STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295011	A. Building B. Wing	02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Lyon Medical Center	213 Whitacre St Yerington, NV 89447

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure an allegation of neglect and abuse was reported to the State Agency (SA) within the required time frame for 1 of 22 sampled residents (Resident #18). This deficient practice could result in allegations of abuse not being investigated timely. Findings include: Resident #18 Resident #18 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including type two diabetes mellitus with diabetic polyneuropathy and chronic obstructive pulmonary disease, unspecified. A Facility Reported Incident (FRI) was submitted to the SA on 11/27/2024, documenting an allegation of resident neglect and abuse by a Certified Nursing Assistant (CNA). The FRI documented the alleged incident occurred on 11/22/2024, and the Chief Nursing Officer (CNO) was notified of the allegations on 11/25/2024 by the long-term care unit secretary. On 01/29/2025 at 1:41 PM, the Director of Nursing Secretary (DON Secretary) verbalized the facility's abuse coordinator was the DON and all allegations of abuse were to be reported to the DON. The DON Secretary recalled an Observation Aide (OA) notified the DON Secretary of an allegation of resident neglect and abuse by a CNA. The DON Secretary verbalized the DON Secretary reported the allegation to the CNO as the facility did not have a DON at the time. The CNO was notified the same day the DON Secretary received the allegations from the OA. On 01/29/2025 at 2:25 PM, an Observation Aide (OA) recalled the OA was working in the evening on 11/22/2024. The OA recalled Resident #18 called out for help and verbalized the resident needed to be changed. Later in the shift, the OA observed from the hallway, Resident #18 had no brief on and was uncovered from the waist down. Resident #18 reported to the OA the CNA had come to change Resident #18's brief and had left without putting a brief on the resident or covering the resident. On 11/25/2024, the OA spoke to the DON Secretary about the incident and asked the DON Secretary how to contact the CNO to report it. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Freedom From Abuse (Residents, Patients), revised May 2021, documented abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish or the deprivation of goods or services necessary to attain or maintain physical, mental, and psychosocial well-being. Neglect was defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. Any person identifying signs of resident abuse or neglect were to immediately report to the charge nurse and the charge nurse would notify the DON and the Chief Risk Officer. The DON or the Chief Risk Officer would report suspected abuse to the SA within 24 hours. FRI #NV00072852

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, document review, and interview the facility failed to demonstrate effective administration by not ensuring the Chief Executive Officer (CEO) and the Chief Nursing Officer (CNO) adequately interpreted and implemented effective infection control protocols per the Centers for Disease Control and Prevention (CDC) guidance to effectively prevent the spread of COVID-19 (COVID) resulting in a wide spread outbreak of COVID amongst facility staff and residents. Findings include: A facility COVID tracking sheet documented between [DATE] and [DATE], 16 employees and 16 of 22 residents residing in the facility tested positive for COVID. (See Tag F880 for details). On [DATE] at 3:04 PM, the Chief Nursing Officer (CNO) confirmed the facility had a COVID outbreak in the facility around October or November. The CNO explained the rooms at the far end of the hallway had been used in the past to isolate residents with COVID. The residents would have been able to ambulate in the hallways without coming in contact with COVID negative residents due. The CNO explained the rooms were able to be separated from the rest of the facility by closing the firewall doors. However, the CNO explained an interim (travel) Director of Nursing (DON) verbalized to the CNO, the facility could not require residents to stay in their rooms. On [DATE] at 3:06 PM, the CNO confirmed the facility had not used the isolated pods due to the travel DON flat out saying they were the DON and they (the DON) had said no. The CNO verbalized unfortunately, they allowed the COVID positive residents to go to the dining room and this was how a lot of the residents became sick. On [DATE] at 3:08 PM, the CNO confirmed the DON was the CNO's subordinate. The CNO confirmed the CNO had the authority to instruct the DON regarding resident care and the functioning of the facility including the use of the rooms on the other side of the fire doors. The CNO confirmed the CNO should have instructed the DON to ensure COVID positive residents were isolated and did not intermingle with other residents and had failed to do so. On [DATE] at 3:10 PM, the CNO verbalized during the COVID outbreak staff attempted to get residents and visitors to wear mask. The CNO explained during the COVID outbreak staff wore surgical mask but as more employees and residents became infected with COVID, staff began to wear N95 respiratory mask. The rationale for the selection of source control was as the outbreak got larger, the facility decided it would behoove them all to wear N95 respirator mask to help prevent further spread. The CNO explained surgical mask were effective in the prevention of spreading COVID as long as the mask were not worn for too long of a period. On [DATE] at 3:12 PM, the CNO verbalized the Infection Preventionist (IP) working at the facility during the outbreak agreed with the use of surgical mask, but after speaking with the DON it was decided the facility should switch to N95 respirator mask. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 1:19 PM, the acting Long Term Care (LTC) Medical Director verbalized the facility had hired a physician to take over as the Medical Director for LTC. However, the physician's state licensure was taking longer than expected and around the first week of October, the Medical Director became involved with the facility's COVID outbreak and explained at this time there were approximately five COVID positive residents. The Medical Director verbalized during this time the facility had an interim (travel) Director of Nursing (DON) and the DON reviewed the facility's policies regarding COVID testing and quarantine. The Medical Director explained the facility's COVID policies were unclear regarding when to stop testing and there was confusions and debate amongst facility leadership. The Medical Director recalled reviewing CDC guidance with another physician and argued against 48 hour testing. The Medical Director confirmed testing was completed on residents and staff every 48 hours and believed this practice continued for a week or two. The Medical Director explained during past COVID outbreaks the facility was able to separate and isolate residents. Due to the amount of exposure which had already occurred, it was decided not to move residents around. The Medical Director confirmed Resident #12 was sent to an acute care hospital outside of the facility's hospital system and confirmed Resident #12 expired during the hospitalization. On [DATE] at 2:11 PM, the CNO confirmed the facility followed the Centers for Medicare and Medicaid (CDC) guidance. Cross reference with F880

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, document review, and interview, the facility failed to ensure the Centers for Disease Control and Prevention (CDC) guidance and the facility's Infection Prevention and Control Plan (IPCP) were followed regarding the management of COVID-19 (COVID). This failure resulted in an outbreak of COVID within the facility resulting in 16 employees and 16 of 22 residents (Resident #14, #18, #4, #19, #9, #10, #3, #11, #16, #21, #15, #2, #5, #6, #17, and #12) becoming infected with COVID during September and [DATE]. Resident #12 was transferred to an acute care hospital for treatment of COVID symptoms the facility was not able to manage. Resident #12 expired during this hospitalization. Findings include: Employees An untitled and undated facility spread sheet utilized for tracking employee COVID status, documented during the months of September and [DATE], facility employees were tested for COVID as follows. -On [DATE], a consulting physician with a hire date of [DATE], tested positive for COVID and tested negative for COVID on [DATE]. The physician complained of a cough, stuffy/runny nose, and pain beginning on [DATE] and worked on [DATE]. The documentation indicated the physician was tested on day two and day five following the onset of symptoms. The spread sheet lacked documented evidence of additional testing and did not indicate when the employee could or did return to work. -On [DATE], a Dietary Aide with a hire date of [DATE], tested positive for COVID. The Dietary Aide tested negative on [DATE]. The Dietary Aide complained of sore throat and congestion starting on [DATE] and had worked all week while wearing a mask. The documentation indicated the Dietary Aide was tested on day four and day 10 following the onset of symptom. The spread sheet lacked documented evidence of additional testing and did not indicate when the employee could or did return to work. -On 09/30, 10/02, and [DATE], a Physical Therapist (PT) with a hire date of [DATE] tested positive for COVID. The PT tested negative on [DATE]. The PT called in sick on [DATE], and complained of a sore throat, runny nose, cough, and fever. The documentation indicated the PT was tested on day zero, day two, and day four, and day seven. The spread sheet lacked documented evidence of additional testing and did not indicate when the employee could or did return to work. -On 10/02 and [DATE], a Minimum Data Set (MDS) Coordinator with a hire date of [DATE], tested positive for COVID. The MDS Coordinator tested negative on [DATE]. The MDS Coordinator had complained of body aches and fever starting on [DATE]. The documentation indicated the MDS Coordinator was tested on day two, day four, and day seven. The spread sheet lacked documented evidence of additional testing and did not indicate when the employee could or did return to work. -On 10/02 and [DATE], Certified Nursing Assistant (CNA) with a hire date of [DATE], tested positive for COVID. The CNA tested negative on [DATE]. The CNA had complained of fever, sore throat, cough, body aches and gastrointestinal symptoms starting on [DATE]. The documentation indicated the CNA was tested on day two, day four, and day seven. The spread sheet lacked documented evidence of additional testing and did not indicate when the employee could or did return to work. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-On 10/03, 10/04, and [DATE], an Aide with the hire date of [DATE] tested positive for COVID. The Aide tested negative on [DATE]. The Aide had complained of a runny nose, cough and sore throat starting on [DATE]. The CNA worked on 09/30 and [DATE]. The Aide was sent home on [DATE]. The documentation indicated the aide was tested on day two, day three, and day six. The spread sheet lacked documented evidence of additional testing and did not indicate when the employee could or did return to work. -On 10/05, 10/07, 10/09, and [DATE] an Assistant Housekeeping Supervisor with a hire date of [DATE] tested positive for COVID. The Housekeeping Supervisor tested negative on [DATE]. The housekeeper complained of having a hoarse voice on [DATE]. The documentation indicated the Housekeeping Supervisor was tested on day two, day four, day six, day eight, and day 11. The spread sheet lacked documented evidence of additional testing and did not indicate when the employee could or did return to work. -On 10/07 and [DATE] a Housekeeping Supervisor with a hire date of [DATE]. tested positive for COVID. The Housekeeping Supervisor tested negative on [DATE]. The Housekeeping Supervisor complained of a fever, headache, sore throat, cough, and a stuffy nose on [DATE]. The documentation indicated the Housekeeping Supervisor was tested on day two, day four, and day six. The spread sheet lacked documented evidence of additional testing and did not indicate when the employee could or did return to work. -On [DATE], a CNA with a hire date of [DATE] tested positive for COVID. The CNA tested negative for COVID on [DATE]. The CNA complained of fever, chills, body aches, runny nose, and headache starting on [DATE]. The documentation indicated the CNA was tested on day two and day four. The spread sheet lacked documented evidence of additional testing and did not indicate when the employee could or did return to work. -On 10/08 and [DATE] a CNA with a hire date of [DATE], tested positive for COVID. The CNA tested negative on [DATE]. The CNA complained of symptoms starting on [DATE]. The documentation indicated the CNA was tested for COVID on day three, day five, and day seven. The spread sheet lacked documented evidence of additional testing and did not indicate when the employee could or did return to work. -On 10/08 and [DATE], a Dietary [NAME] with a hire date of [DATE], tested positive for COVID. The Dietary [NAME] tested negative on [DATE]. The CNA complained of chills, aches, congestion, and a sore throat starting on [DATE]. The documentation indicated the Dietary [NAME] was tested on day two, day four, and day six. The spread sheet lacked documented evidence of additional testing and did not indicate when the employee could or did return to work. -On [DATE], a Housekeeper with a hire date of [DATE], tested positive for COVID. The Housekeeper tested negative on [DATE]. The Housekeeper complained of headache, sore throat, and runny nose starting on [DATE]. The documentation indicated the Housekeeper was tested on day two and day four. The spread sheet lacked documented evidence of additional testing and did not indicate when the employee could or did return to work. -On [DATE], a CNA with a hire date of [DATE], tested positive for COVID. The CNA tested negative on [DATE]. The CNA complained of a cough, headache, and runny nose starting on [DATE]. The documentation indicated the CNA was tested on day three and day five. The spread sheet lacked documented evidence of additional testing and did not indicate when the employee could or did return to work. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-On 10/10 and [DATE] a CNA with a hire date of [DATE] tested positive for COVID. The CNA tested negative on [DATE]. The CNA complained of symptoms starting on [DATE]. The documentation indicated the CNA was tested for COVID on day two, day four, and day six. The spread sheet lacked documented evidence of additional testing and did not indicate when the employee could or did return to work. -On 10/14 and [DATE] a Licensed Practical Nurse (LPN) with a hire date of [DATE] tested positive for COVID. The LPN tested negative on [DATE]. The LPN complained of a sore throat and stuffy nose starting on [DATE]. The documentation indicated the LPN was tested on day two, day four, and day six. The spread sheet lacked documented evidence of additional testing and did not indicate when the employee could or did return to work. Additionally, an untitled and undated flow sheet documented on 09/282024 and [DATE], a Registered Nurse (RN) with a hire date of [DATE], tested positive for COVID. The RN tested negative on [DATE]. The RN complained of a cough and sore throat starting on [DATE] and was not scheduled to work until [DATE]. The documentation indicated the RN was tested on day three, day six, and day eight. The flow sheet lacked documented evidence of additional testing and did not indicate when the employee could or did return to work. The RN was not included on the facility's COVID testing spread sheet and was not included on the facility's employee list. On [DATE] at 3:24 PM, the Chief Nursing Officer (CNO) verbalized in the beginning of the COVID outbreak, staff wore surgical mask. The CNO confirmed surgical mask were worn, and explained the surgical mask were worn for no more than two weeks. The CNO verbalized during the beginning of the outbreak the Centers for Medicare and Medicaid Services (CMS) and the Infection Preventionist's (IP) instructions were followed. The CNO explained when an employee tested positive for COVID, the employee was not allowed to return to work until symptoms resolved and the employee tested negative for COVID. On [DATE] at 2:11 PM, the CNO confirmed the facility followed CDC guidance. On [DATE] at 2:44 PM, during a telephone interview, the Chief Executive Officer (CEO) confirmed the facility followed CDC guidance as much as possible and added the facility was stricter than CDC guidance. The CNO explained we can be stricter, and we have so much data we can show. The CEO confirmed employees and residents were tested every other day. A CDC memo titled Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 (COVID) Infection or Exposure to COVID, dated [DATE], documented health care workers with mild to moderate illness who were not moderately or severely immunocompromised could return to work after the following criteria was met: -At least seven days had passed since symptoms first appeared if a negative viral test was obtained within 48 hours prior to returning to work (or after 10 days if testing was not performed or if a positive test was obtained at days 5-7), AND -At least 24 hours had passed since the last fever without the use of fever reducing medications, AND -Symptoms such as cough and shortness of breath had improved. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The return-to-work criteria for healthcare workers who were exposed to individuals with confirmed SARS CoV-2 infection included: -A series of three viral tests for COVID infection. Testing was recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. -All recommended infection prevention and control practices were to be followed, including wearing well-fitting source control, monitoring for fever or symptoms consistent with COVID, and health care workers were not to report to work when ill or if testing positive for COVID. Health care workers who have entered the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a National Institute for Occupational Safety and Health (NIOSH) approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i. e., goggles or a face shield that covers the front and sides of the face). The facility policy titled Healthcare Personnel (HCP) with a COVID-19 Diagnosis or Exposure and their Return to Work revised on 04/2023, documented HCP with mild to moderate illness who were not moderately or severely immunocompromised could return to work after the following criteria was met: -At least seven days had passed since symptoms first appeared if a negative viral test was obtained within 48 hours prior to returning to work (or after 10 days if testing was not performed or if a positive test was obtained at days 5-7), AND -At least 24 hours had passed since the last fever without the use of fever reducing medications, AND -Symptoms such as cough and shortness of breath had improved. The return to work criteria for healthcare workers who were exposed to individuals with confirmed SARS CoV-2 infection included: -A series of three viral tests for COVID infection. Testing was recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. -All recommended infection prevention and control practices were to be followed, including wearing well-fitting source control, monitoring for fever or symptoms consistent with COVID, and health care workers were not to report to work when ill or if testing positive for COVID. The facility policy titled COVID-19: Source Control, revised 06/2024, documented source control options for HCP's included a NIOSH approved particulate respirator with N95 filters or higher, a respirator approved in other countries could be used if a NIOSH approved N95 was not available. A barrier face covering that met ASTM F3502-21 requirements including Workplace Performance and Workplace Performance Plus mask, OR a well-fitting facemask. A NIOSH approved particulate respirators with N95 filters or higher was recommended during the care of a patient with SARS-CoV-2 infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Residents Resident #14 Resident #14 was admitted to the hospital on [DATE], with diagnoses including dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, unspecified severe protein-calorie malnutrition, and chronic obstructive pulmonary disease (COPD). A laboratory (lab) report documented Resident #14 tested positive for COVID on 10/012024. The report did not document any additional COVID testing. An untitled and undated facility COVID tracking spread sheet documented Resident #14 tested positive for COVID on 10/01, 10/03, 10/07, 10/09, and [DATE]. The resident tested negative on [DATE]. Resident #18 Resident #18 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including type II diabetes mellitus with diabetic polyneuropathy, COPD, and unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A lab report documented Resident #18 tested positive for COVID on 10/02, 10/04, 10/06, and [DATE]. The resident tested negative on [DATE]. An untitled and undated facility COVID tracking spread sheet documented Resident #18 tested positive for COVID on 10/02, 10/04, 10/06, and [DATE]. The resident tested negative on [DATE]. Resident #4 Resident #4 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unspecified dementia, unspecified severity, with other behavioral disturbance, and deficiency of other specified B group vitamins, and nutritional anemia, unspecified. A lab report documented Resident #4 tested positive for COVID on 10/04, 10/07, 10/09, and [DATE]. An untitled and undated facility COVID tracking spread sheet documented Resident #4 tested positive for COVID on 10/02, 10/07, 10/09, and [DATE]. The resident tested negative on [DATE]. Resident #19 Resident #19 was admitted to the facility on [DATE], with hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, essential (primary) hypertension, unspecified disorder of circulatory system, and adult failure to thrive. A lab report documented Resident #19 tested positive for COVID on 10/02, 10/04, 10/07, and 10/09. The resident tested negative on [DATE]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An untitled and undated facility COVID tracking spread sheet documented Resident #19 tested positive for COVID on 10/02, 10/04, 10/07, and 10/09. The resident tested negative on [DATE]. Resident #9 Resident #9 was admitted to the facility on [DATE], with diagnoses including multiple sclerosis, essential (primary) hypertension, and vitamin D deficiency, unspecified. A lab report documented Resident #9 tested positive for COVID on 10/02, 10/04, and [DATE]. The resident tested negative on [DATE]. An untitled and undated facility COVID tracking spread sheet documented Resident #9 tested positive for COVID on 10/02, 10/04, and [DATE]. The resident tested negative on [DATE]. Resident #10 Resident #10 was admitted to the facility on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right non-dominant side. A lab report documented Resident #10 tested positive for COVID on 10/03, 10/07, and [DATE]. The resident tested negative for COVID on 10/02 and [DATE]. An untitled and undated facility COVID tracking spread sheet documented Resident #10 tested positive for COVID on 10/03, 10/07, and [DATE]. The resident tested negative for COVID on 10/02 and [DATE]. Resident #3 Resident #3 was admitted to the facility on [DATE], with diagnoses including alcoholic hepatic failure without coma, alcoholic cirrhosis of liver with ascites, essential (primary) hypertension, and unspecified protein-calorie malnutrition. A lab report documented Resident #3 tested positive for COVID on 10/04, 10/07, 10/09, and [DATE]. The resident tested negative for COVID on [DATE]. An untitled and undated facility COVID tracking spread sheet documented Resident #3 tested positive for COVID on 10/04, 10/07, 10/09, and [DATE]. The resident tested negative for COVID on 10/02 and [DATE]. Resident #11 Resident #11 was admitted to the facility on [DATE], and last readmitted on [DATE], with diagnoses including Alzheimer's disease, unspecified, essential (primary) hypertension, presence of cardiac pacemaker, and shortness of breath. A lab report documented Resident #11 tested positive for COVID on 10/04, 10/07, and [DATE]. The resident tested negative for COVID on 10/02 and [DATE]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An untitled and undated facility COVID tracking spread sheet documented #11 tested positive for COVID on 10/04, 10/07, and [DATE]. The resident tested negative for COVID on 10/02 and [DATE]. Resident # 16 Resident #16 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including COPD, type II diabetes mellitus without complications, polyneuropathy, unspecified. A lab report documented Resident #16 tested positive for COVID on 10/04, 10/07, 10/09, 10/11, 10/14, 10/16 and [DATE]. The lab report did not document a negative COVID test result. An untitled and undated facility COVID tracking spread sheet documented Resident #16 tested positive for COVID on 10/04, 10/07, 10/09, 10/11, 10/14, 10/15 and [DATE]. The resident tested negative for COVID on [DATE], prior to testing positive. The tracking spread sheet did not document any additional COVID test. Resident #21 Resident #21 was admitted to the facility on [DATE], with diagnoses including cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery, essential (primary) hypertension, acute respiratory failure with hypoxia, unspecified asthma, and dependence on long term (current) use of antibiotics. A lab report documented Resident #21 tested positive for COVID on 10/04 and [DATE]. The resident tested negative for COVID on 10/02 and [DATE]. An untitled and undated facility COVID tracking spread sheet documented Resident #21 tested positive for COVID on 10/04 and [DATE]. The resident tested negative for COVID on 09/23, 10/02 and [DATE]. Resident #15 Resident #15 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including hemiplegia, unspecified affecting right dominant side, essential (primary) hypertension, and vascular dementia, unspecified severity, with other behavioral disturbance. A lab report documented Resident #15 tested positive for COVID on 10/04, 10/07, 10/09, 10/11, 10/14, 10/16, and [DATE]. The lab report did not document a COVID negative test. An untitled and undated facility COVID tracking spread sheet documented Resident #15 tested positive for COVID on 10/04, 10/07, 10/09, 10/11, 10/14, 10/15, and [DATE]. The resident tested negative for COVID on [DATE], prior to testing positive. The tracking spread sheet did not document any additional COVID test. Resident #2 Resident #2 was admitted to the facility on [DATE], with diagnoses including vascular dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, disease of pancreas, unspecified, and essential (primary) hypertension. (continued on next page)

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	295011	A. Building B. Wing	02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Lyon Medical Center	213 Whitacre St Yerington, NV 89447

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A lab report documented Resident #2 tested positive for COVID on [DATE]. The resident tested negative for COVID on 10/03 and [DATE]. An untitled and undated facility COVID tracking spread sheet documented Resident #2 tested positive for COVID on [DATE]. The resident tested negative for COVID on 10/03 and [DATE]. Resident #5 Resident #5 was admitted to the facility on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side, hypertensive heart disease with heart failure, and occlusion and stenosis of unspecified carotid artery. A lab report documented Resident #5 was tested negative for COVID on 10/02 and [DATE]. The lab report did not document any additional COVID test. An untitled and undated facility COVID tracking spread sheet documented Resident #5 tested positive for COVID on 10/07, 10/09, 10/11, and [DATE]. The resident tested negative for COVID on 10/02, 10/03, and [DATE]. Resident #6 Resident #6 was admitted to the facility on [DATE], with diagnoses including pleural effusion, not elsewhere classified, adult failure to thrive, and chronic atrial fibrillation, unspecified. A lab report documented Resident #6 tested positive for COVID on 10/07 and [DATE]. The resident tested negative for COVID on 10/04, 10/11, and [DATE]. An untitled and undated facility COVID tracking spread sheet documented Resident #6 tested positive for COVID on 10/07 and [DATE]. The resident tested negative for COVID on 09/13, 09/18, 10/02, 10/04, 10/11, and [DATE]. Resident #17 Resident #17 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including acute respiratory failure with hypoxia, hypertensive heart disease with heart failure, acute on chronic diastolic (congestive) heart failure, type II diabetes mellitus with hyperglycemia, obstructive sleep apnea, and morbid (severe) obesity due to excess calories. A lab report documented Resident #17 tested positive for COVID on 10/11 and [DATE]. The resident tested negative on 10/02, 10/03, 10/09, and [DATE]. An untitled and undated facility COVID tracking spread sheet documented Resident #17 tested positive for COVID on 10/11 and [DATE]. The resident tested negative on 10/02, 10/03, 10/09, and [DATE]. Resident #12 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #12 was admitted to the facility on [DATE], and was last re-admitted to the facility on [DATE], with diagnoses including quadriplegia, unspecified, hydrocephalus, unspecified, hypotension, unspecified, respiratory failure, unspecified, unspecified whether with hypoxia or hypercapnia, unspecified severe protein-calorie malnutrition, and adult failure to thrive. A diagnosis of COVID was added on [DATE], and a diagnosis of pneumonia due to corona virus disease 2019 was added on [DATE]. A lab report documented Resident #12 tested positive for COVID on 10/06 and [DATE]. The resident tested negative for COVID on 10/02 and [DATE]. An untitled and undated facility COVID tracking spread sheet documented Resident #12 tested positive for COVID on 10/06 and [DATE]. The resident tested negative for COVID on 10/02 and [DATE]. A Health Alert note dated [DATE], documented Resident #12's oxygen saturating had begun to deteriorate to 88 percent (%). The resident's oxygen was increased to three liters per minute (LPM) with little effect and a physician was notified of the resident's condition. A Change of Condition note entered by a physician and dated [DATE] documented Resident #12 had a fever of 101.5 degrees Fahrenheit (F) on [DATE]. On [DATE], the resident had more of a cough and was tired. The resident's oxygen saturation had decreased to 88% on one LPM of oxygen. The oxygen was increased to three LPM and the resident's oxygen saturation remained at 88%. Resident #12 had received two nebulizer treatments while in the resident's regular room. Resident #12 was tested for COVID, and results were pending. The physician documented the physician believed the resident was COVID positive and planned to move the resident to a negative pressure room. The continued to document Resident #12's COVID test results had just come back positive, and the resident would be moved to a negative pressure room. A Health Status Note dated [DATE], documented Resident #12 was COVID positive and receiving antibiotics for pneumonia. A Health Status Note dated [DATE], documented Resident #12 was receiving oxygen at five LPM via nasal cannula and the resident's oxygen saturations were in the 60's. The resident did not want to go to the emergency room (ER) and requested to try a face mask for oxygen delivery. A face mask was applied and the resident's oxygen saturations increased to 75%. The resident agreed to be transferred to the ER. A Health Status Note dated [DATE], documented Resident #12's oxygen saturations remained in the 70's with oxygen being delivered at five LPM via face mask. The resident's heart rate was tachycardia in the 140's and the resident was transferred to the ER. On [DATE] at 3:04 PM, The Chief Nursing Officer (CNO) confirmed the facility had a COVID outbreak in the facility around October or November. The CNO explained the rooms at the far end of the hallway had been used in the past to isolate residents with COVID. The CNO explained the rooms were able to be separated from the rest of the facility by closing the firewall doors and residents would have been able to ambulate in the hallways without coming in contact with COVID negative residents. However, the CNO explained an interim (travel) Director of Nursing (DON) verbalized to the CNO, the facility could not require residents to stay in their rooms. (continued on next page)

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