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	04/08/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **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) residents' medications were administered and accurately documented for 2 of 8 sampled residents (Residents 1 and 2) and 2) medication errors were reported and follow-up was completed when medication errors were identified for 1 of 8 sampled residents (Resident 1). The deficient practice had the potential to result in unmanaged pain, delayed treatment, compromised continuity of care, an increased risk for complications, decline in functional status, hospitalization, and decreased quality of life.Findings include:1) Resident 1 (R1) was admitted on [DATE], with diagnoses including chronic pain syndrome, diabetic polyneuropathy, pressure ulcers to the sacral region and unstageable right heel.A Physician Order dated 01/23/2026, documented Oxycodone Hydrochloride oral tablet 20 milligram to give one tablet by mouth every 6 hours as needed (PRN) for pain.The Social Services Summary dated 01/24/2026, documented R1 was alert and oriented. A Brief Interview for Mental Status score of 15/15 indicated intact cognition, evidenced by accurate recall and orientation.A Care Plan dated 01/24/2026, documented R1 had acute/chronic pain with an intervention to administer pain medication as ordered and to monitor.The Physician Progress Note dated 01/24/2026, documented a plan for ongoing medical management, including pain management with medications referenced in the nursing Medication Administration Record (MAR).The MAR dated 01/25/2026, documented Oxycodone was administered at 5:39 AM.The Controlled Drug Record dated 01/25/2026, did not reflect that Oxycodone was removed from the controlled substance supply. The Nursing Progress Note dated 01/25/2026, documented a family member expressed concern R1's pain medication was not administered at 5:30 AM. The MAR indicated the medication was signed or documented as given; however, review of the narcotic book and count indicated the medication was not administered at that time.The Nursing Progress Note dated 01/25/2026, documented the nurse administered the pain medication at approximately 10:30 AM due to the electronic MAR timing. Family members expressed dissatisfaction with the nurse and the charge nurse regarding the delay and discrepancy.The Nursing Progress Note dated 01/25/2026, documented family requested a formal apology from the nurse and administration, and the concern was communicated to social services.On 04/06/2026 in the afternoon, the Social Worker indicated there had been complaints related to food; however, the Social Worker was unaware of any medication error involving R1.On 04/06/2026 at 2:10 PM, during a telephone interview a Licensed Practical Nurse (LPN) assigned to R1 on the night shift from 01/24/2026-01/25/2026 was unable to recall R1 or any medication error involving R1. The LPN described the process for PRN Oxycodone administration as assessing the resident's pain, documenting the need for medication, administering the medication, and then documenting administration in the Medication Administration Record (MAR). The LPN acknowledged medication should not have been documented as administered prior to actual administration. The LPN confirmed that documenting a medication as administered when it was not given, while the medication remained in the controlled substance supply constituted a medication error. The LPN indicated medication errors should have been reported to the supervisor for investigation. On 04/06/2026 at 3:25 PM, the Assistant Director of Nursing (ADON1) verified and confirmed that Oxycodone was documented as (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ADON2 confirmed documentation prior to administration was not consistent with standard nursing practice, as the outcome of administration must be known before recording in the MAR.On 04/07/2026 at 10:30 AM, the ADON1 described expectations for medication administration. ADON1 indicated staff were expected to verify the resident and medication using the five rights, prepare medications, perform required assessments, administer medications, and document administration after the medication was successfully administered. ADON2 confirmed that documentation prior to administration was not consistent with standard nursing practice, as residents may refuse or not ingest medications, resulting in inaccurate documentation and increasing the risk for medication errors.On 04/08/2026 in the afternoon, the attending physician acknowledged that licensed nurses were expected to exercise clinical judgment in administering medications as ordered and to document administration appropriately in the resident's record.A facility policy titled Administration of Medications (undated), indicated medications were to be administered as prescribed by the resident's provider and in accordance with the resident's plan of care. The policy indicated the nurse administering the medication was to document administration after the medication was given. The policy further indicated when PRN medications were administered, the nurse was to document the date and time of administration and subsequently document the resident's response to the medication, as appropriate.