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	05/30/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **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 resident was free from physical restraints for 1 of 8 sampled residents (Resident 7). The deficient practice placed the resident at risk of physical and psychosocial harm. Findings include: Resident 7 (R7) R7 was admitted on [DATE] with diagnosis including dementia. A brief interview for mental status (BIMS) was conducted on 04/10/2025 and determined R7 had a score of 03 indicating R7 had severe cognitive impairment. The facility policy titled restraints (revised April 2025), documented it was the facility policy to ensure each resident was not restrained for the purpose of discipline or convenience. A restraint device assessment would be conducted to determine if the resident would be safe using the specific restraint. A physician order would be obtained indicating the type of device to be used, indication, duration, and how often it was supposed to be released. A report to the state agency documented upon admission to the facility R7 had abdominal and chest restraint applied. The report indicated the admission nurse untied the restraint to move R7 to the facility bed and then tied restraint to bed. The report concluded the admission nurse did not have a physician order for use of restraint. The facility completed the internal investigation and submitted report to the state agency on 04/14/2025 with the following timeline of events: On 04/08/2025 at approximately 9:00 PM, R7 was admitted to the facility, was assessed and indicated R7 was restrained to the bed with abdominal and chest restraint which allowed movement of upper body to sit up and lay down which confined R7 to the bed. (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/08/2025 in the evening, the Certified Nursing Assistant (CNA1) indicated asking the Licensed Practical Nurse (LPN1) about the restraints. LPN1 verbalized being aware of restraints and instructed CNA1 to keep restraints in place after the CNA was complete with cleaning resident. CNA1 indicated LPN1 had verbalized not having time to keep checking on the resident. A thorough review of video documented LPN1 did not check on resident until it was time to start passing medications between 4:00 AM and 5: 00 AM on 04/09/2025. On 04/09/2025 at approximately 6:00 AM, there was a shift change, and a different Licensed Practical Nurse (LPN2) was responsible for R7. Through interviews with LPN2 it was discovered LPN1 did not advise LPN2 about R7 being in restraints. LPN2 discovered the restraints during assessment and immediately removed due to no physician order. LPN2 then contacted the Director of Nursing (DON). The Abuse Coordinator was notified, and investigation was initiated. On 05/30/2025 at 9:00 AM, Administrator (Abuse Coordinator) indicated R7 had been in facility previously and arrived most recently on 04/08/2025 in the evening with a variety of restraints. The administrator verbalized the facility attempts to avoid the use of restraints. The administrator confirmed the admitting nurse, LPN1, had reapplied the restraints once R7 was moved to the facility bed. The morning nurse removed restraints after assessment and notified the DON and Administrator. On 05/30/2025 at 9:15 AM, a Registered Nurse (RN) indicated the facility general practice was to not use restraints. If a resident was to arrive at facility with restraint it would be immediately removed and physician contacted. To continue with restraints, the resident would need to be assessed for use and a physician order would be needed to document the reason for restraint, which could not be determined until the resident was assessed and assessed for safety with the specific type of restraint to be used. On 05/30/2025 at 9:45 AM, the Assistant Director of Nursing (ADON) explained the facility was a restraint/lift free facility meaning the use of restraints was discouraged. The ADON indicated when a resident was admitted to the facility with a restraint it would immediately be removed until an assessment was completed. Further, the resident would be assessed for the specific type of restraint to determine if it was needed and if the resident would be safe with the restraint. The ADON verbalized it would be inappropriate to reapply a restraint without a physician order including reason for restraint, how long the restraint would be used, off time of restraint and how often it would be monitored. On 05/30/2025 at 1:02 PM, the Director of Nursing (DON) indicated the investigation was started immediately upon notification from LPN2. LPN1 was suspended by phone and initial interviews were started. The DON indicated LPN1 confirmed being aware of the restraints and acknowledged applying a restraint without a physician order. The DON explained after having reviewed the video surveillance of nursing station and based on multiple corroborating interviews LPN1 was terminated on 04/11/2025. The following actions were confirmed to have been completed by the facility to correct the deficient practice during and immediately following the investigation: - Oncoming staff immediately released restraint. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Reported to ADON, DON, Abuse Coordinator (initial to state agency on 04/09/2025, final on 04/14/2025). - Initiated investigation on 04/09/2025. - Suspended staff member on 04/09/2025. - Surveillance video reviewed with transcript of timeline. - Conducted interviews with guardian, CNA's, nurses, a few residents - Terminated staff member involved on 04/11/2025 - Reported to the Board of Nursing on 04/29/2025. - Notified state agencies, Public Guardian, family member, physician on 04/09/2025 - Education to all staff with sign in sheet and education topic provided. FRI report indicated staff education on restraint use, abuse/neglect training and education provided. Education started on 04/10/2025 and completed 04/14/2025. FRI NV00074000

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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** 51395 Based on interview, record review, and document review, the facility failed to provide documented evidence assistance with activities of daily living (ADL) was provided for 1 of 8 sampled residents (Resident 6). The deficient practice had the potential for the resident's skin integrity to be compromised. Findings include: Resident 6 (R6) R6 was admitted on [DATE] and discharged on [DATE] with diagnoses including end stage renal disease, muscle weakness, and type 2 diabetes mellitus. The Admission Minimum Data Set (MDS) dated [DATE], documented R6 was frequently incontinent of bowel and bladder and dependent with toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement). R6's activities of daily living (ADL) documentation for toilet hygiene lacked documented evidence the task was performed every shift on the following days: -03/21/2025 through 03/23/2025 -03/25/2025 -03/28/2025 -03/30/2025 and 03/31/2025 -04/02/2025 and 04/03/2025 -04/09/2025 and 04/10/2025 On 05/30/2025 at 8:21 AM, a Certified Nurse Assistant 1 (CNA 1), explained the process for documenting a resident's incontinent care had been provided was to document the task in the resident's chart every shift under toileting hygiene. On 05/30/2025 at 8:30 AM, a Certified Nurse Assistant 2 (CNA 2) explained resident toileting assistance and peri care were documented in the resident chart under toileting hygiene each shift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/30/2025 at 8:35 AM, the MDS Coordinator explained the process for staff to document care for incontinent residents was to document under toileting hygiene. The MDS Coordinator reviewed R6's Admission MDS and confirmed R6 was frequently incontinent of bowel and bladder and dependent upon staff for assistance. The MDS Coordinator reviewed the ADL documentation for R6's toileting hygiene from March 2025 through April 2025 and confirmed there were shifts blank with no documentation of toileting hygiene. The MDS Coordinator explained if the task was blank with no documentation, then the task did not occur. The MDS Coordinator explained residents that are incontinent and require staff assistance would have a care plan indicating their needs and interventions staff were to take. The MDS Coordinator reviewed R6's care plan and verified there was no care plan for incontinence. On 05/30 2025 at 11:51 AM, the Director of Nursing (DON) explained the process for documenting toileting assistance and hygiene was for staff to document under the ADL task labeled toileting hygiene to indicate the care was provided. The DON explained the expectation was for staff to document daily and as needed (PRN). The DON explained residents who are assessed as incontinent requiring staff assistance, would have a care plan indicating the incontinence and care interventions to be provided. The DON reviewed R6's ADL toileting hygiene documentation and confirmed there were shifts with no documentation and explained no documentation indicated the task was not performed. The facility policy titled Standards of Care for CNA Practice, undated, documented the CNA would assist the resident in ADLs such as eating, drinking, turning and positioning, transfer and ambulation including walking, bathing, oral care, grooming, dressing, toileting, communication and socialization. The CNA would accurately, and timely document care provided. NV#00073877

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29141 Based on record review, interview, and document review, the facility failed to follow physicians' orders for the application of a BiLevel Positive Airway Pressure BiPAP (a non-invasive ventilation device that facilitates breathing and improve oxygenation for conditions that impair breathing like COPD) for 1 of 8 sampled residents (Resident #3). The deficient practice had the potential to cause inadequate oxygenation, respiratory distress, or worsening of underlying conditions such as COPD, placing the resident in a risk for complications, including hypoxia, increased carbon dioxide retention, and respiratory failure. Findings include Resident #3 (R3) R3 was admitted on [DATE], with diagnoses including acute on chronic hypercapnic respiratory failure, chronic obstructive pulmonary disease (COPD) exacerbation, and history of chronic hypoxic respiratory failure. A hospital history and physical dated 01/19/2025, documented R3 was admitted to the emergency department due to complaining shortness of breath (SOB) for two days. R3 had history of home oxygen use at 4 liters per minute (lpm). The hospital discharge summary dated 01/26/2025, documented R3 was placed on nightly BiPAP to lower pCO2 levels (partial pressure of carbon dioxide measures the amount of carbon dioxide in the blood, helping clinicians assess how well the lungs are removing CO2 and maintaining proper breathing function) to less than 55 millimeters of mercury (mmHg) per pulmonologist recommendation. A physician's order dated 01/30/2029, revealed Bi-PAP to be used during hours of sleep and the resident would be assisted with the device setup. The order directed the staff to document refusal of use. An incident report investigation conducted by the facility revealed that, according to nursing staff, the BiPAP was applied to R3 on the nights of 01/30/2025 through 02/01/2025. However, the report indicated R3 went two nights without BiPAP and instead received oxygen at 2 LPM via nasal cannula, per physician orders. As part of the facility's internal investigation, an interview was conducted with LPN (LPN2), who stated the BiPAP was applied to R3 on 01/30/2025. However, on 01/31/2025, LPN2 received a report a piece of the BiPAP device was missing, resulting in the resident being unable to use the device. LPN2 acknowledged signing the Medication Administration Record (MAR) on 01/31/2025, indicating the BiPAP was applied, but noted it could have been documented as by mistake. Furthermore, LPN2 stated the attending physician was not notified, as it was believed the issue had already been reported and the facility was awaiting the replacement part. A treatment administration record for January and February 2025, revealed the BiPAP was documented as applied on 01/30/2025, 01/31/2025, 02/01/2025, and 02/03/2025. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing progress note dated 01/31/20245 at 2:23 AM, documented BiPAP machine was on for the night and R2 was tolerating well. Nursing progress note dated 01/31/20245 at 10:30 PM, indicated R3 had BiPAP at night. On 05/29/2025 at 2:58 PM, a Licensed Practical Nurse (LPN1) reported had received information an elbow connector (a component that enables a breathing tube to be attached to the BiPAP machine at a 90-degree angle) may have been lost when R3 was relocated to a different room on 01/31/2025. LPN1 indicated due to the missing connector, the BiPAP device could not be used. The matter was reported to the Director of Nursing (DON) and the Administrator. LPN1 further stated that they do not work night shifts and could not confirm whether the BiPAP was used without the missing elbow connector. On 05/29/2025 at 3:15 PM, the Director of Nursing (DON) stated that the elbow connector of the BiPAP device may have been misplaced during Resident R3's room transfer and could not be located. The facility attempted to replace the missing piece; however, R3's daughter called 911, leading to the resident being transported to a hospital. The DON confirmed that nursing staff did not notify the attending physician about the inability to apply the BiPAP device due to the missing connector, preventing the implementation of alternative respiratory measures. Additionally, the DON acknowledged nurses should not have documented the application of the BiPAP device when it had not been used. The most recent revision of the facility policy, titled Significant Change in Condition, Response, dated January 2022, stated if a team member recognized a change in a resident's care needs, a licensed nurse or nurse supervisor was required to be notified. According to the policy, the nurse was responsible for performing and documenting an assessment, identifying the need for additional interventions. The nurse would then determine whether to implement existing physician orders or, if necessary, communicate with the attending physician using SBAR (Situation, Background, Assessment, Recommendation) or a similar process to obtain new orders or interventions. Complaint #NV00073441