

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295017	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2026
NAME OF PROVIDER OR SUPPLIER Horizon Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review, the facility failed to ensure a resident's medical record was updated to reflect a physician established medication stop date for a psychotropic medication and a psychotropic medication verbal consent contained two witness signatures for 1 of 43 sampled residents (Resident 109). The deficient practice had the potential to result in continued administration of psychotropic medication beyond the physician established duration and lacked documented verification of informed consent for psychotropic medication use. Findings include: Resident 109 (R109) was admitted [DATE], with diagnosis including depression, and anxiety disorder. A Care Plan dated 04/18/2026, documented R109 was currently taking psychotropic medications for mood and/or behavior such as restlessness, sadness, mood changes, and irritability. A physician order dated 04/20/2026, documented Hydroxyzine Hydrochloride 25 milligram (mg) tablet, special instructions included mood and/or behavior of restlessness, every 6 hours, as needed (PRN). The order end date was documented as open-ended. A Pharmacist Consultation Report dated 04/01/2026 through 04/23/2026, documented a recommendation to evaluate R109's PRN Hydroxyzine HCl order. The rationale for the recommendation included Centers for Medicare & Medicaid Services (CMS) requirements limiting PRN non-antipsychotic psychotropic drugs to 14 days unless the prescriber documented the diagnosed specific condition treated, rationale for the extended time period, and duration of the PRN order. The consultation report documented the physician accepted the recommendation with modification, maintained the current dose, documented gradual dose reduction was not appropriate due to risk of decompensation, and established a stop date/duration of 06/07/2026. R109's medical record lacked documented evidence the Hydroxyzine HCl order was updated to reflect the physician established stop date of 06/07/2026. On 05/21/2026 at 3:30 PM, the Director of Nursing (DON), acknowledged R109's Hydroxyzine HCl order had not been updated to reflect the physician establish stop/duration date of 06/07/2026. The DON acknowledged the order stop date should have been updated in the medical record and confirmed failure to update the order could have resulted in extended administration of the medication beyond the physician-established duration. A facility policy titled Principles of Medication Management revised 04/17/2024, documented the Interdisciplinary Team will ensure that each resident's drug/medication regimen is developed, managed, monitored, and modified to promote or maintain the resident's highest practicable mental, physical, and psychosocial wellbeing. The facility should ensure medications that run the course of a specific dosage regimen, when so ordered are stopped accordingly. A Care Plan initiated 05/01/2026, documented R109 had self-care deficit with functional abilities (self-care and mobility) related to impaired mobility, impaired balance, drug-induced Parkinsonism, Anemia, depression, anxiety, neuralgia, muscle spasms, and pain. R109 required total dependence with activities of daily living. On 05/19/2026 at 9:57 AM, R109 was in bed with bilateral arms flexed at the (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 295017	If continuation sheet Page 1 of 6

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	elbows toward the head and positioned closely against the torso. Bilateral wrists were positioned outward. Observation identified limited upper extremity movement. A Minimum Data Set assessment dated [DATE], documented a Brief Interview for Mental Status score of 12, R109 was cognitively intact. A physician order dated 04/20/2026, documented Hydroxyzine Hydrochloride 25 milligram (mg) tablet, special instructions included mood and/or behavior of restlessness, every 6 hours, as needed (PRN). A physician order dated 04/20/2026, documented Citalopram 20 mg tablet, once a day. Special instructions included mood and/or behavior of sadness. A physician order dated 04/20/2026, documented Quetiapine 100 mg tablet, every 8 hours. Special instructions included mood and/or behavior of mood changes. A Consent for Psychoactive Medication dated 04/18/2026, documented verbal consent was given to use psychoactive medications. The psychotropic medication ordered was Hydroxyzine. The consent form documented only one handwritten staff signature identified as a Licensed Practical Nurse (LPN). A Consent for Psychoactive Medication dated 04/18/2026, documented verbal consent was given to use psychoactive medications. The psychotropic medication ordered was Citalopram. The consent form documented only one handwritten staff signature identified as a Licensed Practical Nurse (LPN). A Consent for Psychoactive Medication dated 04/18/2026, documented verbal consent was given to use psychoactive medications. The psychotropic medication ordered was Quetiapine. The consent form documented only one handwritten staff signature identified as a Licensed Practical Nurse (LPN). On 05/21/2026 at 3:30 PM, the Director of Nursing (DON), acknowledged R109's verbal consents for psychoactive medication use lacked the second signature required to validate the verbal consents. The DON confirmed two staff members were required to witness and sign the verbal consents and acknowledged a second staff signature should have been obtained. On 05/22/2026 at 9:30 AM, the Infection Preventionist (IP), acknowledged R109's verbal consents for the use of Hydroxyzine, Citalopram, and Quetiapine lacked the signature of a second staff witness. The IP explained two staff members should have witnessed and signed the verbal consents to ensure accuracy and adherence to facility policy requirement of two staff signatures for verbal consents. A facility policy titled Medication Management Psychotropic Drugs - Use of, revised 04/17/2025, documented a consent would have been completed for each psychotropic medication prescribed. Consents could be obtained in two ways, which included resident/patient or legal representative's given written consent or telephone consents were acceptable when the required information was discussed with the resident/patient or legal representative and documented in the chart. If a telephone consent was received, it required the signature of two witnesses.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to ensure a resident received a shower as scheduled for 1 of 43 sampled residents (Resident 85). This deficient practice had the potential to compromise the resident's hygiene, comfort, dignity, and overall quality of life. Findings include: Resident 85 (R85) was admitted on [DATE], with diagnoses including incomplete paraplegia secondary to suspected spinal cord infarction and depression. On 05/19/2026 at 8:30 AM, R85 was observed in their room and appeared ungroomed. The resident presented with a strong, noticeable body odor consistent with infrequent bathing. The odor was detectable upon entering the room and included a sour, musty smell. R85 verbalized showers were supposed to be provided on Mondays and Thursdays but reported they had only been receiving bed baths instead. The Minimum Data Set (MDS) quarterly assessment dated [DATE] indicated R85 was dependent on staff for toileting hygiene and required substantial to maximal assistance for showers. A physician order dated 10/15/2025, documented the resident's bathing schedule as Bath/Shower on Mondays and Thursdays, 6:00 AM - 2:00 PM. A physician order dated 10/15/2025 documented the following bathing schedule: Bath/Shower on Mondays and Thursdays between 6:00 AM - 2:00 PM. The point of care history, which documents activities of daily living including resident hygiene, showed that R85 received a shower on 05/21/2026 at 9:49 AM. The record was amended by a CNA at 12:33 PM, invalidating the original entry due to wrong resident and documented a complete bed bath was performed. On 05/21/2026 at 11:35 AM, R85 reported no shower had been provided as scheduled that day. R85 reported although showers were scheduled for Mondays, on Thursdays they typically received only bed baths. The resident stated the assigned certified nursing assistant (CNA) did not provide the shower due to being unable to locate a sling for the Hoyer lift (a mechanical lifting device used to safely transfer individuals who cannot bear weight or assist with transfers). On 05/21/2026 at 11:40 AM, the CNA assigned to R85 explained a shower was not provided that morning because the resident required total assistance and a Hoyer lift, but no slings for the lifting device were available at the time. The CNA reported a bed bath would be provided instead and acknowledged that the shower should not have been documented as completed. On 05/21/2026 at 11:45 AM, during an inspection of the laundry area. A laundry services staff confirmed approximately 20 Hoyer lift slings were available for use. The staff member presented three clean, ready-for-use slings. On 05/21/2026 at 11:48 AM, the Environmental Services (EVS) manager confirmed Hoyer lift slings were available in the laundry room. The EVS Manager explained nursing staff used the slings throughout the day, after which they were sent to the laundry to be washed and stored. The point of care history from 02/01/2026 to 05/19/2026 showed R85 received only 3 showers and 12 complete bed baths out of 31 scheduled bathing opportunities (16 Mondays and 15 Thursdays). The record indicated the resident refused the shower on one occasion. All remaining entries documented as baths reflected partial bed baths. On 05/21/2026 at 2:40 PM, R85 indicated that a bed bath had been provided but not the shower they were expecting. On 05/22/2026 at 12:30 PM, the Director of Nursing (DON) indicated it was the expectation for residents to receive showers according to their scheduled bathing plan and for all services provided to be accurately documented in the medical record. The facility policy titled Activities of Daily Living, Optimal Function, dated 05/05/2023, documented the facility would provide necessary care to all residents that were unable to carry out activities of daily living on their own to ensure they maintain proper grooming and hygiene. The facility policy titled Shower/Bathing, dated 05/05/2023, stated showering and bathing promote personal hygiene and help stimulate circulation. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy indicated staff were to provide bathing on scheduled shower days or upon resident request.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, and document review, the facility failed to ensure medication was properly secured for 1 of 43 sampled residents (Resident 11). This deficient practice had the potential to place the resident at risk for medication errors and unintended access to the medication. Findings include: Resident 11 (R11) was admitted on [DATE] with diagnoses including hyperlipidemia, solitary pulmonary nodule, bipolar disorder, and anxiety disorder. On 05/19/2026 at 3:20 PM, a medication cup with a white powdery substance was observed on R11's bedside table. R11 did not know what the white powder was or who had placed it on the bedside table. R11 reported the white powder did not belong to them. On 05/19/2026 at 3:25 PM, a Licensed Practical Nurse (LPN) reported the medication cup with the white powder found on the resident's bedside table was an antifungal medication. The LPN was unsure whether the medication should have been kept in the resident's room or why it had been left there. The LPN indicated R11 was confused and legally blind. On 05/20/2026 at 8:38 AM, the Assistant Director of Nursing (ADON), explained if a resident refused or did not take prescribed medication, the nurse must return the medication to the medication cart and document the reason the dose was not administered. The ADON confirmed medications were not to be left at the resident's bedside at any time. The ADON indicated leaving medications unattended posed a safety risk, as any resident could potentially ingest or misuse the medication by placing it in their mouth or eyes. On 05/20/2026 at 9:09 AM, the Director of Nursing (DON) indicated medications were not to be left on a resident's bedside table unless there was a specific physician's order permitting bedside medication administration. The DON clarified that such an order would only be appropriate if the residents were alert and oriented times three. The DON explained if a resident was not alert and oriented, medications must never be left at the bedside under any circumstances. The DON confirmed leaving medications unattended created a significant safety risk, including the possibility the resident may not understand how to correctly take or apply the medication, or another resident could access and ingest the medication, potentially causing harm. A physician order dated 04/24/2023, documented R11 was not permitted to self-administer medications. The Care plan dated 09/07/2023 documented R11 had an alteration in vision due to a history of traumatic brain injury (TBI). On 05/22/2026, R11 medical record showed there was no evidence indicating a self-medication assessment form had been completed. The facility's policy titled Bedside Storage of Medication, revised on 04/17/2024, stated a written order for bedside medication storage was required to be placed in the resident's medical record. The policy also required an assessment to determine the resident's capability to self-administer medications, using a self-medication assessment form to document any limitations.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working 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 an oxygen concentrator used to administer oxygen to a resident was maintained in sanitary conditions for 1 of 43 sampled residents (Resident #56). This deficient practice had the potential to increase the resident's risk of infection, compromise respiratory hygiene, and reduce the effectiveness of the oxygen delivered. Findings include: R56 was admitted on [DATE], with diagnoses including anemia, epilepsy, diabetes, and hypertension. A physician order dated 11/30/2025 documented for Oxygen (O2) to be administered at 2 liters per minute as needed via nasal cannula to maintain O2 saturation greater than 92%. On 05/19/2026 at 8:00 AM, R56 was observed in bed receiving oxygen via nasal cannula at 2 liters per minute from an oxygen concentrator. The grille of the concentrator's air filter was visibly dusty. A sticker on the device indicated the last preventive maintenance had been performed in December 2024. On 05/20/2026 at 12:40 PM, the Director of Maintenance confirmed the observation and explained that the oxygen concentrators were rented from a contractor responsible for preventive maintenance. The Maintenance Director acknowledged the dusty air filter and grille could cause insufficient air intake, preventing the concentrator from producing quality medical-grade oxygen and should have been cleaned or replaced. The facility policy titled Electrical Safety Checks for Rental Equipment documented cleaning and filter maintenance, preventive maintenance, and manufacturer-required services of vendor-owned equipment should remain the responsibility of the contracted vendor. The facility policy titled Equipment Round General dated 02/12/2024, indicated staff should verify oxygen equipment in use, and inlet filter on oxygen concentrator should have been visually inspected and cleaned or replaced as necessary.		