STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295084	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Neurorestorative	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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure a care plan for enteral feeding was reviewed and updated after a resident was hospitalized for aspiration pneumonia for 1 of 22 sampled residents (Resident 7). The deficient practice placed the residents at risk for repeat aspiration episodes and other tube feeding-related complications. Findings include: Resident 7 (R7) was admitted on [DATE] and readmitted [DATE], with diagnoses including malignant neoplasm of the brain and gastrostomy status. A respiratory flow chart summary dated 01/07/2026, documented R7 had been vomiting since 4:30 AM and was placed up in wheelchair at 6:30 AM. R7 was looked pale and Oxygen saturation did not have good reading. R7 placed back in bed, started to vomit through tracheostomy and nose, elevated to 90 degrees and suction obtained orange/yellow thin secretions. R7 was placed on ventilator.A change of condition form dated 01/07/2026, revealed a physician ordered R7 to be transferred to the hospital for nausea, vomiting and increased confusion and disorientation.A hospital Discharge summary dated [DATE], revealed R7 was treated for septic shock and aspiration pneumonia. R7 had significant mucous plugging. A computed tomography (CT) scan performed on 01/08/2026, revealed R7 was found to have moderate to large areas of consolidation identified on bilateral lower lobes with few scattered areas of nodular opacities identified at bilateral lung bases and right middle lobe and lingula segment.R7's tube feeding care plan initiated 05/11/2018, documented a goal to keep R7 free from aspiration, and complications associated with tube feeding. Interventions included: keep head of bed elevated 45 degrees during feeding and 30 minutes before and after, check for tube placement, hold feed if greater than 50% of enteral volume, listen to lung sounds, monitor for aspiration and provide care to gastrostomy site. The medical record lacked documented evidence R7's tube feeding care plan was reviewed and updated after R7 returned from the hospital on [DATE] following an aspiration pneumonia episode.A Licensed Practical Nurse (LPN) recalled being assigned to R7 on 01/07/2026 (days) but R7 was in transit to hospital when the LPN arrived for shift. The LPN indicated being informed R7 had been vomiting and the respiratory therapist (RT) had suctioned orange/yellow secretions which was most likely R7's enteral formula. The LPN confirmed R7's tube feeding care plan should have been reviewed and updated when R7 returned from the hospital on [DATE].On 04/16/2026 at 2:53 PM, two Registered Nurses (RNs) who alternated as charge nurses indicated being familiar with R7 who received nutrition by enteral means. The RNs reviewed R7's care plan and verbalized there was no evidence R7's care plan was reviewed and updated when R7 returned from the hospital after being treated for aspiration pneumonia. The RNs explained R7 had a special tube feeding schedule five times a day lasting one hour long at 6:00 AM, 11:00 AM, 4:00 PM, 8:00 PM and 1:00 AM. On 04/16/2026 at 3:31 PM, the Director of Nursing (DON) indicated care plans needed to be reviewed and updated after a change of condition. The DON indicated being informed R7 was treated for aspiration pneumonia which according to the DON was highly likely related to the resident's tube feeding given the color of the secretions suctioned by RT. The DON reviewed R7's tube feeding care plan and confirmed there was no evidence it had been reviewed and updated after the aspiration episode in January 2026.The (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility Care Plan policy revised 09/27/2018, revealed care plans would be updated as issues arise or upon a change in condition.

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(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 a resident's crib environment was free from accidental hazards when cords were observed hanging into a crib for one unsampled resident (Resident 35). The deficient practice placed the resident at risk for entanglement.Findings include:Resident 35 (R35) was admitted on [DATE], with diagnoses including extreme immaturity of a newborn at 26 weeks, cortical blindness and anoxic brain injury. The annual minimum data set (MDS) dated [DATE], revealed R35 had no impairment on upper and lower extremity, was nonverbal and hard of hearing. On 04/16/2026 at 7:45 AM, R35 was asleep inside crib. On the left side of the crib hung two cords - one for the light switch and one for the call system. On the right side of the crib was a red electrical outlet which had three equipment plugged into it namely, the enteral feeding pump, Oxygen saturation device and suction equipment. On 04/16/2026 at 8:18 AM, a life safety code inspector indicated R35's crib was cluttered with too many cords which was a safety concern. The inspector demonstrated how the cords were long enough to become a ligature risk for R35.On 04/16/2026 at 8:29 AM, R35 was awake and was moving inside the crib. R35 would sit up and lie back down and at one-point R35's left hand grabbed on to the electrical cord attached to the Oxygen saturation device which was clamped to the resident's crib.On 04/16/2026 at 10:00 AM, the Administrator entered R35's room and held the cords which dangled form the light switch and call system. The Administrator confirmed R35 did have the cognitive ability to use the cord to call for staff or turn on lights and were mainly for staff use. Two life safety inspectors were present when the Administrator demonstrated how the cords were long enough to loop around R35's neck causing entanglement and the position of the crib was a safety concern.R35's care plan included an intervention to ensure and provide the resident with a safe environment.The facility Safety and Security Management Plan revised 06/22/2010, revealed the safety and security plan was designed to provide a safe and secure environment for residents and intervene whenever conditions or situations of safety existed which posed as a threat or danger to life.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review, the facility failed to act upon a pharmacist's recommendation to monitor seizures for 1 of 22 sampled residents (Resident 28). The deficient practice placed the resident at risk for ineffective seizure management.Findings include:Based on interview, record review and document review, the facility failed to act upon a pharmacist recommendation to monitor seizures for 1 of 22 sampled residents (Resident 28). The deficient practice placed the resident at risk for ineffective seizure management.Findings include:Resident 28 (R28) was admitted [DATE], with diagnosis including chronic respiratory failure with hypoxia, tracheostomy status, and dependence on respirator ventilator status.A Psychotropic Medication Informed Consent dated 11/01/2025, documented R28's specific condition/diagnosis was seizures. Medication intervention recommended was Diazepam 1 mg every 8 hours for seizures. The beneficial effect expected was a decrease in seizure activity.A Physician order dated 11/01/2025 documented Diazepam oral tablet 2 milligrams (mg). Give 1 mg via gastrostomy tube (G-Tube) every 8 hours for seizures.A Pharmacist Consultation Report dated 01/16/2026 documented R28 received Diazepam but did not have seizure monitoring documented in the medical record. The Pharmacist recommended adding seizure monitoring. The Pharmacist's Consultation report indicated psychotropic medication without adequate indications, in excessive dose, for an excessive duration, or without adequate monitoring may increase the broad range of adverse consequences to the resident.The medical record lacked documented evidence seizure monitoring was implemented following the consultant pharmacist's recommendation.On 04/17/2026 at 7:50 AM, the Director of Nursing (DON), confirmed the pharmacist's recommendation for seizure monitoring for R28 was not implemented and R28 was not monitored for seizures. The DON acknowledged the recommendation should have been implemented. The DON reported the lack of seizure monitoring prevented the facility from determining if the medication was effective, identifying breakthrough seizures, and determining if medication adjustments were needed. A facility policy titled Medication Regimen Review revised 06/01/2024, documented the facility should have encouraged the physician/prescriber or other responsible parties receiving the medication regimen review (MRR) and the Director of Nursing to act upon the recommendations contained in the MRR. The attending physician should have documented in the resident's medical record the identified irregularity had been reviewed and what, if any, action had been taken to address it.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure behavior monitoring was accurately completed for a resident on a psychotropic medication for 1 of 22 sampled residents (Resident 34). The deficient practice placed the resident at risk for receiving unnecessary medications. Findings include:Resident 34 (R34) was admitted on [DATE], with diagnoses including unspecified lack of expected normal physiological development in childhood, gastrostomy status and insomnia.On 04/15/2026 in the morning, R34 lay awake in bed while tube feeding was infusing. R35's left hand was covered with a gray mitten while right hand was being used by the resident for iPad device. A certified nursing assistant (CNA) seated by 34's bedside explained R34 and roommate were on two residents to one staff (2:1) sitter orders due to behaviors. The CNA explained R34 was not aggressive towards staff but exhibited self-harm behaviors such as scratching self and pulling lines.A physician order dated 11/27/2025, documented to give Trazadone (anti-depressant) 150 milligrams via gastrostomy tube at bedtime for insomnia.A physician order dated 07/21/2025, instructed to document behavior monitoring for Trazadone every shift. Use codes for 1) Behavior, 2) Intervention, and 3) Outcome.The medical record lacked documented evidence codes were provided for specific 1) Behaviors, 2) Interventions and 3) Outcome such as number of episodes, behaviors of agitation, scratching self and disturbed sleep cycle and whether the intervention was effective or ineffective.The medication administration record (MAR) for April 2026, revealed R34 had zero behaviors, zero interventions and zero outcomes from 04/01/2026 to 04/15/2026 related to Trazadone use.The quarterly behavior support plan updated by R34's attending physician on 04/14/2026, revealed R34 required a two-to-one (2:1) sitter due to lack of self-awareness, and impulsiveness. Staff utilize the Observation and Monitoring tool every 30 minutes to ensure consistent completion of behavior monitoring. Behavior goals include decreasing maladaptive behaviors such as physical resistance, skin picking, medical line pulling, disruptive behaviors, aggressive and combative behaviors.The medical record lacked documented evidence the Observation/Monitoring Tool was completed for R34.On 04/16/2026 at 12:38 PM, R34 was seated in wheelchair outside room while being supervised by a CNA. R34 was using iPad device when suddenly R34 had a verbal outburst and started shaking wheelchair. On 04/16/2026 at 12:39 PM, a Registered Nurse (RN) was near R34 during the observation. The RN reviewed R34's MAR for behavior monitoring related to Trazadone use which reflected R34 exhibited zero episodes of behaviors, intervention and outcome for the month of April 2026. The RN indicated the physician order was lacking behavior codes, intervention codes and outcome codes for nurses to use and follow during behavior monitoring in the MAR. The RN indicated the MAR was inaccurate based on personal experience because the RN had been assigned to R34 multiple times and R34 constantly had more pronounced behavior during the evening shift.On 04/16/2026 at 1:02 PM, the Director of Nursing (DON) reviewed R34's physician orders for behavior monitoring related to Trazadone use and confirmed 1) physician orders for behavior monitoring were lacking codes for specific behaviors, interventions and outcomes, 2) the Behavior Monitoring and Observation Tool was not utilized or maintained for R34 and 3) the MAR entries were inaccurate.On 04/16/2026 at 1:20 PM, the DON indicated the MAR reflected mechanical documentation by nurses who failed to identify codes were lacking for behaviors/interventions and outcomes and failed to seek clarification from the physician who was in the facility daily. On 04/16/2026 at 1:30 PM, the DON explained the purpose of behavior monitoring was to guide the clinician with regards to effectiveness of medications particularly psychoactive medications. The DON indicated failing to record behaviors accurately prevented the physician from making informed decisions with regards to changing medications, adjusting dosage or discontinuing medications.On 04/16/2026 at 1:32 PM, the DON indicated lack of monitoring may render R34's Trazadone use as unnecessary medication due to the failure to track the medication's effectiveness. The facility (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Psychotropic Medication Use revised 03/01/2025, documented psychotropic medications were drugs which affect mood, perception or behavior, and include antipsychotics, anxiolytics, antidepressants, mood stabilizers or hypnotics. Facility staff should monitor behaviors pursuant to facility policy. The facility Psychotherapeutic Medications policy revised 03/21/2025, documented occurrences of behaviors for which psychotherapeutic medications were used would be documented every shift. Each quarter, at a minimum, the interdisciplinary team reviewed the behavior monitoring sheet with the physician to evaluate the continued need for, or reduction of psychotherapeutic medications.