STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295068	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Manor of Mesquite Rehabilitation LLC	272 W Pioneer Blvd Mesquite, NV 89027

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and facility policy review, the facility failed to ensure four of five residents reviewed (Resident (R) 1, R12, R20, and R79) were provided with written information or education regarding advance directives and the right to formulate an advance directive to ensure their desired level of medical care was known in the event they were unable to direct care on their own. This failure had the potential to affect the ability of cognitively intact residents to direct their care.Findings include:R1 was admitted on [DATE] with diagnoses including transient cerebral ischemic attack, chronic obstructive pulmonary disease (COPD), asthma, altered mental status, sleep disorder, and Alzheimer's dementia. R1's admission Record noted: Advance Directive: Do Not Resuscitate. (Allow Natural Death). Comfort-Focused Treatment. No IV (intravenous) fluids. No artificial nutrition of feeding tube.R1's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/11/2026 revealed a Brief Interview for Mental Status (BIMS) score of indicative of being cognitively intact.R1's electronic medical record (EMR) showed a completed Physician's Order for Life Sustaining Treatment (POLST) form, which was a cardiopulmonary resuscitation directive and not an advance directive. R1's admission Packet did not show any education included regarding an advance directive.R12 was admitted on [DATE] with diagnoses including acute chronic congestive heart failure (CHF), COPD, type 2 diabetes, acute respiratory failure, and chronic kidney disease. R12's admission Record noted: Advance Directive: DNR [Do Not Resuscitate] - Selective Treatment - Artificial nutrition/feeding tube trial.R12's admission MDS with an ARD of 02/06/2025 revealed a BIMS score of 14 indicative of being cognitively intact.R12's EMR revealed R12 had a POLST; however, no advance directive or documentation of education regarding an advance directive was located.R20 was admitted on [DATE] with medical diagnoses including acute and chronic respiratory failure, urinary tract infection, metabolic encephalopathy, hypertensive heart disease, dementia, and heart failure. R20's admission Record noted Advance Directive: Do not resuscitate (Allow Natural Death) Comfort-Focused Treatment. No artificial nutrition or feeding tube.R20's admission MDS with an ARD of 01/16/2026 revealed a BIMS score of 14 indicative of being cognitively intact.R20's EMR revealed R20 had a POLST; however, no advance directive or documentation of education regarding an advance directive was located.On 04/10/2026 at 1:21 PM, when queried if the facility had explained or provided written education regarding advance directives (explained examples were a living will, Healthcare Power of Attorney (HCPOA), or possibly a Five Wishes form), R20 thought they had a living will, but the facility had not asked about it and had not provided any education.R79's was admitted on [DATE] with medical diagnoses including COPD with exacerbation, acute respiratory failure with hypoxia and hypercapnia, pulmonary hypertension due to lung disease and hypoxia, and heart failure.R79's admission Record noted Advance Directive: DNR (Do Not Resuscitate) Comfort Focused Treatment. No artificial nutrition or feeding tube. No IV fluids.R79's admission MDS with an ARD of 03/12/2026 revealed a BIMS score of 15 indicative of being cognitively intact.R79's EMR revealed R79 had a POLST; however, no advance directive or documentation of education regarding an advance directive was located.On 04/10/26 at 1:21 PM, R79 (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was queried if the facility had asked about advance directives and responded No. When asked if the facility had explained or provided written education regarding advance directives and possibly offered to assist R79 if they would like to set one up, R79 replied, Nobody has ever offered. On 04/09/26 at 1:10 PM, the Regional [NAME] President of Operations (RVPO) stated the facility was unable to find anything regarding advance directive education for the four residents. The RVPO stated the Social Worker (from another facility) was there who knows his stuff. We think [name of the former Social Worker] didn't really understand the difference between a POLST and an advance directive. We will ensure we do some education. The RVPO confirmed the facility had no documentation of resident education regarding advance directives. The facility's policy titled, Residents' Rights Regarding Treatment and Advance Directives, implemented 04/11/2025, revealed: . Advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) relating to the provision of health care when the individual is incapacitated . 1. On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive. 2. The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive. 3. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff.

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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** Based on observations, interviews, record review, and facility policy review, the facility failed to ensure oxygen concentrator filters were free of dust and heavy buildup of lint for three of four sampled residents (Residents (R) 62, R5, and R79) out of a total sample of 24 residents. This failure had the potential for the residents to have an increased chance of unnecessary respiratory treatments and/or infection.Findings include: R62's was admitted on [DATE] and diagnoses including bradycardia (slow heart rate), hypoxemia (low blood oxygen level), and atrial fibrillation. R62's Physician Orders dated 03/23/2026 documented Oxygen at 2 L [liters] via NC [nasal cannula] to maintain SPO2 [Peripheral Oxygen Saturation] greater than 90% as needed for SOB [shortness of breath] related to hypoxemia. On 04/07/26 at 2:00 PM, R62 was lying in bed sleeping and wearing oxygen via a nasal cannula. The oxygen tubing was connected to the oxygen concentrator which was set at 2 liters per minute (LPM). The black oxygen cabinet filter located on the left side of the concentrator was observed to be very dirty and full of a thick buildup of white lint. On 04/08/26 at 9:00 AM, R62 was lying in bed and wearing oxygen via nasal cannula. The same black oxygen cabinet filter located on the left side of the oxygen concentrator as the day before was still dirty and full of white lint. On 04/08/26 at 12:00 PM, R62 was lying in bed awake and watching television. R62 was observed wearing oxygen via nasal cannula, and the oxygen concentrator was observed to still be set at 2 LPM. The black oxygen cabinet filter located on the left side of the oxygen concentrator as the day before was still dirty and full of white lint. When R62 was asked if they had ever seen staff change out or clean the filter on the oxygen concentrator, R62 stated, No, I don't think so. On 04/08/2026 at 12:35 PM, Licensed Practical Nurse (LPN) 1 was shown R62's oxygen concentrator and dirty filter located on the side. LPN 1 took the black filter off the oxygen concentrator and confirmed the filter was very dirty with a heavy buildup of white lint and stated that she was not aware of when the filter was last cleaned. I can see it needs to be cleaned, and we will get it done. On 04/08/26 at 3:51 PM, during a review of the Oxygen Concentrator Testing log the Maintenance Director (MD) MD stated, With the oxygen concentrator filters, they should be changed every thirty days. We can take them out, blow them off, rinse them, dry them then put them back. Nursing or the CNAs [Certified Nurse Aides] are supposed to change out the filters at least every thirty days. When asked if aware of R62's oxygen concentrator filter being cleaned, the MD stated, I'm not aware of the filter not being changed out. The MD then stated, It would be my expectation that the day shift nursing and/or CNAs are checking those on the day shift preferably. The MD reviewed an Oxygen Concentrator Testing document which revealed the purchase date for the oxygen concentrator was 04/2024. It further revealed on 01/26/2026 the Filter was clean and changed on 01/26/2026 and was good. The MD stated, It was last tested on [DATE] and that would have been the last time it was cleaned. After that, it would have been in the supply room, and I don't know when it would have made it to the resident to be used. I don't have a record of that. I can see, (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	though, the last time the filter was clean or changed out would have been on 01/26/2026, and I don't have a record if it had been changed out since then. R5 was admitted on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), and chronic cough. R5's Physician Orders revealed, Oxygen: Oxygen at 2L/min per NC. May titrate to keep O2 (oxygen) sats (saturations) > (greater than) 92% as needed for SOB related to Chronic Obstructive Pulmonary Disease. On 04/07/2026 at 2:10 PM, R5 was observed wearing oxygen via nasal cannula. The oxygen tubing was connected to the oxygen concentrator which was set at 2 LPM. The black oxygen cabinet filter located on the left side of the concentrator was observed to be very dirty and full of a thick buildup of white lint. On 04/08/2026 at 8:55 AM, the same black oxygen cabinet filter located on the left side of the oxygen concentrator as the day before was still dirty and full of white lint. On 04/08/2026 at 10:15 AM, R5 was on Oxygen set a 2 LPM. The same black oxygen cabinet filter located on the left side of the oxygen concentrator as the day before was still dirty and full of white lint. On 04/08/26 at 11:30 AM, R5 was awake and watching television. R5 was observed with the oxygen on and set at 2 LPM. The filter was still observed to be dirty and full of white lint. R5 was asked if they had ever seen staff change out or clean the filter on the oxygen concentrator, R5 stated, No, I don't think so. On 04/08/2026 at 12:15 PM, LPN1 stated, We are supposed to be cleaning the filters. Any of the night nurses can change the filters on the concentrators if they are dirty. Usually that would be the nursing staff doing that. They can easily be cleaned with water and replaced. On 04/08/2026 at 12:30 PM, LPN 1 was shown R5's oxygen concentrator and filter located on the side. When LPN 1 took off the black filter from the concentrator, the filter was now observed to be clean. LPN1 stated, I just changed it out today because I saw it needed to be cleaned. It was around 12:25 PM, and I replaced it. LPN1 then stated, I saw it was very dirty and had not been changed. During an interview and review of the Oxygen Concentrator Testing log for R5 with the MD On 04/08/2026 at 3:51 PM, during review of the Oxygen Concentrator Testing log for R5, the MD stated, Someone had brought it to my attention today that the concentrator filter was dirty and had not been changed out. I was not aware of that prior to today, and nobody had brought anything to my attention. When reviewing the Oxygen Concentrator Testing log, it revealed the concentrator was purchased on 02/13/2026, and the Filter Clean/Change Date was listed as 02/16/2026. The MD stated, This was a new concentrator that came in on 02/16/2026 and would have sat in our supply room. I'm not sure when it would have gone out to the resident. I don't have a record of that. The MD further stated, I don't have an additional log or documentation of when the filter was cleaned or changed out after 02/16/2026. R79's was admitted on [DATE] with medical diagnoses including COPD with exacerbation, acute respiratory failure with hypoxia and hypercapnia, pulmonary hypertension due to lung disease with (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hypoxia, and heart failure. On 04/07/26 at 11:49 AM, R79 was observed to be seated in a wheelchair receiving oxygen via nasal canula at 3 LPM, confirmed by R79. Observation of the exterior intake filter of the oxygen concentrator noted a significant buildup of dust/lint. R79 stated they had been at the facility approximately one month. On 04/08/26 at 10:23 AM an observation of the concentrator's exterior filter revealed no changes in the filter status. Registered Nurse (RN) 3 observed the filter on 04/08/26 at 10:35 AM and stated, Oh, that's dirty. RN3 confirmed the filter needed cleaning. On 04/08/2026 3:53 PM, the MD stated concentrators were sent back to their office monthly by hall. The first week of the month the 100 hall was done; second week, 200 hall, third week 300 hall, and the fourth week of the month was the 400 hall. Filters were blown out when the concentrator was reviewed. The MD stated the concentrator for R79 was last serviced on 03/09/2026 and went into service on 03/12/2026. When asked if it was serviced the fourth week of March, the MD stated, No, it hadn't been 30 days. When asked to clarify if servicing was done by week and hall or based on date of issuance, the MD confirmed the concentrator was not serviced the fourth week of March and would not have been done until the fourth week of April. On 04/10/2026 at 2:00 PM, the Regional [NAME] President of Operations stated there were no other policies regarding cleaning. The facility's policy titled, Oxygen Administration, implemented 04/11/2025, revealed: 7. Cleaning and care of equipment shall be in accordance with facility policies for such equipment.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and facility policy review, the facility failed to ensure that laundry staff were aware of what Personal Protective Equipment (PPE) was available for staff to use while sorting dirty laundry. This deficient practice had the potential to spread infectious organisms throughout the facility of 90 residents.Findings include:On 04/10/2026 at 4:00 PM, during an observation of the laundry area, no face shields or goggles were observed anywhere in the vicinity of the sorting area.On 04/10/2026 at 4:01 PM, a laundry aide was asked about PPE in the dirty area where clothes were separated for washing. The laundry aide stated the clothes were brought in the barrel, taken from it, and placed into whites or colored for wash. The laundry aide was asked if aprons, gloves, and eye protection were available and where they were located. The laundry aide stated she had an apron, but it was at home. When asked about gloves and eye protection, the laundry aide stated they wore their reading glasses. During an interview on 04/10/26 at 4:15 PM, the Director of Nursing (DON) was asked to come back to the laundry area. The laundry aide was asked about wearing PPE for sorting laundry. The laundry aide stated they had an apron, but it was at home. The DON asked why it was at home. The laundry aide stated they forgot it when taking it home to wash it. When asked about gloves and eye protection the laundry aide stated the gloves were on the wall. The laundry aide did not know where the eye protection was and never had. The DON stated, I will get you a face shield.On 04/10/2026 at 4:25 PM, the DON was asked what the expectations were for sorting laundry. The DON stated the expectation was not to take aprons home and that there be face shields for eye protection available. The facility's policy titled, Infection Prevention and Control Program, implemented on 04/11/2025, revealed, Policy: This facility had established and maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines . 12. Linens: a. Laundry and direct and direct care staff shall handle, store, process, and transport linens to prevent spread of infection .