STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445471	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Henderson Health and Rehabilitation Center	412 Juanita Drive Po Box 223 Henderson, TN 38340

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, and interview, the facility failed to follow physician's orders for 1 of 3 (Resident #13) sampled residents reviewed for Urinary Tract Infection. The findings include: 1. Review of the undated facility policy titled, Medication Administration, revealed .Medications are administered by licensed nurses.as ordered by the physician.verify dose.administer medication as ordered.Sign Mar [Medication Administration Record] after administered [medications]. 2. Review of the medical record revealed Resident #13 was admitted to the facility on [DATE], with diagnoses including Uropathy, Benign Prostatic Hyperplasia, and Chronic Kidney Disease. Review of the Physician's Order dated 7/31/2025, revealed .Gentamicin Sulfate Solution [an antibiotic used to treat an infection] Inject 80 mg [milligrams] intramuscularly [IM] one time a day for UTI [Urinary Tract Infection] for 3 Days. Review of the Medication Administration Record for July 2025, revealed Gentamicin Sulfate Solution was not documented as administered on 7/31/2025. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #13 had a Brief Interview for Mental Status (BIMS) of 10, which indicated he was moderately cognitively impaired. During an interview on 11/19/2025 at 9:07 AM, the Director of Nursing (DON) was asked if a resident was ordered Gentamicin IM once a day for 3 days should they receive all 3 doses. The DON stated, Yes. The DON was asked should medications be documented when administered. The DON stated, Yes, they [medications] should be documented. The DON was asked if medications should be documented if not given or held. The DON stated, Yes it should have been documented if it was not given. The DON was asked if the Doctor should have been notified if a medication dose was missed. The DON stated, Yes, he [doctor] should have been notified.

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation, and interview, the facility failed to accurately assess nutritional status of residents, failed to follow the facility's policy for monitoring weights and failed to have a nutritional intervention provided timely for 2 of 4 (Resident #8 and #9) residents reviewed for nutrition. The findings include: 1. Review of the facility's policy titled, Weight System, revised 7/9/2025, revealed .Weekly weights are completed for.Significant weight change of 5% [percent] or more in 1 month or less, 7.5% in 3 months or 10% in 6 months.All weight changes are considered unplanned unless the MD [medical doctor] has documented a plan for desired weight change and the facility has care planned PRIOR to the weight change occurring.DON [Director of Nursing] or designee.will review monthly and weekly weights.Request reweights on a resident's weekly weight if a change greater than 2% change and on a resident's monthly weight if greater than 5%, 7.5% or 10% change is noted. DON or designee will also validate that monthly and weekly weights are recorded.Discuss all residents with significant weight change (gain/loss of 5% or more in 1 mo [month], 7.5 % or more in 3 mo., 10% or more in 6 mo.).At risk Meeting.Discuss residents with greater than 2% change in a week.discuss.until.resolved.Residents with significant weight loss or gain of 5% x [for] 1 month will be weighed every week for four weeks (or longer if not stable).Significant weight changes.should be referred to the RD [Registered Dietician].Residents with unstable weights should be discussed.until concern is resolved.Implement or request interventions as needed for residents with significant weight change.DON or designee to notify MD and resident representative of significant weight change and/or intervention in the EMR [electronic medical record]. 2. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Encephalopathy, Dysphagia, and Anxiety. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #8 scored a 9 on the Brief Interview for Mental Status (BIMS) assessment, which indicated she was moderately cognitively impaired. Resident #8 required total dependence for meals. Weight loss was coded as 5% in the last month and over 10% in last 6 months.ˆ Review of Resident #8's weights revealed on 4/2/2025, the resident weighed 119 pounds and on 5/7/2025, the resident weighed 106 pounds which was a 10.9 % loss in 35 days. During an interview on 11/18/2025 at 9:30 AM, the MDS Coordinator was asked what interventions were put into place after Resident #8's May 2025 weight loss. The MDS Coordinator stated, .on 8-9-2025, was an order for fortified food [foods with nutrients added to them] at dinner and add 120 ml [milliliter] house supplement at hs [bedtime] . Review of the Physician Order dated 8/9/2025, revealed, .fortified food [foods with nutrients added to them] at dinner and add 120 ml [milliliter] house supplement at hs [bedtime] . During an interview on 11/17/2025 at 2:41 PM, the Director of Nursing (DON) was asked if weight loss was identified and if an intervention should have been put into place prior to 8/9/2025. The DON stated, Yes Ma'am. 3. Review of medical record revealed Resident #9 was admitted to the facility on [DATE], with diagnoses including Dementia, Diabetes, and Hypertension. Review of the quarterly MDS assessment dated [DATE], revealed Resident #9 scored a 10 on the BIMS assessment, which indicated she was moderately cognitively impaired. Review of Resident #9's weights revealed on 10/05/2025, the resident weighed 145 pounds and on 11/4/2025, the resident weighed 131.2 pounds which was a 9.52% loss for 29 days. Review of Physician's orders dated 11/16/2025, revealed .High Calorie Boost twice daily two times a day for weight stabilization. During an interview on 11/19/2025 at 9:04 AM, the DON was asked if weight loss was identified on 11/4/2025, should the intervention have been implemented before 11/16/2025. The DON stated, Yes ma'am.

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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 policy review, medical record review, observation, and interview, the facility failed to follow physician's orders, provide care and services regarding oxygen therapy, and failed to assess residents for the use of oxygen for 2 of 3 (Resident #42 and #75) sampled residents reviewed for respiratory care.The findings include: 1. Review of the undated facility policy titled, Oxygen Administration, revealed .Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences.Staff shall document the initial and ongoing assessments. Review of the undated facility policy titled, Medication Administration, revealed .Medications are administered by licensed nurses.as ordered by the physician.verify dose.administer medication as ordered.Sign Mar [Medication Administration Record] after administered [medications]. 2. Review of the medical record revealed Resident #42 was admitted to the facility on [DATE], with diagnoses including Congestive Heart Failure, Anemia, Atrial Fibrillation, and Alzheimer's. Review of the Physician's Orders dated 5/21/2024, revealed, .2 LITERS BY NASAL CANNULA [NC] FOR SHORTNESS OF BREATH PRN [as needed] as needed . Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 9, which indicated moderately cognitively impaired. Resident #42 was not coded for the use of oxygen. Review of the Progress Note dated 11/16/2025 at 7:27 PM, revealed, Vital signs obtained.BNC [binasal cannula] on 1 1/2 [1 and 1 half] liters. Review of the Medication Administration Record (MAR) dated 11/2025, revealed the facility failed to document the use of oxygen from 11/1/2025 to 11/18/2025. Observation in the dining room on 11/18/2025 at 10:26 AM, revealed Resident #42 was receiving 2 liters of oxygen via [by way of] a portable oxygen tank. During an interview on the 400 Hall on 11/19/2025 7:32 AM, Licensed Practical Nurse (LPN) B was asked what rate Resident #42's oxygen should be set at. LPN B stated, I believe 1 1/2 to 2 liters. LPN B was asked should oxygen usage be documented on the MAR. LPN B stated, Yes, ma'am it should be documented . 3. Review of the medical record revealed Resident #75 was admitted to the facility on [DATE], with diagnoses including Cervical Myelopathy, Pleural Effusion, and Emphysema. Review of the Physician's Orders dated 7/16/2025, revealed, .2 LITERS BY NASAL CANNULA FOR SHORTNESS OF BREATH AND COMFORT PRN every 1 hours as needed for SHORTNESS OF BREATH . Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 6, which indicated severely cognitively impaired. Resident #75 was not coded for the use of oxygen. Review of the MAR dated 11/2025, revealed the facility failed to document the use of oxygen from 11/1/2025 through 11/18/2025. Observations in the resident's room on 11/17/2025 at 9:35 AM, and 11/18/2025 at 8:36 AM, revealed Resident #75 was receiving oxygen via BNC with the oxygen concentrator set at 1.5 liters per minute. During an observation and interview in Resident #75's room on 11/18/2025 at 8:37 AM, LPN C acknowledged Resident #75's oxygen concentrator was set incorrectly at 1.5 liters per minute and should be set at 2 liters per minute. LPN C was asked if prn medications should be documented on the Medication Administration Record. LPN C stated, Yes. During an interview on 11/18/2025 at 9:56 AM, the Director of Nursing (DON) confirmed Resident #75 should be receiving oxygen at 2 liters per minute. The DON was asked should prn medications be documented on the Medication Administration Record. The DON stated, Yes. During an interview on 11/19/2025 at 7:32 AM, LPN B was asked what Resident #75's oxygen concentrator should be set at. LPN B reviewed the Physician's Orders and stated, It should be 2 liters .