

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295102	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2026
NAME OF PROVIDER OR SUPPLIER Advanced Health Care of Henderson		STREET ADDRESS, CITY, STATE, ZIP CODE 1285 E Cactus Avenue Las Vegas, NV 89183	
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, document review, and record review, the facility failed to ensure a fall prevention was in place for 1 of 22 sampled residents (Resident 62) who was identified as being at risk for falls. This failure resulted in the resident not receiving necessary safety interventions required to reduce the risk of avoidable accidents. Findings include: Based on observation, interview, document review, and record review, the facility failed to ensure a fall prevention was in place for 1 of 22 sampled residents (Resident 62) who was identified as being at risk for falls. This failure resulted in the resident not receiving necessary safety interventions required to reduce the risk of avoidable accidents. Findings include: Resident 62 (R62) was admitted on [DATE] with diagnoses including sepsis, unspecified organism, other specified diseases of liver, pneumonia, chronic obstructive pulmonary disease with (acute) lower respiratory infection, fall, weakness, liver injury with transaminitis, and atrial fibrillation status post cardioversion. On 06/09/2026 at 8:30 AM, R62 indicated falling out of bed the previous night on 06/08/2026. No fall mats were observed beside the resident's bed. R62's significant other verbalized R62 was unable to get out of bed independently. A physician order dated 05/29/ 2026, documented several safety measures for R62 to include the bed must be kept in the lowest position while in bed, fall mats must be placed on the floor when in bed, and non-skid socks must be always worn. The order indicated the interventions were intended to reduce the resident's risk of falls and enhance overall safety. The care plan dated 05/29/2026, document R62 and the caregiver would demonstrate measures to increase safety and prevent falls throughout the resident's stay. The target date for this short-term goal was 08/29/2026. The Care Plan approach documented the facility would identify factors increasing the patient's risk for repetitive falls and implement appropriate interventions. R62's bed would be kept in the lowest position whenever they were in bed. The call light and frequently used items would be placed within easy reach, and R62 oriented to the call light system and encouraged to use it before attempting to ambulate. Staff would respond promptly to call lights. R62 would be oriented to the room, bathroom, and overall environment, and furniture remained in consistent positions to avoid confusion or hazards. Staff would check on R62 every one to two hours. When appropriate, R62 would be placed in a room near the nurse's station or a high-traffic area to enhance monitoring. Physical and occupational therapy services would be involved to support mobility and safety needs. A fall mat would be used when R62 was in bed with responsible partly consent, the bed would be positioned against the wall to further reduce fall risk. An observation detail list report indicated R62 was at risk for falls due to impaired mobility. The R62's care plan included a goal the resident would remain free from serious injury related to falls, provided appropriate interventions were implemented and maintained. A nursing progress note dated 06/09/2026 documented at 8:37 AM, R62 was alert and oriented two to three (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 295102	Facility ID: 295102 If continuation sheet Page 1 of 3

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	times with intermittent confusion and forgetfulness at baseline. In the morning, R62 reported falling out of bed shortly before staff arrived, landing on left side and striking left shoulder and left hip. The progress note documented R62 was able to get up from the floor and return to bed independently before notifying staff. The progress note documented R62's required moderate assistance with transfers and mobility. An assessment showed no visible injuries. A skin assessment revealed no deformity to the left shoulder, left hip, or surrounding areas. R62 denied pain and remained at baseline mental and physical status. R62 would continue to be monitored for any delayed signs of injury or changes in pain, mobility, or overall condition. The progress note indicated fall precautions would remain in place, and staff would continue close observation. A progress note dated 06/09/2026 at 12:20 PM, documented the Occupational Therapist arrived to initiate therapy; however, prior to treatment, R62 reported they had experienced a fall from bed during the previous night, landing on their right shoulder and right hip, resulting in pain in both areas. An assessment was completed, and no visible redness, bruising, swelling, deformity, skin discoloration, or other acute signs of injury were noted in the reported areas. The R62 continued to verbalize pain, though no objective findings were observed. Due to the reported fall and ongoing complaints of pain, the MD was notified of the patient's report and assessment findings. The MD ordered X-rays of the shoulder and hip to rule out an acute injury. A progress note documented X-ray results showed a fracture of the right clavicle and right pubis. The MD ordered R62 to use a right arm sling for the right upper extremity and to remain non-weight bearing on the right side, with weight bearing as tolerated for the right lower extremity. A treatment administration history dated 06/09/2026, documented between 6:00 AM and 6:00 PM, the fall mats were in place when R62 was in bed. Based on direct observation at 8:30 AM, the fall mat was not positioned on the floor as required. This discrepancy showed the documentation did not accurately reflect the residents' actual safety measures at the time of the observation. On 06/11/2026, at 10:05 AM, a Certified Nursing Assistant (CNA) indicated when a resident was identified as a fall risk, a sign was placed on the resident's door. The resident should have a fall mat on the floor, the bed should be kept in the lowest position, and the must be checked frequently, especially when walking down in the hallway. The CNA acknowledged they had not noticed the fall mat on the floor in R62's room. On 06/11/2026, at 10:10 AM, a Registered Nurse (RN), indicated when a resident was identified as a fall risk, a fall risk assessment must be completed, and the resident's record should be reviewed to determine which prevention measures are to be put in place. The RN confirmed that the resident should have a fall mat, the bed should be kept in the lowest position, and the call light must be within reach. Staff would educate the residents about the use of the call light, and the residents should be checked at least every two hours. On 06/11/2026 at 10:15 AM, the Director of Nursing (DON) indicated when a resident was a fall risk, there was a fall assessment upon admission, a fall scale determining what prevention needed to be put in place, sure as a fall mat, lowered bed, non-skid socks. The DON indicated the fall mat should always be on the fall when a resident was in bed. On 06/11/2026 at 10:30 AM, a family member of R62 indicated they had seen the fall mat placed behind the television (TV), rather than on the floor, during their visits with R62. The family acknowledged 06/10/2026 was the first time they had seen the fall mat on the floor. On 06/11/2026 at 10:45 PM, a Physical Therapist (PT) indicated R62 had limited mobility and needed help to get out of bed. The PT indicated R62 mentioned they fell out of bed the previous night and got back into the bed and did not complete therapy on 06/09/2026. The PT indicated reporting the fall to the DON. The PT acknowledged not noticing there was a fall mat on the floor in room R62. The facility's policy titled fall prevention (undated) safety interventions may include but are not limited to fall mats, bed in low position and touch pad call light.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and document review the facility failed to ensure sanitary conditions were maintained related to the storage of chemicals in a manner to prevent contamination of food, food preparation areas, equipment and utensils. The deficient practice had the potential for food contamination for all residents of the facility who receive meals prepared and served by the facility. Findings include: On 06/09/2026 at 10:30 AM, during tour of kitchen various chemicals were observed on top of metal cabinet inside the kitchen bathroom. The chemicals including cleaning products, disinfectants, and spray grease or lubricant were noted on top of the cabinet. On 06/09/2026 at 4:18 PM, the Dietary Manager indicated the cabinet in the bathroom had been in place for nine years. The Dietary Manager verbalized a delivery was made late last week and there was no more room in the cabinet, and a staff member must have placed the additional chemicals on top of the cabinet and should have been placed inside or in the housekeeping storage room in another area of the facility. The facility policy titled Food Storage (undated) documented chemicals must be clearly labeled, kept in original containers when possible, and stored in designated area away from food.		