STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295037	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Henderson Health and Rehabilitation	1180 E. Lake Mead Parkway Henderson, NV 89015

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46265 Based on interviews, record review and document review, the facility failed to ensure a sampled resident (Resident #4) with severe cognitive impairment was adequately supervised and was not able to elope from the facility. The deficient practice had the potential for physical and psychosocial harm to the resident. Findings include: Resident 4 (R4) R4 was admitted to the facility on [DATE] and readmitted on [DATE]with diagnoses including bipolar disorder and dementia. A brief interview for mental status (BIMS) assessment documented a score of 03 indicating the resident had a severe cognitive impairment. A facility report investigation indicated on 10/22/2024, R4 had eloped from the facility and was out of the facility from 3:30 AM and was returned to the facility at 12:30 PM. The following was a timeline based on the investigation notes and interviews from the facility: - after video review it was determined the resident left the building at approximately 3:30 AM. - at 5:40 AM, a nurse in training entered the resident's room and documented R4 refused medication. - at 6:50 AM, a Certified Nursing Assistant (CNA) entered the room of R4 and did not report the resident was missing. - at approximately 8:00 AM, a CNA brought the breakfast tray to R4's room. - at approximately 8:50 AM, the CNA went in R4's room to pick up breakfast tray and noticed it had not been consumed. The CNA notified a nurse and a search for the resident had been initiated. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- according to progress notes, a code white (missing resident) was called at 9:52 AM and a full-scale search was initiated and police contacted. On 11/08/2024 at 9:30 AM, a CNA indicated when on shift at the facility, rounds were to be made approximately every 2-3 hours, however between the CNA and nurse every resident was generally seen more frequently. The CNA explained when a resident was not in the room it was important to locate resident. If the resident was not able to be immediately located the CNA would inform the nurse. The CNA revealed it would not be appropriate to assume where a resident was located without verification. On 11/08/2024 at 9:45 AM, a Licensed Practical Nurse (LPN) verbalized checking on residents was a continuous process throughout the shift and between the nursing staff and CNAs, a resident would be observed nearly every hour. The LPN indicated the expectation would be to notify a nurse if the resident was not in the room and location of resident could not be verified. The LPN explained it would be unprofessional for a nurse to document a resident refused medication when the resident was not in room. On 11/08/2024 at 10:10 AM, an Assistant Director of Nursing (ADON) confirmed R4 had eloped from facility on 10/22/2024. The ADON explained there were several points of concern regarding the incident, including a nurse who documented the resident refused a blood glucose check when the resident had already left the building and a CNA who failed to communicate with nursing staff regarding the resident not being in the room without attempting to locate the resident. The ADON verbalized when a resident was not in the room it was expected staff would attempt to locate the resident and then inform a supervisor if the resident was not able to be found. Following the event on 10/22/2024, it was determined the facility took the following actions during the investigation and immediately following to correct the deficient practice: - the nurse in training was immediately suspended and terminated. - the CNA who did not report resident was not in room was reprimanded and provided further education. - an interdisciplinary team meeting was held to discuss additional safety concerns in the area the resident was able to elope from. - additional training regarding elopement was mandated and completed within 3 days of incident. On 11/08/2024 at 11:30 AM the Director of Nursing (DON) confirmed elopement and verified during the investigation concerns with staff actions were identified and corrected at the time the facility became aware. The DON indicated the nurse in training was suspended during investigation and terminated when it was determined the nurse had falsely documented R4 refused a blood glucose check. The first CNA to check on resident should not assume the location of the resident and should have reported to the nurse and was subsequently educated on proper procedure. The DON revealed all staff had received additional training on elopement and the facility policy. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Elopement/Unsafe Wandering documented, elopement was defined as occurring when a resident leaves the facility premises or a safe area without the facilities knowledge. The staff would promptly report any resident attempting to leave the premises or missing to the charge nurse or supervisor to evaluate the need for further interventions. Facility Reported Incident #NV00072512