STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295037	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Henderson Health and Rehabilitation	1180 E. Lake Mead Parkway Henderson, NV 89015

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a comfortable homelike environment was maintained for 2 of 35 sampled residents (Residents 215 and 12) and 3 unsampled residents (Residents 160, 33, and 65). The failure to provide a homelike environment had the potential risk to cause psychosocial distress to the residents. Findings include:On 07/29/2025 in the morning, the following was observed during a tour of the 2200 and 2300 halls:-In room [ROOM NUMBER] B the blinds were broken and missing some slats. The resident's dresser drawer was broken and coming apart, hanging down toward the floor.-In room [ROOM NUMBER] B the coaxial cable box in the wall was missing a cover and the cable wires and splitter were hanging out of the wall. The resident's dresser was missing a middle drawer. -In room [ROOM NUMBER] A the dresser drawer was broken and coming apart causing the drawer to be very loose. -In room [ROOM NUMBER] B the blinds were broken and missing some slats.-In room [ROOM NUMBER] B the blinds were broken and missing some slats.A maintenance work order was initiated and marked completed for broken blinds and missing slats for room [ROOM NUMBER] on 06/24/2025.On 07/31/2025 at 8:53 AM, the Maintenance Director reported no knowledge of the broken blinds, broken furniture, or uncovered coaxial cable holes in the wall during. The Maintenance Director was aware open holes in the walls should be covered. The Maintenance Director agreed these rooms were not currently presented as a home-like environment.On 07/31/2025 at 11:12 AM, the Assistant Director of Nursing (ADON) for the 2200 and 2300 halls was unaware of the broken blinds, broken furniture, or uncovered coaxial cable holes in the wall. The ADON explained if had known about the issues, work orders would have been submitted. The ADON confirmed these items should be continually maintained just like a homelike environment.The facility's Resident Right's Policy documented the residents had a right to a safe, clean, comfortable, and homelike environment.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review, the facility failed to ensure the state mental health authority was notified after a significant change in the mental health condition of a resident with a history of mental health disorder for 1 of 35 sampled residents (Resident 12). The deficient practice had the potential to deprive residents of necessary behavioral health services.Findings include:Resident 12 (R12) was admitted to the facility 05/21/2025, with diagnoses including other schizoaffective disorders, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, and anxiety disorder. R12's admission paperwork noted the resident was admitted to a local hospital on [DATE]. The resident had been sent to the Emergency Department from a Nursing Facility on a legal hold because R12 became homicidal towards other residents in the facility. R12 had a past medical history of psychiatric diagnoses. R12 was transferred from the Emergency Department back to a skilled nursing facility on 05/21/2025 after being deemed no longer suicidal or homicidal and tolerating all medications well.A Pre-admission Screening and Resident Review (PASARR) level one document dated 08/09/2018, revealed R12 did have the dementia diagnosis, however, no other mental illness (MI), intellectual disability, (ID) mental retardation (MR) or any related condition (RC) and was deemed appropriate for nursing facility placement.A review of the resident's hospital behavioral health notes on 05/12/2025 and hospital discharge note on 05/21/2025 revealed R12's schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder was previously diagnosed; however, the resident had a change of condition which led the resident to become homicidal, possibly post-traumatic stress from a previous assault in 2022.On 07/30/2025 at 1:49 PM, the Director of Social Services (DSS) explained Social Services were responsible for referring residents who met criteria for PASARR level two by completing the PASARR referral in the PASARR system. The DSS indicated a diagnoses of cognitive communication deficit, bipolar disorder, anxiety disorder, and metabolic encephalopathy would be representative of mental illness, intellectual disability, dementia, or a related condition the Medicaid Service Manual documents a PASARR II must be completed. The DSS explained not necessarily as these were old past diagnoses; however, the resident being sent out on a legal hold to the Emergency Department for a change in mental condition would necessitate a PASARR level two referral. The DSS acknowledged R12 did have a legal discharge due to a psych change of condition and a referral for a PASARR level two should have been completed.The Division of Health Care Financing and Policy- Medicaid Services Manual- for Nursing Facilities Policy dated 05/01/2015, documented when an individual has been identified with possible indicators of mental illness, intellectual disabilities or related condition, a PASARR level two screening must be completed to evaluate the individual and determine if nursing facility services and/or specialized services are needed and can be provided in the nursing facility. Examples include: a resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting a presence of a mental disorder (where dementia is not the primary diagnoses), or an intellectual disability or related condition was not previously identified and evaluated through PASARR. Social services would be responsible for keeping track of each resident's PASARR screening status and referring to appropriate authority.A facility document titled Pre-admission Screening and Resident Review (PASRR), dated November 2017, revealed upon a significant change in status, the facility referred residents currently diagnosed with or residents with newly evident or possible mental disorder, intellectual disability, or a related condition for a PASRR level two review.The medical record lacked documented evidence, a referral for a PASARR level two screening was completed for R12.

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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, and document review, the facility failed to ensure a smoking safety assessment was completed for 1 of 35 sampled residents (Resident 137), and an Oxygen tank place inside a resident room was properly secured in a tank holder for 1 of 35 sampled residents (Resident 147). The deficient practice had the potential for placing residents' safety at risk for fire and severe injury.Findings include: 1. Resident 137 (R137) was admitted on [DATE], with diagnoses including contracture of muscles - multiple sites and muscle weakness.On 07/29/2025 at 11:10 AM, R137 was observed to be in bed waiting for the certified nursing aide (CNA) to assist the resident to get into the Geri-chair (a specialized recliner designed to provide comfort and support for individuals with mobility limitations). R137 had moderate contracture of the left hand and some impairment of mobility at the right hand. R137's pack of cigarettes and lighter was visible at the bedside table. R137 indicated was able to smoke by self even with the impairment of mobility on both hands. R137 stated wishing to be able to go out more often for more frequent smoke breaks.On 07/30/2025 at 3:44 PM, R137 was observed to be out of bed in a Geri-chair getting ready to go for a smoke break. The CNA accompanying the resident indicated R137 was able to manage handling a cigarette on the right hand and would need monitoring to ensure safety.R137's Physician admission Note dated 04/24/2025 and every succeeding physician's note documented the resident was a smoker.R137's medical record lacked documented evidence, a smoking safety assessment was completed, and a physician order was obtained. On 07/30/2025 at 4:10 PM, a License Practical Nurse (LPN) indicated the nurse completing the admission assessment was responsible for asking if an incoming new resident smokes and if the resident verbalized wanting to smoke while at the facility, a smoking assessment should have been completed. The LPN indicated any nursing staff could have completed a smoking assessment upon noticing if a resident did not have one.On 07/31/2025 at 3:13 PM, an Assistant Director of Nursing (ADON) reviewed R137's medical record and confirmed there was no smoking assessment completed. The ADON agreed it was important for R137 to have a smoking assessment, especially with contractures and limited dexterity.The facility policy titled Smoking/Tobacco Policy and procedure revised 12/05/2024, documented upon admission, resident who desires to smoke will be assessed and be informed of our smoking policy.2. Resident 147 (R147) was admitted on [DATE], with diagnoses including atherosclerotic heart disease and chronic kidney disease.On 07/29/2025 at 10:00 AM, R147 was in bed receiving Oxygen (O2) 1.5 liters via nasal canula delivered by an O2 concentrator. R147 indicated being on O2 around the clock and used an O2 tank when in a wheelchair. Against the wall at the foot of the bed of R147 was a half full O2 tank not held by any stand or secured to a fixed fixture.On 07/29/2025 at 10:10 AM, an LPN caring for R147 confirmed the O2 tank should have been placed on an O2 caddy. The LPN acknowledged an unsecured O2 was very dangerous and could severely hurt someone. On 07/31/2025 at 3:27 PM, the ADON confirmed O2 should be in a caddy even when in storage.The facility policy titled Oxygen Storage and Assembly (undated), documented Small Tank: Always place cylinder in a stand or cart.

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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 interview, record review and document review, the facility failed to ensure a physician order for specialist consultation was arranged for 1 of 35 sampled residents (Resident 6). The deficient had potential for prompt medical interventions or recommendations to be delayed.Findings include:Resident 6 (R6) was admitted on [DATE], with diagnoses including overactive bladder and morbid obesity.On 07/29/2025 at 2:00 PM, R6 verbalized just finished a round of antibiotics for treatment of a urinary tract infection (UTI). R6 indicated having frequent UTI and was concerned about taking too many antibiotics. R6 indicated the physician had ordered a urologist (a medical specialist who diagnoses and treats conditions related to the urinary tract and reproductive system) consult and R6 had been patiently waiting to hear from the staff.A Nursing Note entry dated 05/23/2025 at 3:20PM, documented the patient reported having burning sensation upon urination. It was reported to the Nurse Practitioner (NP). The NP stated R6 had been treated with different types of anti-microbial. The NP authorized a referral to a Urologist.R6's physician's order documented, Referral to Urologist: No directions specified for order dated 05/23/2025.A Progress Note entry dated 05/26/2025 at 8:06 AM, documented Alert Charting: Resident complained of burning upon urination. New orders to collect Urine for analysis. R6 had an order for Urologist consultation. Please notify the physician if the symptoms get worse.The medical record lacked documentation, the ordered consultation was scheduled or was completed. On 07/30/2025 at 3:15 PM, a License Practical Nurse (LPN) indicated any ordered outpatient consultation would be relayed in writing or verbally to the scheduler or transporter. The scheduler would notify the nurse if an appointment had been scheduled and the specifics of the appointment would be placed in the electronic health record as part of the physician order.On 07/31/2025 at 2:08 PM, the Director of Transportation reviewed R6's medical record and confirmed the order for a urology consultation was not scheduled. The Director had no explanation as to why the appointment was not scheduled. The Director explained hurdles in scheduling a consultation from insurance coverage to medical offices scheduling back log and indicated that regardless of the reason for the delay, nursing staff should be well informed so the physician would be informed as well. The facility policy titled Physician's Order revised June 2021, documented entry of orders into the electronic health record requires the license nurse to confirm the order to acknowledge the receipt of the physician's order to acknowledge receipt and physician notification and to activate the order.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the tube-feeding (TF) formula bag and tubing was labeled for 3 of 35 sampled residents (Residents 118, 251, and 222). The deficient practices could have the potential for formula contamination, inaccurate nutrient intake, infection, dehydration, and nutritional compromise.Findings include:1) Resident 118 (R118) was admitted on [DATE], and readmitted on [DATE], with diagnoses including epilepsy and anoxic brain damage. On 07/29/2025 at 10:36 AM, R118's TF bag was unlabeled except for the date 07/28/2025. On 07/31/2025 at 1:38 PM, R118's TF bag was labelled with R118's name, date, and time but no TF rate and nurse initials. On 07/31/2025 at 2:25 PM, a Licensed Practical Nurse (LPN) indicated the TF bag should have been completely labeled with formula, TF rate, resident's name, room number, nurse initials, date, and time. On 07/31/2025 at 2:26 PM, the Assistant Director of Nursing (ADON) indicated the TF should have been completely labeled. 2) Resident 251 (R251) was re-admitted on [DATE], with diagnoses including cognitive communication deficit, metabolic encephalopathy, dementia, altered mental status, unspecified intellectual disabilities, and generalized anxiety disorder. On 07/29/2025 in the morning, R251 had a feeding tube pump in the room. The tube feeding line was not dated and the date on the tube feeding solution was 07/27/2025. 3) Resident 222 (R222) R222 was re-admitted on [DATE], with diagnoses including seizures, anxiety disorder, depression, and lack of expected normal physiological development in childhood. On 07/29/2025 in the morning, R222 was attached to an active feeding tube line which was not dated. On 07/29/2025 in the morning, the unit Nurse verified the 7/27/2025 date on the feeding tube solution and the undated tubing in the room of R251 and the undated tubing in the room of R222. On 07/31/2025 at 08:28 AM, the LPN described the dating process when it was time to change the residents feeding. The date and time had to be checked for the entire system as it needed to be replaced every 24 hours. This included noting the date and time on the formula and on the tubing lines after the formula was hung and the tubes were changed.

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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 observation, interview, record review, and document review, the facility failed to ensure Oxygen (O2) was administered as ordered and failed to clean the Oxygen concentrator for 2 of 35 sampled residents (Resident 123 and 166). The deficient practice had the potential to result in resident hypoxemia or Oxygen toxicity due to incorrect flow rates, equipment malfunction, and transmission of respiratory pathogens from contaminated equipment, thus compromising respiratory status and overall safety.Findings include:1) Resident 123 (R123) was admitted on [DATE], with diagnoses including edema and atherosclerotic heart disease.A Physician Order dated 11/04/2022, documented to administer O2 inhalation at 2-3 liters per minute (LPM) though nasal cannula as needed for O2 saturation below 90 percent (%) to maintain O2 saturation above 90%.The medical record lacked documented evidence that R123's Oxygen administration and saturation was being monitored to ensure the flow rate was appropriate to keep the resident's oxygenation saturation above 90. On 07/29/2025 at 10:50 AM, R123 was in bed confused, with O2 flowing at 5.0 liters per minute (LPM) through nasal cannula. No signs and symptoms of respiratory distress.On 08/30/2025 at 8:05 AM, R123 was in bed with O continuously flowing at 5 LPM through nasal cannula.On 08/31/2025 at 2:04 PM, R123 was in bed with O2 continuously flowing at 5LPM via nasal cannula. A Licensed Practical Nurse (LPN) confirmed R123's O2 was flowing at 5 LPM continuously when the order was for 2-3 liters. The LPN indicated the Licensed Nurses were responsible for ensuring Oxygen orders were being followed as prescribed to prevent toxicity.On 08/31/2025 at 2:00 PM, the Assistant Director of Nursing (ADON) confirmed R123's O2 was administered at 5 LPM when the order was 2-3 LPM through nasal cannula. The ADON indicated that the Licensed Nurses were expected to check and monitor the residents' O2 as prescribed. 2) Resident 166 (166) was admitted on [DATE] and readmitted on [DATE], with diagnoses including asthma, and hypotension.A Physician Order dated 03/14/2025, documented O2 at 2 LPM through nasal cannula as needed.A Care Plan dated 03/14/2025, documented R166 had O2 therapy at 2LPM through nasal cannula. The interventions included to administer and monitor O2 as ordered.On 07/29/2025 at 10:50 AM, R123's Oxygen was observed flowing at 3.5 LPM through nasal cannula. The cannula was not positioned in R123's nostrils. The O2 concentrator filter was covered with dust. No signs or symptoms of respiratory distress were observed.On 07/30/2025 in the morning, R123's O2 flowing at 3.5 ml via nasal cannula. The O2 concentrator filter was covered with dust.On 07/31/2025 at 1:50 PM, R123's O2 flowing at 3.5 ml through nasal cannula. The Oxygen concentrator filter was covered with dust. A Licensed Practical Nurse (LPN) confirmed the O2 was flowing continuously at 3.5 LPM when the order was 2 LPM through nasal cannula as needed. The LPN was uncertain who was responsible for cleaning the filter because there was no order in place. The LPN confirmed R166's O2 liter flow and saturation should have been monitored but there was no monitoring order in place.On 07/31/2025 at 2:00 PM, the Discharge Planner confirmed O2 saturation was not monitored, and the liter flow was not administered as ordered. The physician orders should have been clarified to include the indication for use, delivery method (PRN or continuous), specific liter flow, and oxygen saturation parameters. The Discharge Planner acknowledged failure to include this information resulted in a lack of monitoring and incomplete implementation of the O2 orders per protocol.A facility policy titled Oxygen Administration (undated), documented to obtain physician orders for O2 administration including the O2 saturation. Monitor the resident's response to O2 therapy.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to ensure the ordered pain-scale parameters were followed for 1 of 35 sampled residents (Resident 8). This deficient practice had the potential to result in unmanaged pain, delayed or inappropriate analgesic administration, functional decline, and diminished quality of life. Findings include: Resident 8 (R8) was admitted on [DATE], with diagnoses including quadriplegia (complete paralysis of all four limbs), a non-pressure chronic ulcer of the buttock, and muscle spasms. On 07/29/2025 at 2:05 PM, R8 indicated having frequent pain with a pain scale of 7-10. R8 indicated the pain medication was administered as needed.A Physician Order dated 12/20/2022, documented Oxycodone Hydrochloride tablets, 10 milligrams (mg), by mouth every 4 hours as needed for severe pain level 7-10.The Medication Administration Record showed Oxycodone was administered when pain levels were below the ordered pain level of 7-10 on the following dates:-July 1, 2025: Pain level 5; medication administered twice/day.-July 7, 2025: Pain level 5; medication administered twice/day.-July 8, 2025: Pain level 5; medication administered once/day.-July 14, 2025: Pain level 6; medication administered once/day.-July 15, 2025: Pain level 6; medication administered once/day-July 21, 2025: Pain level 5; medication administered once/day.-July 30, 2025: Pain level 6; medication administered twice/day.On 08/01/2025 at 12:02 PM, the Assistant Director of Nursing (ADON) indicated nursing staff were expected to follow physician orders as written, particularly for as needed pain medication. ADON explained when an order specified administration for pain levels 7 to 10, medication was not to be given if the reported pain level was below 7. The ADON indicated the nurse was to notify the provider to clarify or adjust the order or request an alternative pain management intervention.On 08/01/2025 at 12:02 PM, the Director of Nursing (DON) confirmed nursing staff were expected to follow the pain level or parameters as prescribed.A facility titled Medication Administration (undated), documented resident medications were administered in accordance with written orders of the physician.A facility policy titled Pain Management, revised August 2012, documented the goal of the pain management program was to ensure pain was identified and treated effectively and consistently.

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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 foods were stored properly and ice machines were cleaned in 1 of 2 ice makers in the facility. This deficient practice posed a potential risk to safety and health standards which could lead to contamination and place residents at risk of foodborne illness. Findings include: On 07/29/2025 in the morning, there was an open bottle, without a lid, containing apple cider vinegar in the dry food storage area with a use-by date of October 19, 2024.There was an open bottle of lemon juice in the reach in cooler with a use-by date of July 20, 2025.On 07/29/2025 at 8:34 AM, the Dietary Director explained the apple cider vinegar should not have been stored without a lid and both the lemon juice and the apple cider vinegar should have been discarded on or before the use-by date.On 07/31/2025 in the morning, there was an ice machine in the B building back auxiliary hall closet with a white and brownish film on the bottom of the inner ice shield, and the plastic ice scoop was resting on the top of the ice machine.On 07/31/2025 at 10:26 AM, the Dietary Director explained the ice machines were cleaned periodically and had been recently cleaned. The Dietary Director stated the ice scoop should be in a holder on the side of the machine.A document titled Food and Nutrition Services, revised February 2017 revealed all storage, preparation, distribution, and service of food and beverage was conducted under sanitary conditions in accordance with state regulations and federal law.A document titled Food Storage and Retention Guide referenced the facility used the Food and Drug Administration (FDA) 2017 Food Code.The FDA 2017 Food Code documented a use-by date was the last date recommended for the use of the product. Stored food or beverage which has been packaged by a food processing establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date. Any food or beverage must be discarded if it exceeded a manufacturer's use-by date.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to ensure Enhanced Barrier Precaution (EBP) signage was posted and staff wore appropriate personal protective equipment (PPE) when providing direct care to residents with indwelling medical devices for 4 of 35 sampled residents (Residents 132, 196, 89 and 194). These deficient practices had the potential to place residents, staff, and visitors at risk for cross-contamination and transmission of multidrug-resistant organisms (MDROs), compromising the infection prevention and control program.Findings include:1) Resident 132 (R132) R132 was admitted on [DATE], with diagnoses including dysphagia (difficulty swallowing), gastrostomy, and colostomy. A review of medical records revealed R132 had a percutaneous endoscopic gastrostomy tube (PEG), colostomy and a wound on the left great toe. On 07/29/2025 in the morning, there was no enhanced barrier precaution signage posted by the door, and no PPE was available at the door entrance. On 07/30/2025 in the morning, the staff members were in and out of room [ROOM NUMBER] and providing direct care with R132. On 07/31/2025 at 8:00 AM, a Licensed Practical Nurse (LPN) was not aware of residents with indwelling devices such as gastrostomy tubes, intravenous lines, and urinary catheters required Enhanced Barrier Precautions (EBP), and PPE should have been worn during the provision of direct care. The LPN was unable to explain the difference between transmission-based precautions and enhanced barrier precautions. On 07/31/2025 at 10:10 AM, the Infection Preventionist (IP) indicated the facility was in the final phase of implementing Enhanced Barrier Precautions (EBP) in alignment with Centers for Disease Control (CDC) guidelines. The IP confirmed the facility was not in compliance with EBP requirements at the time of the survey but emphasized that a structured rollout plan was underway. The IP stated residents with a history of multidrug-resistant organisms (MDROs), indwelling devices (such as G-tubes), or chronic wounds were identified for EBP. The IP indicated the primary risk of not wearing appropriate PPE was potential exposure to organisms with the possibility of transmission from one resident to another. 2) Resident 89 (89) was originally admitted on [DATE] and readmitted on [DATE] with diagnoses including type 2 diabetes mellitus, and dysphagia. On 07/29/2025 at 11:38 AM, R89 was noted to have a feeding tube in place. There were no signs on the resident's door indicating Enhanced Barrier Precautions. Staff were observed providing care without putting on gowns. On 07/31/2025 at 10:42 AM, a Licensed Practical Nurse (LPN) acknowledged the need for PPE, and wearing gown, the LPN added had brought this issue to the infection control manager's attention and was told not to worry about it yet and the LPN indicated had not received an in-service training on wearing a gown. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295037	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Henderson Health and Rehabilitation	1180 E. Lake Mead Parkway Henderson, NV 89015

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/31/2025 at 2:41 PM, a Registered Nurse (RN), was unaware wearing a gown was required when providing care for residents with a feeding tube. There was no signage to indicate the resident was on enhanced barrier precautions and the RN had not received formal training. On 07/31/2025 at 2:43 PM, a Licensed Practical Nurse was unaware wearing a gown was required when providing care for residents with a feeding tube. The LPN was notified on 07/31/2025 to start wearing a gown when performing tube feeding care. On 08/01/2025 at 8:51 AM, a Licensed Practical Nurse wore gloves for when providing tube feeding care but not a gown, as staff were not trained to do so unless the resident had a known infection. 3) Resident 194 (R194) was admitted on [DATE], readmitted [DATE], with diagnosis including anoxic brain damage, dysphagia (difficulty swallowing), and encounter for attention to gastrostomy (a surgical procedure to create an opening in the stomach for feeding). On 07/29/2025 in the morning, R194's feeding pump was next to the bed. There was no signage indicating enhanced barrier precautions or information regarding what personnel protective equipment (PPE) was required for staff to wear while provided care to R194's gastrostomy tube (G-tube). The medical record lacked documented evidence of a physician order for enhanced barrier precautions related to R194's G-tube. On 07/30/2025 at 4:40 PM, a Licensed Practical Nurse (LPN), confirmed R194 received feeding enterally via G-tube. The LPN confirmed there were no enhanced precautions signage posted on R194's door. The LPN reported enhanced precautions were not required for a resident that had tube feeding. The LPN wore gloves, and no gown was needed while providing care to R194's G-tube. The LPN explained enhanced precautions which would include additional PPE required would be for a resident receiving wound care. On 07/31/2025 at 10:22 AM, the Infection Preventionist (IP), explained gowns and gloves were both required while providing care to residents with a G-tube. The IP explained training had not been provided to nurses regarding implementation of the facility's standard and transmission-based precautions program. The IP acknowledged the facility had not yet posted enhanced barrier precaution (EBP) signage for all residents identified as requiring such precautions. On 07/31/2025 at 3:03 PM, the Assistant Director of Nursing (ADON), explained that a resident requiring EBP related to tube feeding should have had a physician order for EBP. The ADON explained the expectation was nurses wear a gown and gloves when providing G-tube care. The ADON reported nurses may not have known what PPE was required to be used during G-tube care, due to training not completed for nurses. 4) Resident 196 (R196) was admitted on [DATE], with diagnoses including aphasia and attention to gastrostomy (G-tube) tube. (continued on next page)

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	295037	A. Building B. Wing	08/01/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/30/2025 at 1:26 PM, a License Practical Nurse caring for R196 confirmed the facility had not informed nursing staff a G-tube would require enhanced barrier precaution, wherein a staff had to utilize personal protective equipment (PPE) when caring for residents with an indwelling medical device. The nurse confirmed being aware of guidelines for years now and when asked about it at the facility, the response would be it would be coming soon. On 07/30/2025 at 1:26 PM, a Certified Nursing Assistant (CNA) verbalized not putting on PPE when proving incontinent care to residents with indwelling medical device because the facility had not imposed the practice. On 07/31/2025 at 10:45 PM, the Infection Preventionist (IP) confirmed the facility was aware of the Center for Disease Control guidelines (CDC) for EBP and the facility followed CDC guidelines when implementing infection control practices. The IP indicated the facility was slowly integrating the EBP guidelines for indwelling medical devices and currently had only implemented EBP for wounds and multi drug resistant organisms (MDRO) colonized residents. The IP stated the facility was in the process of incorporating the integration as part of the quality assurance process. The IP was not able to explain the delay in implementing the policy approved in April 2025. The facility policy titled Infection Prevention and Control Program (IPCP) Standard and Transmission – Based Precautions revised on 04/2025 documented Enhanced Barrier Precautions (EBP): All residents with any of the following. Wounds and /or indwelling medical devices (e.g. central line, feeding tube, tracheostomy or ventilator) regardless of MDRO colonization status. During high contact resident activities: Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use of: central line, feeding tube, tracheotomy/ventilator, wound care – any skin opening requiring a dressing. Required PPE: Gloves and gowns prior to high contact care activity. Change PPE before caring for another resident. Face protection may also be needed if performing activity with risk of splash or spray.