review of facility documentation and inter-disciplinary team (IDT) reports. Once a resident was identified to benefit from bedside psychotherapy services, the vendor would obtain Medicaid approval and if approved the resident would receive bedside psychotherapy services. ADON2 indicated R55 should have been identified by the IDT for BHS referral to be able to be considered for psychotherapy services. The DON reviewed medical record and confirmed R55 had not been seen by BHS nor referred by the IDT for psychotherapy services and should have been. The Behavioral Health Services policy revised 06/09/2023, documented each resident must receive and the facility must provide necessary behavioral health care and services to attain and maintain the highest practicable physical, mental and psycho-social well-being. Provided services and attempts to provide services would be documented in the resident's medical record.

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	06/13/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, document review, and record review, the facility failed to ensure target behaviors were monitored for a resident receiving medication to treat Post Traumatic Stress Disorder (PTSD) for 1 of 26 sampled residents (Resident #26). This deficient practice had the potential to cause the residents to use unnecessary medication, which may result in possible adverse effects. Findings include: Resident 26 (R26) R26 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including chronic respiratory failure with hypercapnia and post-traumatic stress disorder (PTSD). A physician's order dated 04/02/2025 documented Prazosin capsule two milligrams (mg) by mouth every 12 hours for PTSD, target behaviors: night terrors. The psychotropic consult report dated 01/20/2019 documented R26 had a history of being abused as a child and witnessing a violent crime. R26 experienced night terrors related to the incident and had trouble sleeping. R26's medical record lacked documented evidence target behaviors were being monitored for R26 related to the medication Prazosin. On 06/12/25 at 12:05 PM, the Assistant Director of Nursing (ADON) indicated being familiar with R26. The ADON confirmed R26 had been on Prazosin for PTSD for many years, with target behaviors of night terrors. The ADON explained Prazosin was not a psychotropic medication but was ordered for off-label use to address R26's PTSD. The ADON indicated if a medication was used to treat a psychiatric diagnosis such as PTSD, target behaviors must still be monitored. The ADON confirmed R26's night terrors were not being monitored per the physician's order. The ADON indicated the purpose of monitoring Prazosin medication was to identify adverse effects and to determine if the medication was effective. On 06/12/25 at 12:06 PM, the Director of Nursing (DON) explained that Prazosin was an alpha-blocker (a cardiovascular drug) which could be used to improve sleep quality and reduce nightmares. The DON corroborated the ADON's interview, stating medications used for psychotropic diagnoses even if used off-label, must be monitored for target behaviors. The DON indicated monitoring psychotropic medications ensured adverse effects were identified and the medication is effective, particularly in this case for night terrors. The Psychotropic Drugs policy, revised 04/17/2024, documented the facility would monitor and document the resident's response to psychotropic medications for efficacy and adverse consequences. Symptoms, behaviors, and side effects were to be monitored.

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	06/13/2025

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 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** Based on observation, interview, document review, and record review, the facility failed to ensure a medication error rate of less than 5% was obtained during medication pass. There were 31 opportunities observed, which revealed three errors. The medication error rate was 9.68%. Failure to follow physician orders during medication administration had the potential to cause harm or injury to residents. Findings include: Resident 82 (R82) R82 was admitted on [DATE], with diagnosis including hemiplegia affecting left nondominant side, major depressive disorder recurrent severe without psychotic features, and generalized anxiety disorder. On 06/12/2025 at 7:17 AM, a Licensed Practical Nurse (LPN) prepared and administered R82 six medications including Aspirin 81 milligrams (mg) one tablet by mouth and Vistaril (hydroxyzine pamoate) 25 mg (a medication used to treat anxiety), one capsule by mouth. R82's medical record lacked a physician order for Aspirin 81 mg one tablet by mouth. A Physician order dated 11/15/2024, documented Multivitamin (multivitamin-minerals (min)-iron-folic acid (fa)-vit K) tablet, 18 mg, iron-400 micrograms (mcg) oral, once a day at 9:00 AM. A Physician order dated 11/20/2024, documented Vistaril (hydroxyzine pamoate) capsule, 25 mg, amount 1, oral. Special instructions documented for anxiety and poor sleep, do not change the time, twice a day at 9:00 AM and 9:00 PM. A Care Plan edited 05/31/2025, documented R82 had potential for complications related to blood thinning medication and anticoagulant use. R82 had restlessness related to anxiety. Approach included to administer medication as ordered. On 06/12/2025 at 9:23 AM, the LPN, confirmed had administered R82 Aspirin 81 mg one tablet. The LPN acknowledged R82 did not have a physician order for Aspirin 81 mg, and it was administered in error. The LPN acknowledged did not administer the Multivitamin 18 mg, iron-400 mcg tablet. The LPN explained mistook the Aspirin bottle for the Multivitamin bottle, the Aspirin was given to R82 in error and the Multivitamin was not administered as ordered. The LPN confirmed the physician order for Vistaril (hydroxyzine pamoate) 25 mg 1 capsule included specific instruction not to change the time of administration. The LPN acknowledged the Vistaril (hydroxyzine pamoate) 25 mg 1 capsule should have been administered at 9:00 AM as ordered and it was administered at 7:17 AM in error. The LPN acknowledged medication should have been administered as ordered by the physician. (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	06/13/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/12/2025 at 9:32 AM, the Assistant Director of Nursing (ADON), confirmed R82 did not have a physician order for Aspirin, and it was administered in error. The ADON explained R82 had a physician order for Multivitamin which was not administered and should have been administered instead of the Aspirin. The ADON reported Vistaril (hydroxyzine pamoate) 25 mg had physician instructions not to change the time of administration of 9:00 AM and confirmed it was administered too early at 7:17 AM, outside of the time ordered by the physician. The ADON reported medication had to be administered as ordered. On 06/13/2025 at 10:58 AM, the Pharmacist Consultant, during a phone interview, explained was concerned R82 was administered Aspirin instead of a Multivitamin due to the resident already taking another anticoagulant. The Pharmacist Consultant explained the Aspirin had the potential to cause bleeding. The Pharmacist Consultant reported the expectation was for staff to follow orders and administer the correct medication at the appropriate time as specified by the physician. On 06/13/2025 at 11:24 AM, the Nurse Practitioner (NP), during a phone interview, acknowledged was the prescriber of R82's Vistaril (hydroxyzine pamoate) 25 mg order. The NP explained ordered the medication to be given at 9:00 AM and 9:00 PM, with instructions not to change the time, due to the resident experiencing consistent episodes of anxiety in the morning and to help with sleep in the evenings. The NP reported the expectation was for the medication to be administered as ordered. A facility policy titled Nursing Policies and Procedures, Medication Management Program revised 05/05/2023, documented preparing for the medication pass included staff understanding the eight medication rights including the right drug and the right time.

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	06/13/2025

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. Based on observation, interview, and document review, the facility failed to maintain proper food storage practices in the dry storage area, and temperature control in the refrigerators. The deficient practice had the potential to compromise food safety and increase the risk of foodborne illness among residents. Findings include: On 06/10/2025 at 8:40 AM, a kitchen inspection was conducted alongside a cook, during which the following deficiencies were identified: - A refrigerator used for storing tray line salads, ham, salami, shredded and sliced cheese displayed a temperature of 42°F on its thermometer screen. However, an internal check showed temperatures ranging between 45-50°F. A bag of shredded cheese registered 50°F, while a packet of salami held at 45°F. The temperature log for June 2025 did not document any readings above 40°F, and the refrigerator lacked an internal thermometer for verification. The Kitchen Manager confirmed the recorded food temperatures. - A second refrigerator in the tray line used for storing beverages, including dairy products, displayed a temperature of 42°F, while an internal thermometer measured 50°F. A one quarter liter of whole milk recorded 42°F. This observation was confirmed by the Kitchen Manager, who also observed ice covering the condenser, acknowledging that the refrigerator required defrosting. - In the dry storage, several expired food items were found, including: A baker lane container with sugar had expiration date 02/02/2025. A baker lane container with oatmeal had expiration date 07/05/2024. A baker lane container with white rice had expiration date 08/12/2024. A baker lane container with flour had expiration date 08/12/2024. A baker lane container with brown rice did not document expiration date. On 06/10/2025 at 11:00 AM, the Kitchen Manager stated staff should have been regularly inspecting and labeling food items to ensure expired products were identified and removed in a timely manner. The facility's Food Services Plan, effective from 01/01/2022 to 01/01/2027, outlined requirements for maintaining refrigerator temperatures at 40°F, ensuring that refrigerator thermometers are functional and properly calibrated, and regularly monitoring temperatures. Additionally, the policy specified that food items must not exceed the manufacturer's use-by date.

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	06/13/2025

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and document review, the facility failed to ensure a Quality Assurance Performance Improvement (QAPI) plan was in place. This deficient practice has the potential to negatively affect the outcomes of resident care and the quality of each resident's life. Findings include: On 06/13/2025 at 1:20 PM, the Administrator acknowledged the facility did not have a specific QAPI plan in place. The Administrator explained the facility was using their QAPI policy as their plan. A facility policy titled, Quality Assurance and Performance Improvement Program Committee Guidelines, revised on 12/03/2019, did not identify the requirement of developing a QAPI Plan containing the processes that will guide the nursing home's efforts in assuring care and services are maintained at acceptable levels of performance and continually improved. However, it did document the QAPI Plan is used to guide the organizational and facility performance improvement efforts. According to the state operations manual, the facility is required to develop a QAPI plan and present its plan to federal and state surveyors at each annual recertification survey and upon request during any other survey, and to CMS upon request. The QAPI plan should describe the process for identifying and correcting quality deficiencies. Key components of the process include tracking and measuring performance; establishing goals and thresholds for performance measurement; identifying and prioritizing quality deficiencies; systematically analyzing underlying causes of systemic quality deficiencies; developing and implementing corrective action or performance improvement activities; and monitoring or evaluating the effectiveness of corrective action/performance improvement activities and revising as needed. On 06/13/2025 in the afternoon, the Administrator confirmed the facility did not have a specific QAPI plan in place. The Administrator provided Quality Assurance & Performance Improvement continuing education course materials which documented the QAPI Plan should have a vision statement, mission statement, purpose statement, and guiding principles individualized for the facility. It also stated the program plan can serve as a guide for the program. The Administrator conceded the QAPI policy should be part of the plan, but the plan should be tailored to reflect the specific units, programs, departments, and unique population the facility serves, as identified in the facility assessment.