

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: 295037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Henderson Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review and document review, the facility failed to ensure residents were free from sexual abuse for one of ten sampled residents (Resident 4). The deficient practice placed other residents at risk of being sexually abused. Findings include: Based on interview, record review and document review, the facility failed to ensure residents were free from sexual abuse for one of ten sampled residents (Resident 4). The deficient practice placed other residents at risk of being sexually abused. Findings include: On 07/20/2026 at 4:27 PM, A facility report incident documented R5 grabbed or pinched R4's breast. The incident was captured on facility video, witnessed by other residents, and reported to staff. The video showed R4 quickly jerking away as R5 extended an arm and appeared to make contact. Witnesses stated R4 screamed when R5 grabbed the breast. Staff overheard that two weeks earlier R5 had made inappropriate comments to R4. Resident 5 (R5) was readmitted to the facility on [DATE] with diagnoses including encephalopathy, type 2 diabetes mellitus, schizoaffective disorder, and dysphagia. The resident was discharged on 07/22/2026 after being found unresponsive and expired. A quarterly minimum data set (MDS) assessment dated [DATE] documented a BIMS score of 05/15 with behavioral symptoms directed towards others. Physician order dated 05/29/2026 documented R5 may be seen and treated by a psychiatrist and by a mental health worker. A change in condition note dated 07/20/2026 documented the resident inappropriately touched a female resident's breast. The evaluation recommended continued monitoring and transferring the resident to a different building. The family/resident representative was notified on 07/20/2026. A physician progress note dated 07/20/2026 documented psychiatric follow up. A physician order dated 07/21/2026 documented monitoring for increased sexual behaviors towards peers and staff every shift for 3 days. Care plans and monitoring physical and verbal and verbal behaviors, impaired cognition, thought process, and inappropriate physical contact. Interventions included immediate redirection, relocating the resident Building A, psychosocial monitoring, and psychiatric consult as indicated. Resident 4 (R4) was readmitted to the facility on [DATE] with diagnoses including cerebral palsy, impulse disorder, hypotension and unspecified intellectual disabilities. A physician order dated 11/19/2025 (resume all previous orders) included behavior monitoring related to generalized anxiety and impulse disorders. A minimum data set (MDS) assessment dated [DATE] documented the resident was moderately impaired cognitive skills with verbal behavioral symptoms and wandering present. A physician order dated 06/27/2026 documented patient on 1:1 every shift for inappropriate behaviors. A physician order dated 07/06/2026 documented to consult with psychotherapist for Cognitive Behavioral Therapy (CBT) related to violent behaviors when not getting their way. A physician order dated 07/08/2026 documented to discontinue 1:1 and downgrade to line of site observations every 15 minutes x 24 every shift for Impulsive/ Physically (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
--	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Henderson Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aggressive. Care plans and monitoring in place included for communication, behaviors, wandering, yelling/screaming, combative, impulse control, physical abuse, and antipsychotic/antianxiety medications. A review of progress notes documented behavior monitoring including episodes of yelling, screaming, grabbing other residents' food, lowering self to the floor and putting hands into brief/private part area. The notes also documented monitoring of right breast for redness or bruising every shift. A change in condition note dated 07/20/2026 documented the provider was notified, an assessment was completed, and no new changes were observed. The physician progress note indicated the resident was nonverbal with functional debility and had no new skin issues. The provider recommended discharge to a structured, restricted environment with 1:1 supervision due to altered mental status and elopement risk. Case management was initiated for discharge planning to an appropriate facility. A separate change in condition note dated 07/20/2026 documented that the family/resident representative was notified that the resident had been inappropriately touched on the breast by a male resident; no redness or bruising was observed. Weekly skin checks dated 07/20/2026 documented no new skin issues found on evaluation. The facility policy titled Abuse: Prevention of and Prohibition Against, dated 10/2022, documented residents have the right to be free from sexual abuse. Sexual abuse was defined as non-consensual sexual contact of any type with a resident. On 07/23/2026 at 1:30 PM, a Registered Nurse (RN), indicated abuse training occurred at onboarding and was discussed at staff meetings. The RN explained the abuse coordinator was notified when allegations of abuse occurred, and vulnerable residents were kept safe depending on the resident and the scenario. The RN explained the resident of concern (R4) was redirected to do activities often or would be taken to another building to divert from a situation. On 07/23/2026 at 1:36 PM, a Licensed Practical Nurse (LPN) reported abuse training occurred annually. The LPN recalled working the day of the incident and hearing that R5 grabbed R4's right breast in the hallway. The LPN indicated the incident was reported, an assessment completed, monitoring initiated, notifications made, and R5 was relocated. The LPN verbalized staff ensured R4 remained in view and conducted skin checks each shift, and 1:1 supervision was used when needed. On 07/23/2026 at 1:36 AM, a Licensed Practical Nurse (LPN) reported abuse training occurred annually. The LPN explained abuse was reported to the administrator, the resident was assessed, and the physician and family were notified. The LPN recalled working the day of the incident and hearing that R5 grabbed R4's right breast in the hallway. The LPN was unsure who witnessed the incident but stated the event was reported, an assessment was completed, monitoring was initiated, notifications were made, and R5 was moved to another building. The LPN explained following the incident, staff ensured R4 remained in view and conducted skin checks each shift. The LPN indicated all staff were responsible for protecting residents, often redirecting R4 or bringing them to safe areas away from other residents. The LPN indicated R4 could not be isolated but 1:1 supervision was provided when needed for safety. On 07/23/2026 at 1:55 PM, R4 was observed calm sitting in their wheelchair, eating popcorn. R4 was nonverbal and communicated using touch and expression. A skin check was completed by nursing staff; revealed no redness and no pain to right breast area. On 07/23/2026 at 2:05 PM, the administrator indicated suspected abuse was immediately reported. The administrator indicated staff were not expected to determine whether abuse occurred but to discuss with nursing and social services for follow up. Abuse training occurred upon hire and annually and covered all forms of abuse. The administrator recalled the incident and indicated other residents reported the incident to activity staff that a male resident (R5) attempted to grab the breast of a female resident (R4). The administrator explained that an investigation ensued, confirmed contact occurred between the residents, and verified the abuse occurred. The administrator explained staff were expected to be (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Henderson Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	situationally aware to protect vulnerable residents, and the interdisciplinary team was used to address safety concerns. The administrator explained that R4 could not be secluded and benefited from being around other residents. The administrator acknowledged staff recognized which residents R4 was safe to be around, and a camera was intentionally placed outside R4's room for monitoring. The administrator confirmed that two abuse incidents involving R4 occurred within a three-month period. The administrator explained the expectation was for residents to be free from abuse, or that abuse did not occur at the facility. On 07/23/2026 at 2:54 PM, the Social Worker (SW), explained when abuse or neglect was reported, the abuse coordinator was notified, and a decision made to investigate and/or to report. The SW indicated R4 was under guardianship and would be considered a vulnerable adult. The SW indicated priorities to keep R4 safe included individual monitoring, one-to-one (1:1), addressing concerns with the guardian and appropriate placement. On 07/23/2026 at 3:08 PM, the Assistant Director of Nursing (ADON), explained staff was aware that R4 required frequent redirection and was often taken to their room, the unit or activities to keep busy. Nursing staff used line-of-sight, or 1:1 supervision for safety when behaviors occurred. The ADON explained R4 liked to touch others, and staff were aware to keep R4 separate when concerns arose. Alert charting was entered in the electronic medical record (EMR) for nurses to be aware of the R4's needs and was moved to Building B or other areas when issues could occur. The ADON explained following an abuse incident in July 2026, 1:1 supervision was ordered from 06/27/2026 to 07/08/2026. The ADON 1:1 supervision meant staff (usually a Certified Nursing Assistant (CNA) remained with the resident to redirect, de-escalate and provide care with changing, dressing and related tasks. On 07/23/2026 at 4:11 PM, the Director of Activities indicated they did not see incident, two residents reported it. The Director of Activities interviewed witnesses, who explained R4 was walking in the hallway and R5 grabbed R4's breast. The Director of Activities reported two weeks prior, activity staff overheard R5 inappropriately whisper to R4 in Spanish something like Do you want me to lick you, or do you want to lick me? The verbal message was reported to the administrator and on call nurse. The Director of Activities indicated following the incident, the residents were told to separate, R5 was told not to speak inappropriately to R4. The Director of Activities staff were advised to keep the residents separated. On 07/23/2026 at 4:42, the administrator indicated being aware of the verbal interaction between R5 and R4 but did not consider it reportable. The administrator verbalized depending on the severity, verbal interactions could be considered abuse. The administrator explained the language barrier complicated the incident being reportable and revealed R5 only spoke Spanish and the staff translator only spoke English. The administrator indicated the staff member could not repeat what was said in English equivalent to the Spanish translation and therefore the translation was questionable and left doubt on the reporting of what was said. The IDT team agreed with the findings that it was not a reportable incident. The administrator acknowledged R5 grabbed R4's breast 2 weeks later. The facility policy titled Abuse: Prevention of and Prohibition Against, dated 10/2022, documented residents have the right to be free from sexual abuse. Sexual abuse was defined as non-consensual sexual contact of any type with a resident. FRI #3105888		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Henderson Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 the medication was administered as ordered for 2 of 10 (Residents 2 and 3). The deficient practice had the potential to result in ineffective treatment, exacerbation of existing medical conditions, recurrence or progression of symptoms, avoidable discomfort or distress and compromised resident safety. Findings include: Based on observation, interview, record review, and document review, the facility failed to ensure the medication was administered as ordered for 2 of 10 (Residents 2 and 3). The deficient practice had the potential to result in ineffective treatment, exacerbation of existing medical conditions, recurrence or progression of symptoms, avoidable discomfort or distress and compromised resident safety. Findings include: Resident 3 (R3) was admitted on [DATE], with diagnoses including bipolar disorder, anxiety disorder and epilepsy. The Hospital Discharge summary dated [DATE], documented R3's discharge medications including Clonazepam 0.5 mg by mouth twice a day. A Physician Order dated 07/21/2026, documented Clonazepam oral tablet 0.5 milligrams (mg) to give 1 tablet by mouth twice a day for anxiety disorder. On 07/23/2026 at 8:15 AM, during observation of the medication administration pass, a Registered Nurse (RN) prepared and administered R3's medications, except Clonazepam. The RN indicated the Clonazepam was unavailable and would contact the pharmacy. The Medication Administration Record (MAR) dated 07/22/2026 and 07/23/2026, documented R3's Clonazepam was not administered as ordered on three occasions. On 07/23/2026, at 8:40 AM, a Registered Nurse (RN) confirmed Clonazepam, ordered on 07/21/2026, was not administered as prescribed, resulting in the resident missing three scheduled doses. The RN explained nursing staff were responsible for completing medication reconciliation upon admission, ensuring all required prescriptions were obtained, promptly notifying and following up with the physician and pharmacy when prescribed medications were unavailable, ensuring medications were obtained and available for timely administration, and documenting all communications, prescriptions obtained, and interventions in the resident's progress notes. On 07/23/2026, at 8:45 AM, R3 was in bed, alert, oriented and verbally responsive having been admitted to the facility approximately two to three days earlier and that the medications were still being transitioned. R3 indicated not receiving prescribed medications that had been routinely taken prior to admission and expected the medications to be administered timely. On 07/23/2026, at 5:14 PM, the Pharmacist confirmed no prescription had been received for R3's Clonazepam, as to why the medication had not been dispensed or delivered. The Pharmacist explained that controlled substances and psychotropic medications required an electronic prescription before the pharmacy could dispense the medication. The Pharmacist indicated the pharmacy's scheduled deliveries to the facility occurred at 5:00 AM, 1:00 PM, and 12:00 AM. The Pharmacist indicated once the required electronic prescription was received, the medication would be delivered on the next scheduled delivery. Resident 2 (R2) was admitted on [DATE], with diagnoses including encephalopathy and rhabdomyolysis. The Hospital Discharge summary dated [DATE], documented R2's discharge medications including Temazepam 30 milligram (mg) 1 capsule by mouth at bedtime. A Physician Order Dated 04/02/2026, documented Temazepam 30 mg 1 capsule by mouth at 8:00 PM for insomnia. A Care Plan dated 04/03/2026 documented R2 was receiving hypnotic therapy related to a history of insomnia prior to admission to the facility. The Medication Administration Record (MAR), dated 04/03/2026 and 04/04/2026, documented a code of 7, indicating the medication was not administered and to refer to the nurse's notes. The Nursing Progress Notes dated 04/03/2026, documented Not in patient's stock. Follow up pharmacy or Primary Care (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Henderson Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician. The Nursing Progress Notes dated 04/04/2026, documented Per pharmacy, no prescription was received. Will follow up with the attending physician. R2's medical record lacked documented evidence that the facility successfully contacted the sending hospital or the attending physician to obtain the required prescription following R2's admission. On 07/23/2026 at 9:10 AM, the Charge Nurse (CN) verified R2 was admitted on [DATE], and confirmed Temazepam for insomnia was ordered on 04/02/2026, but was not administered on 04/03/2026 and 04/04/2026, as documented. The CN explained the admission process required nursing staff to transcribe physician orders based on the hospital discharge medications. The CN indicated controlled substances and psychotropic medications required a physician's prescription to be sent to the pharmacy for dispensing. Nursing staff were expected to obtain the medication from Pyxis (facility medication dispenser) to prevent a delay in administration, if authorized. The CN explained the assigned nurse was responsible for ensuring the medication was available for administration within the scheduled medication administration window of one hour before to one hour after the scheduled administration time. On 07/23/2026 at 12:12 PM, the attending physician indicated hospital physicians were responsible for providing prescriptions for controlled substances, including R2's Temazepam, upon discharge to the facility. The physician acknowledged hospitals did not consistently provide discharge prescriptions for controlled substances, which could contribute to delays in initiating the medication. The physician explained that if the hospital failed to provide the prescription, the facility was expected to notify the provider so a prescription could be issued. The physician indicated there was no recollection of being notified that R2's Temazepam was unavailable or that doses had been missed. The physician indicated during daily evaluations at the facility that the physician did not receive a report that R2 was not receiving Temazepam or that there was difficulty obtaining the medication. The physician indicated the expectation was for nursing staff to promptly notify the provider whenever a psychotropic medication was unavailable so appropriate intervention could occur. On 07/23/2026 at 2:20 PM, the Director of Nursing (DON) indicated nursing staff were expected to ensure medications ordered upon admission were available for administration. The DON explained that if a resident arrived without the required prescription from the discharging hospital, nursing staff were expected to attempt to obtain an electronic prescription from the hospital. If a prescription was unavailable, nursing staff were expected to promptly notify the attending physician or provider to obtain an emergency prescription. The DON indicated nursing staff were expected to document physician notification and any interventions taken when prescribed medication was unavailable. The DON indicated that if a medication was not administered because it was unavailable, nursing staff were expected to accurately document the omission, the reason the medication was not administered, and the physician notification in the progress note. On 07/23/2026, at 5:14 PM, the Pharmacist indicated Temazepam was a psychotropic medication that required an electronic prescription before it could be dispensed. The Pharmacist confirmed no prescription had been received for R2's Temazepam. The Pharmacist explained that the facility was aware the pharmacy could not dispense medications requiring a prescription until the required prescription had been obtained and received by the pharmacy before the medication could be delivered. A facility policy titled, Medication Administration, (undated), directed staff to administer medications accurately, safely, and timely in accordance with the attending physician's written orders and to document physician communications in the resident's medical record, as appropriate. Complaint 2979289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Henderson Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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** Based on observation, interview, record review, and document review, the facility failed to ensure the resident's wheelchair was properly secured in the transportation van, and the required pre-trip inspection was completed prior to transport for 1 of 10 sampled residents (Resident 1). The deficient practice resulted in an actual resident fall, had the potential to cause serious injury during transportation, and placed residents at risk for avoidable accidents and fall-related injuries. Findings include: Resident 1 (R1) R1 was admitted on [DATE], with diagnoses including end stage renal disease, muscle weakness and dependence on renal dialysis. The Minimum Data Set, dated [DATE], documented a score of 13/15, which indicated R1's cognitive status was intact. The facility report dated 06/03/2026, documented the facility driver acknowledged failing to complete the required pre-trip safety checklist and using a cell phone while driving contrary to facility policy. The investigation determined that R1's wheelchair had not been properly secured to the front wheelchair anchors and combined with the driver's distraction and abrupt braking, resulted in the wheelchair tipping and the resident slipping from the wheelchair. The facility camera review revealed on 05/29/2026, the Driver failed to properly secure R1's front wheelchair securement hooks before transport. As a result, when the Driver braked abruptly, the wheelchair tipped backwards, causing R1 to fall. On 07/23/2026 at 10:15 AM, the loading process of another resident into the facility transportation van was observed. The Senior Driver demonstrated the required transportation procedure by securing the two rear wheelchair securement locks, applying the resident's lap belt and shoulder harness, and securing the two front wheelchair securement locks. The Senior Driver verified the wheelchair was properly secured by ensuring it did not move before transport. The Senior Driver also demonstrated completion of the required pre-trip checklist before transport and the post-trip checklist after transport. The Senior Driver indicated that the involved Driver failed to follow the required transportation pre-trip process, which resulted in R1's fall. The Senior Driver explained R1's wheelchair tipped backward because the two front wheelchair securement hooks had not been properly secured before transport. A Counseling/Disciplinary Notice documented disciplinary action against the involved Driver dated 06/01/2026, documented the involved Driver failed to complete pre & post checklist on transport, on cellular phone during transport 05/29/2026, during R1's transfer. The involved Driver was suspended pending investigation. On 07/23/2026, at 1:05 PM, the Transportation Supervisor (TS) indicated receiving a telephone report from the driver on 05/29/2026, regarding R1's fall during transportation back to the facility. The TS confirmed the driver reported failing to secure the front wheelchair anchors before transport and acknowledged pre-trip checklist had not been completed. The TS explained the pre-trip inspection included both the vehicle safety inspection and wheelchair securement verification to ensure all four wheelchair anchor points, the lap belt, and shoulder harness were properly secured before transport. The TS indicated failure to complete the pre-trip inspection created a risk that the wheelchair was not properly secured. The TS further explained drivers were expected to refrain from using cell phones while operating the vehicle. The TS confirmed the driver had completed the required transportation training before the incident but failed to follow the facility's transportation protocols and was terminated following the incident. On 07/23/2026, at 2:20 PM, the Director of Nursing (DON) indicated the driver initially reported the front wheelchair securement had been completed; however, after reviewing the transportation camera footage, the driver acknowledged the front wheelchair lock had not been secured. The DON confirmed (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Henderson Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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	the transportation pre-trip checklists for the day of the incident had not been completed and explained all drivers were required to complete and submit the transportation checklists at the beginning and end of each shift. The DON confirmed the driver was terminated following the incident. The DON indicated R2 was immediately assessed, neurological evaluations were completed, emergency medical services were activated, and R2 was transferred to the hospital for further evaluation. The DON indicated the attending physician requested a CT scan, which was reported as negative and no fracture. On 07/23/2026, at 2:45 PM, R1 was interviewed in R1's room with the assistance of a Certified Nursing Assistant (CNA) serving as a Spanish interpreter. R1 was Spanish-speaking, alert, oriented, verbally responsive, and exhibited no signs of acute distress. R1 recalled the 05/29/2026 transportation incident while returning from dialysis. R1 indicated the wheelchair moved backward during a sudden stop, tipped backward, and caused R1 to strike the back of the head and injure an arm. R1 indicated not observing whether the wheelchair had been properly secured because R1 had been seated during transport. R1 indicated the facility responded promptly following the incident, R1 was monitored, and was transported to the hospital for evaluation. R1 denied fractures and denied any current pain, injury, or lasting effects. On 07/23/2026 in the afternoon, the Director of Transportation (DOT) indicated being aware the transportation incident had occurred before the DOT's employment. The DOT indicated the required pre-trip and post-trip transportation checklists should have been completed for each transport. The DOT indicated the four wheelchair securement locks, lap belt, and shoulder harness should have been properly secured before transport to ensure the resident's safety. The DOT indicated all drivers were expected to follow the facility's transportation protocols and indicated the Director would ensure the required pre-trip and post-trip transportation checklists were completed for each driver. A facility policy titled Fall Management revised January 2022, required the facility to implement appropriate interventions, including adequate supervision and assistive devices, to assist each resident in attaining and maintaining the highest practicable level of function and to minimize the risk of falls and fall-related injuries.		