

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295011	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER South Lyon Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review, the facility failed to promote and protect a resident's right to be treated with respect and dignity and to make informed decisions when the facility declined to readmit the resident following an acute hospitalization. This deficient practice had the potential to result in psychosocial harm to the resident due to lack of lodging/place to live and services. Findings include: Resident #35 Resident #35 was admitted was admitted to the facility on [DATE], with diagnoses including quadriplegia, abnormal posture, chronic pain, idiopathic constipation and anxiety. On 04/13/2026 the facility issued Resident #35 a 30-day involuntary discharge notice. The discharge notice documented the reasons for discharge included failure to pay, possession of marijuana, recording staff without consent and violation of behavior agreement. On 4/23/2026 a typed letter, written by the facility's administrator documented the facility rescinded the 30-day involuntary discharge notice until an appropriate and safe alternative placement could be secured. A Nursing Note dated 05/12/2026, documented Resident #35 approached the Registered Nurse (RN) and reported chest tightness, chills/diaphoresis, headache and abdominal discomfort. The RN assessed the resident's abdomen, abdomen noted to be soft and not distended. The resident reported generalized discomfort without visible signs of acute distress. The RN obtained vital signs and offered to transfer the resident to the local emergency room (ER) for further evaluation. The resident refused, stating the resident had been there multiple times and they had not done anything. The resident stated the resident preferred to go to another ER instead. The RN notified the Director of Nursing (DON). The DON informed the RN there were two options. First was to go to the local ER and have ER-to-ER transfer if needed, or the facility could give the resident a ride to another ER using the facility van, if the resident was stable/safe enough, with the RN to go with the resident. The options were presented to the resident, and the resident chose the second option. Around 12:40 PM, the nurse and resident arrived at an acute care hospital ER. The resident wheeled into the ER and checked in. The RN handed paperwork to the ER staff and told both the resident and the ER staff to call the facility with any questions. The RN explained to the resident the RN was returning to the facility. A Doctor's Note dated 05/12/2026, documented Resident #35 was transported to the ER per the resident's choice. Nursing assessment reviewed and demonstrated Resident #35 was medically stable for transfer. Resident #35 was offered evaluation in the local ER and declined. While out of the facility, the physician requested housekeeping take the opportunity to clean Resident #35's room. The resident declined on multiple occasions to have the room cleaned which posed an infection control concern. An administrative decision was made to not readmit Resident #35 to the facility and the justification for the Notice of Decision Not to Readmit was reviewed by the physician. On 07/30/2026 at 10:05 AM a Licensed Practical Nurse (LPN) verbalized Resident #35 was generally independent (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: 295011	Facility ID: 295011
		If continuation sheet Page 1 of 11

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with activities of daily living but required catheter care and bowel care. The LPN confirmed Resident #35 exhibited impulsive and verbally aggressive behaviors at times but reported the facility was able to meet Resident #35's care needs. On 07/30/2026 at 11:20 AM the Social Services Designee (SSD) verbalized the Ombudsman informed the facility to rescind the 30-day involuntary discharge notice because there was insufficient justification to proceed. The Social Worker confirmed the facility continued extending the discharge while attempting to locate a safe alternative placement and confirmed a hospital was not considered a nursing facility placement. The facility policy titled Resident Rights, revised 12/2015, documented the facility was to permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless: the transfer or discharge was necessary for the resident's welfare and the resident's needs could not be met by the facility, the transfer or discharge was appropriate because the resident's health had improved sufficiently so the resident no longer needed the services provided by the facility, the safety and/or health of individuals in the facility was endangered, the resident failed to pay for a stay at the facility, or the facility ceased to operate. Residents were to be notified of the transfer or discharge and the reasons for the move in writing. Before a nursing facility transferred a resident to a hospital or allowed a resident to go on therapeutic leave, the nursing facility was to provide written information to the resident and a family member or legal representative that specified the duration of the bed-hold policy under the state plan, if any, during which the resident was permitted to the return and resume residence in the facility. The facility was to establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeded the bed-hold period under the state plan, was readmitted to the facility immediately upon first availability of a bed in a semi-private room if the resident required the services provided by the facility and was eligible for Medicaid nursing facility services. CPT 304830. Cross reference tag F627 and F628.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review, the facility failed to provide documented evidence a thorough investigation was conducted for incidents with the potential to indicate abuse and neglect for 3 of 4 Facility Reported Incidents (FRIs) investigated. This deficient practice had the potential for ongoing physical and/or psychosocial harm to residents due to allegations of neglect and abuse not being thoroughly investigated and documented to ensure appropriate protections were put in place to prevent future neglect and abuse. Findings include: Resident #9 Resident #9 was admitted to the facility on [DATE], with diagnoses including vascular dementia, unspecified severity, with agitation, insomnia, and disorder of kidney and ureter, unspecified. Resident #32 Resident #32 was admitted to the facility on [DATE], with diagnoses including type two diabetes mellitus with diabetic neuropathy, unspecified, essential (primary) hypertension, and chronic vascular disorders of intestine. FRI #2591438 submitted by the facility on 08/15/2025, documented the type of incident as physical abuse. The FRI Report documented a Licensed Practical Nurse (LPN) overheard Resident #32 yell out quit kicking me. The LPN observed Resident #9 seated a few feet away from Resident #32. Resident #32 had reported to the LPN Resident #9 had kicked the resident's leg three times. A Behavior Incident progress note dated 08/08/2025, documented Resident #32 was overheard yelling at Resident #9. Resident #32 was standing up, pointing a finger at Resident #9, yelling at Resident #9 to stop kicking Resident #32. The two residents were separated. No signs of injury or bruising were located on Resident #32. Resident #6 Resident #6 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including hemiplegia, unspecified affecting right dominant side, aphasia, and vascular dementia, unspecified severity, with other behavioral disturbance. FRI #2703876 submitted by the facility on 12/30/2025, documented Resident #6 was getting a brief change by a Certified Nursing Assistant (CNA). Resident #6 was being combative with the CNA during the brief change and had obtained a skin tear to the right hand. The resident had pointed to the resident's hand when asked, indicating the resident had scratched themselves causing the skin tear. A Skin/Wound Note dated 12/25/2025, documented Resident #6 was combative with staff during a brief change. During the brief change, Resident #6 had obtained a skin tear to the hand. The CNA had reported the skin tear to the Registered Nurse (RN). The RN had assessed the resident, located a skin (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tear, cleansed the skin tear, and applied barrier cream. Resident #28 Resident #28 was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease, unspecified and dementia in other disease classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Resident #8 Resident #8 was admitted to the facility on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right non-dominant side and vascular dementia, moderate, with agitation. A final FRI report for FRI #3029831, submitted by the facility on 06/02/2026, documented Resident #28 was touching Resident #8's back in the dining room on 05/30/2026. Resident #8 motioned for Resident #28 to move away. When Resident #28 did not move away, Resident #8 slapped Resident #28 on the hand. On 07/30/2026 at 9:36 AM, the Chief Nursing Officer (CNO) could not provide documentation of the facility's investigation for FRI #2591438, FRI #2703876, and FRI #3029831. The CNO confirmed FRI initial and final reports were provided to the State Agency; however, the documentation of the facility's investigation into each FRI could not be located. The CNO verbalized the Assistant Director of Nursing (ADON) had been trained by the previous Director of Nursing (DON) on what to do and what to keep related to FRI investigations. The CNO verbalized the CNO had gone through the ADON's office and could not locate documentation of the investigations. The CNO could not recall the details into each investigation, how the conclusions were made for each FRI, and confirmed all investigations into FRIs needed to be documented with all information necessary to substantiate or unsubstantiate each FRI. On 07/30/2026 at 1:09 PM, the DON verbalized the ADON typically completed most of the investigations for FRIs. The DON confirmed the DON had participated in the investigation process in the past and verbalized an investigation would typically include interviews with staff, review of camera footage, completing additional interviews if information didn't align, coming to a conclusion based on the information and putting changes in place or providing education to staff based on the conclusion. The DON verbalized any interviews and observations completed as part of the investigation should have been written down, dated, and timestamped. The facility policy titled Abuse Prevention, approved 07/22/2026, documented residents would be free from abuse, neglect, mistreatment, exploitation of person or property and isolation. Any alleged, suspected or observed behaviors by staff or visitors which could be indicative of prohibited behavior would be immediately reported as outlined in this policy or as required by law. Alleged, suspected or observed abuse, neglect, mistreatment or exploitation would be reported immediately and an investigation begun. The initial report would be made to the charge registered nurse. The charge nurse would notify administrative staff of the problem. Administrative staff, including the CNO and the (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Quality Management would be responsible to initiate and jointly conduct a thorough investigation into the situation reported. Documentation of the occurrence would be made in the nurses' progress notes. The report of alleged violation would be forwarded to the Director of Quality Management who was responsible to ensure all notifications, actions, findings and conclusions were documented. FRI #2591438, #2703876, and #3029831.		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interview and document review, the facility failed to document the specific needs the facility could not meet and attempts to meet the resident's needs when the facility declined to readmit a resident following an acute care hospitalization. This deficient practice had the potential for residents to be discharged from the facility without a safe discharge plan. Findings include: Resident #35 Resident #35 was admitted was admitted to the facility on [DATE], with diagnoses including quadriplegia, abnormal posture, chronic pain, idiopathic constipation and anxiety. On 04/13/2026 the facility issued Resident #35 a 30-day involuntary discharge notice. The discharge notice documented the reasons for discharge included failure to pay, possession of marijuana, recording staff without consent and violation of behavior agreement. On 4/23/2026 a typed letter, written by the facility's administrator documented the facility rescinded the 30-day involuntary discharge notice until an appropriate and safe alternative placement could be secured. A Nursing Note dated 05/12/2026, documented Resident #35 approached the Registered Nurse (RN) and reported chest tightness, chills/diaphoresis, headache and abdominal discomfort. The RN assessed the resident's abdomen, abdomen noted to be soft and not distended. The resident reported generalized discomfort without visible signs of acute distress. The RN obtained vital signs and offered to transfer the resident to the local emergency room (ER) for further evaluation. The resident refused, stating the resident had been there multiple times and they had not done anything. The resident stated the resident preferred to go to another ER instead. The RN notified the Director of Nursing (DON). The DON informed the RN there were two options. First was to go to the local ER and have ER-to-ER transfer if needed, or the facility could give the resident a ride to another ER using the facility van, if the resident was stable/safe enough, with the RN to go with the resident. The options were presented to the resident, and the resident chose the second option. Around 12:40 PM, the nurse and resident arrived at an acute care hospital ER. The resident wheeled into the ER and checked in. The RN handed paperwork to the ER staff and told both the resident and the ER staff to call the facility with any questions. The RN explained to the resident the RN was returning to the facility. A Doctor's Note dated 05/12/2026, documented Resident #35 was transported to the ER per the resident's choice. Nursing assessment reviewed and demonstrated Resident #35 was medically stable for transfer. Resident #35 was offered evaluation in the local ER and declined. While out of the facility, the physician requested housekeeping take the opportunity to clean Resident #35's room. The resident declined on multiple occasions to have the room cleaned which posed an infection control concern. An administrative decision was made to not readmit Resident #35 to the facility and the justification for the Notice of Decision Not to Readmit was reviewed by the physician. On 07/30/2026 at 10:05 AM a Licensed Practical Nurse (LPN) confirmed Resident #35 was generally independent with activities of daily living but required catheter care and bowel care. The LPN stated Resident #35 exhibited impulsive and verbally aggressive behaviors at times but reported the facility was able to meet Resident #35's care needs. On 07/30/2026 at 11:20 AM the Social Services Designee (SSD) confirmed the involuntary discharge notice had been rescinded after the Ombudsman informed the facility there was insufficient support for the discharge. The Social Worker stated the facility continued extending the discharge while attempting to locate a safe alternative placement and acknowledged a hospital was not considered a skilled nursing placement. The Social Worker could not verify whether the original notice had been signed by the resident. The facility's Bed Hold Policy documented, In an effort (continued on next page)		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to accommodate residents who are transferred to other facilities for more intense medical care, a bed hold will be placed on the resident's bed for a period of 7 days.The facility's Resident Rights Policy documented, the facility is required to provide residents transferred to a hospital written information regarding the facility's bed-hold policy and the resident's right to return to the facility.CPT 3040830Cross reference tags F550 and F628		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interview and document review, the facility failed to provide written notice of the facility's bed-hold policy to a resident and the resident's family member/legal representative upon transfer to an acute care hospital. This deficient practice had the potential to result in psychosocial harm to residents due to not being able to return to the facility and to the resident's previous room. Findings include: Resident #35 Resident #35 was admitted was admitted to the facility on [DATE], with diagnoses including quadriplegia, abnormal posture, chronic pain, idiopathic constipation and anxiety. A Nursing Note dated 05/12/2026, documented Resident #35 approached the Registered Nurse (RN) and reported chest tightness, chills/diaphoresis, headache and abdominal discomfort. The RN assessed the resident's abdomen, abdomen noted to be soft and not distended. The resident reported generalized discomfort without visible signs of acute distress. The RN obtained vital signs and offered to transfer the resident to the local emergency room (ER) for further evaluation. The resident refused, stating the resident had been there multiple times and they had not done anything. The resident stated the resident preferred to go to another ER instead. The RN notified the Director of Nursing (DON). The DON informed the RN there were two options. First was to go to the local ER and have ER-to-ER transfer if needed, or the facility could give the resident a ride to another ER using the facility van, if the resident was stable/safe enough, with the RN to go with the resident. The options were presented to the resident, and the resident chose the second option. Around 12:40 PM, the nurse and resident arrived at an acute care hospital ER. The resident wheeled into the ER and checked in. The RN handed paperwork to the ER staff and told both the resident and the ER staff to call the facility with any questions. The RN explained to the resident the RN was returning to the facility. A Doctor's Note dated 05/12/2026, documented Resident #35 was transported to the ER per the resident's choice. Nursing assessment reviewed and demonstrated Resident #35 was medically stable for transfer. Resident #35 was offered evaluation in the local ER and declined. While out of the facility, the physician requested housekeeping take the opportunity to clean Resident #35's room. The resident declined on multiple occasions to have the room cleaned which posed an infection control concern. An administrative decision was made to not readmit Resident #35 to the facility and the justification for the Notice of Decision Not to Readmit was reviewed by the physician. On 07/30/2026 at 11:20 AM the Social Services Designee (SSD) confirmed residents generally received a 30-day discharge notice for involuntary discharges and confirmed the facility had rescinded Resident #35's discharge notice after the Ombudsman informed the facility there was insufficient justification to discharge Resident #35. The SSD verbalized the facility continued to seek appropriate placement for Resident #35 and a hospital was not considered a skilled nursing placement. The SSD acknowledged she could not verify whether the resident had signed the discharge notice that had been rescinded. The SSD could not confirm whether Resident #35 received written bed-hold notice at the time of his hospital transfer and was not able to provide documentation of the bed-hold notice. The facility policy titled Bed Hold Policy, documented, In an effort to accommodate residents who are transferred to other facilities for more intense medical care, a bed hold will be placed on the resident's bed for a period of 7 days. The facility policy titled Resident Rights, (revised December 2015) documented before a nursing facility transferred a resident to a hospital or allowed a resident to go on therapeutic leave, the facility was to provide written information to the resident and a family member or legal representative specifying the duration of the (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed-hold policy under the State plan, if any, during which the resident was permitted to return and resume residence in the facility, as well as the facility's policies regarding bed-hold periods.CPT 3040830Cross reference tags F550 and F627		

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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 interview, clinical record review, and document review, the facility failed to ensure the safety of a resident with wandering behaviors when 1 of 13 sampled residents (Resident #9) eloped from the facility and staff failed to check all doors egressing to the outside when an audible door alarm was activated. The deficient practice had the potential for continued elopements from the facility resulting in injuries to the residents. Findings include: Resident #9 Resident #9 was admitted to the facility on [DATE], with diagnoses including vascular dementia, unspecified severity, agitation, insomnia, and disorder of kidney and ureter, unspecified. A Facility Reported Incident (FRI) dated 06/02/2026, documented Resident #9 had eloped from an alarmed door of the facility. Resident #9 was found outside on the ground and complained of pain and was sent to the emergency room for evaluation. A Fall progress note dated 06/01/2026, documented Resident #9 had an unwitnessed fall after exiting the facility through the back hallway door. Resident #9 was found on the street out of the wheelchair with an abrasion to the left hand little finger and tenderness to the left lower extremity. The emergency room was called for physicians to examine Resident #9. A Communication progress note dated 06/02/2026, documented Resident #9 had sustained a ground level fall outside of the facility. Resident #9 had left leg pain and a computed tomography (CT) scan was completed. The CT scan impression showed an age indeterminate defect across the greater trochanter of the left proximal femur with fragments separated by less than four millimeters, possibly representing an acute or chronic fracture. Resident #9 verbally expressed pain when weight was applied to the lower left extremity. Resident #9's exit seeking care plan initiated on 06/29/2026, documented Resident #9 often exit seeks by opening and shaking exit doors. Interventions included taking Resident #9 to the porch or for short walks upon request. Resident #9's elopement care plan initiated 06/02/2026, documented Resident #9 had exited the facility through doors near the physical therapy department on 06/01/2026. Interventions included all staff being in serviced on door alarm response. The facility's internal investigation included statements from three employees working during Resident #9's elopement. Statement #1 dated 06/02/2026, documented an alarm sounding at approximately 8:10 PM. The employee checked two facility doors but failed to check the final door in the hallway. The employee reset the alarm and was unaware Resident #9 had eloped. Statement #2 dated 06/01/2026, documented at approximately 7:30 PM the door alarm sounded while the employee was assisting another resident. The employee rushed care and attempted to check the alarm status. The employee heard the alarm shut off and assumed the situation had been handled. Statement #3 dated 06/02/2026, documented during approximately the times of 7:30 PM to 8:00 PM, Resident #9 had eloped. The employee heard the alarm sound shut off. The employee assumed the situation had been addressed and did not follow up to verify resolution. On 07/30/2026 at 9:36 AM, the Chief Nursing Officer (CNO) explained Resident #9 was an elopement risk and attempted exit seeking behaviors daily. Staff had attempted stop strips across doors but were informed these could not be placed on emergency exits. Staff were required to keep Resident #9 within line of sight. The CNO verbalized on 06/01/2026, Resident #9 had eloped from the facility through the door next to the physical therapy department. Staff were not previously trained to check that door when alarms sounded. When the alarm sounded in the facility, staff checked the main door to the facility and the door next to activities. Staff did not observe anyone outside of those doors, assumed the issue was resolved, and deactivated the alarm. The CNO verbalized a passerby discovered Resident #9 outside next to a toppled wheelchair. Staff (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	retrieved Resident #9 and sent the resident to the Emergency Room. The CNO explained reviewing camera footage on the night of 06/01/2026, and discovered Resident #9 had been outside for approximately 10 minutes before staff were able to locate the resident. The CNO verbalized all staff were in-serviced after the incident and instructed to check all three doors when the alarm sounded. On 07/30/2026 at 12:29 PM, a CNA explained Resident #9 had an increase in aggression several days prior to the resident eloping from the facility. The CNA could not recall an in-service training provided to staff; however, was able to recall being instructed to check all three doors every 30 minutes. When staff check the doors, the staff were to be checking to make sure alarms functioned and documented completion of the check in a binder located at the nursing station. On 07/30/2026 at 1:13 PM, a Licensed Practical Nurse (LPN) verbalized Resident #9 had weekly behaviors related to exit seeking behaviors. The LPN explained staff were required to check all the doors every 30 minutes; however, prior to the resident's elopement, staff were only checking two of the three doors if the alarm sounded. The LPN verbalized there was no formal system in place prior to the incident and confirmed because there was no formal system in place to check the doors, the resident eloped from the facility and experienced an injury. The facility policy titled Abuse Prevention last revised May 2023, documented neglect was the failure of a person who had a legal responsibility or a contractual obligation, or had voluntarily assumed responsibility to care for an older person, including failure to provide food, shelter, clothing, or services necessary to maintain the physical or mental health of that person. Abuse would be prevented by ensuring residents would be assessed and provided prevention methods to avoid abuse and neglect from occurring. FRI #3035419		