

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2025
NAME OF PROVIDER OR SUPPLIER Neurorestorative		STREET ADDRESS, CITY, STATE, ZIP CODE 7690 Carmen Blvd Las Vegas, NV 89128	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46265</p> <p>Based on observation, interview, and document review, the facility failed to ensure a portable oxygen tank was secured in the room of one sampled resident (Resident 22). The deficient practice had the potential to cause injury to residents and staff.</p> <p>Findings include:</p> <p>Resident 22 (R22)</p> <p>R22 was admitted on [DATE] with diagnoses including severe hypoxic ischemic encephalopathy (not enough oxygen or blood being supplied to the brain), and chronic respiratory failure.</p> <p>On 04/16/2025 at 10:29 AM, there was a portable oxygen tank standing upright in the corner of room for R22. The tank was free-standing and not attached to the wall or secured to any type of portable carrying device or cart. There was no regulator to determine amount of oxygen still left in bottle.</p> <p>On 04/16/2025 at 10:35 AM, a Licensed Practical Nurse (LPN) confirmed the tank was in the room and not secured. The LPN indicated all portable oxygen tanks should be secured whether empty or full. The LPN explained empty tanks would be taken to storage and kept separated from tanks which were full.</p> <p>On 04/17/2025 at 3:00 PM, a Respiratory Therapist (RT) indicated portable oxygen tanks should not be left attended without being secured in stand with buckle. Oxygen tanks were always kept in cart or [NAME] and then taken to storage area and kept separate from full tanks in a secured container rack. The RT verbalized it did not matter if tank was full, half full or empty all oxygen tanks should be secure at the tanks could cause injury to residents or staff if knocked over.</p> <p>On 04/17/2025 at 3:16 PM, the Director of Nursing (DON) explained checking room for potential hazards was shared task among leadership and staff. Respiratory equipment such as portable oxygen tanks would be in carrier bags, or a metal oxygen holder. The DON indicated the portable oxygen tank found in room for R22 should have been in an oxygen holder. The nursing staff and respiratory staff were primarily responsible for ensuring rooms were safe from hazards while making the normal rounds throughout the day. The DON verbalized there would be an increased risk of injury for kids roaming around who may inadvertently knock over a tank if not secured.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy titled Administration of Oxygen Therapy (revised 06/2015) documented safety measures to include making sure the oxygen was in an approved stand to prevent rolling or accidental fall. Empty oxygen tanks were stored in a separate location or storage cart, oxygen storage areas were identified as oxygen storage full and oxygen storage empty.</p>		