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	07/24/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, interview, and document review, the facility failed to ensure a resident with intellectual disabilities (Resident #20) was provided the necessary care and services to address the resident's scratching and picking at their arms and legs. This deficient practice had the potential to cause the resident preventable discomfort and placed the resident at risk of skin infections from scratching and picking at skin. Findings include:Resident #20 was admitted to the facility on [DATE], with diagnoses including traumatic subarachnoid hemorrhage with loss of consciousness status unknown, subsequent encounter, mild intellectual disabilities, and unspecified dementia, unspecified severity, with agitation.Resident #20's Comprehensive Care Plan documented a care plan related to communication. The care plan documented an alteration in communication related to intellectual disability, dementia. The interventions included determining the resident's communication methods and comprehension level and adapt communication techniques based on the resident's responses.Resident #20's Comprehensive Care Plan documented a care plan for the use of the medication hydroxyzine. The care plan documented the resident was prone scratching and picking at the resident's skin and causing bleeding. The care plan included interventions related to the adverse side effects of the medication.A physician's order documented to wash arms and apply lotion to both arms. Apply geri sleeves to both arms related to the resident picking and scratching. If geri sleeves were not available, may use tubi grip.A physician's order documented Hydroxyzine 25 milligram (mg) tabs, give 25 mg by mouth every eight hours as needed for itching, scratching causing bleeding, and picking at skin. The medication had a start date of 07/15/2025.Resident #20's Medication Administration Record for July 2025, documented the medication was given one time on 07/17 and 07/18/2025, and twice on 07/19/2025.A Communication with physician note dated 06/28/2025, documented Resident #20 had open areas and scratch marks to the left shin. Blood was noted on the resident's fingers from scratching and active bleeding was observed. There were multiple small, scattered broken spots.An Orders Administration Note dated 06/28/2025, documented Resident #20's right shin had scattered open spots.A Communication with Family note dated 07/15/25, documented Resident #20 documented Resident #20 was being given hydroxyzine for scratching and picking at both arms and both legs.On 07/21/2025 at 11:23 AM, Resident #20 had geri sleeves to both arms what appeared to be scratch marks could be seen on the resident's wrists.On 07/24/2025 at 8:38 AM, a Licensed Practical Nurse (LPN) verbalized Resident #20 wore geri sleeves to help prevent scratching and picking at the resident's skin.On 07/24/2025 at 8:42 AM, the LPN verbalized Resident #20 did not have the cognitive ability to ask for PRN medications and was not sure why the medication was ordered as a PRN medication. The LPN explained nurses would give the resident hydroxyzine if they noticed the resident scratching The LPN confirmed the resident was not capable of telling anyone when the resident was feeling itchy.On 07/24/2025 at 11:30 AM, the Chief Executive Officer (CEO) and the interim Director of Nursing (DON) verbalized they would like to defer resident questions to Registered Nurse (RN1) due to RN1 spent more time with the residents. The CEO and DON confirmed the preference to have questions deferred to RN1.On 07/24/2025 at 12:50 PM, RN1 verbalized RN1 was not sure why the Resident #20 had an order for PRN hydroxyzine rather than scheduled. RN1 explained nurses knew when Resident #20 needed a dose of Hydroxyzine when nurses observed the resident itching and scratching. The RN confirmed Resident #20 did not have the ability to ask for medications when needed.A facility policy titled Care of Residents with Intellectual and Developmental Disabilities dated 08/2022, documented Intellectual Disability (ID) was a disability characterized by significant limitations in intellectual functioning and adaptive behavior. The facility ensured the provision of appropriate and individualized care to residents with intellectual and developmental and intellectual disabilities.

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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. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to ensure 1 of 13 sampled residents (Resident #1) was provided medication for pain relief per the physician's order and failed to ensure medications prescribed for pain as needed (PRN) included the severity of pain the medication was prescribed for. This deficient practice had the potential to result in discomfort, prolonged or unmanaged pain and/or an adverse drug event.Findings include:Resident #1 was admitted to the facility on [DATE], with diagnoses including alcoholic cirrhosis of the liver without ascites, pain, unspecified, low back pain, unspecified, and age-related osteoporosis without current pathological fracture.A Physician's order dated 10/30/2024, documented to give Tylenol (acetaminophen) give 650 milligrams (mg) by mouth every four hours as needed for general discomfort for a pain level 1-4.The order did not specify the pain scale to used, such as 0-10, and did not include instructions regarding how much acetaminophen not to exceed (NTE) during a 24 time frame. (3,250 milligrams, (mg) of acetaminophen should not be exceeded during a 24 hour time frame)A Physician's order dated 06/28/2025, documented to give Percocet oral tablet 5-325 mg (oxycodone/acetaminophen), give one tablet by mouth every eight hours as needed for pain, unspecified. The order did not include instructions regarding the pain level (mild, moderate, severe) to administer the medication for and did not include a method for assessing the pain such as a numeric pain scale of 0-10. The order did not include NTE instructions for acetaminophen.Resident #1's Medication Administration Record (MAR) dated June 2025, documented from 06/01/2025 - 06/30/2025, Resident #1 was not administered Tylenol including when the resident reported a pain level of four.Resident #1's MAR dated June 2025, documented from 06/28/2025 - 6/30/2025, the resident was administered Percocet two times per day on 06/28/2025, and three times per day 06/29 and 06/30/2025. Percocet was administered for a pain level of four one time on 06/30/2025.Resident #1's MAR dated July 2025, documented the resident was not given Tylenol during July 2025, including for pain rated at 4.Resident #1's MAR dated July 2025, documented the resident was administered Percocet as follows:-07/01/2025 - 07/21/2025, Resident #1 was given Percocet two times per day for seven in 21 days. The resident was given Percocet three times per day for 14 times in 21 days.The MAR documented Resident #1 reported pain levels at four or less and was administered Percocet and not Tylenol as follows:-A pain level of zero was documented one time on 07/06/2025.-A pain level of one was documented one time on 07/02/2025.-A pain level of four was documented four times on 07/01, 07/20, 07/21, and 07/22/2025.Resident #1's Comprehensive Care Plan included a care plan initiated on 01/13/2025 for increased back pain related to chronic compression fractures. The care plan documented the resident had Computed Topography (CT). The CT found the resident had acute/sub-acute and chronic compression fractures, retropulsion of bone fragments causing stenosis of the spinal cord, and bilateral neural foramina.The resident reported chronic pain in the resident's left leg related to an old fracture with hardware. The resident had arthritis and plate in the right leg.The care plan documented to administer pain medications as ordered and keep the physician updated on effectiveness/ineffectiveness.On 07/21/2025 at 2:24 PM, Resident #1 verbalized the resident had chronic pain and the resident's pain was worse when it was cold. The resident verbalized the resident's room was always cold, especially at night. The resident explained the resident had back pain from compression fractures of the spine and the pain was often pretty bad.On 07/24/2025 at 8:11 AM, a Licensed Practical Nurse (LPN) verbalized pain was what ever the resident said it was. A numerical scale of 0-10 was used to assess residents pain.On 07/24/2025 at 8:14 AM, the LPN confirmed Resident #1's order for Tylenol included a pain rating of 1-4, and confirmed the resident's Percocet did not include parameters, such as a numerical scale.On 07/24/2025 at 12:26 PM, a Registered Nurse (RN) verbalized Resident #1 watched the clock and did not have the signs of pain you would expect to see. The RN acknowledged the resident had back surgery for compression fractures and had been on a lot of pain medications during this time.On 07/24/2025 at 12:38 PM, the RN confirmed Resident #1's order for Percocet was written for generalized pain and did not include a pain scale. The RN explained physician orders for PRN medications at the facility were sometimes entered for mild, moderate, or severe pain but did not include a pain scale to define what mild, moderate, and severe pain were on a pain scale. The RN verbalized not being familiar with setting parameters for PRN pain medications when there was more than one medication ordered for pain.On 07/24/2025 at 2:40 PM, the Interim Director of Nursing (DON) confirmed Resident #1's order for Percocet should have included parameters, and when the resident reported a pain of

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interview, and document review, the facility failed to ensure coordination of care between the facility and the dialysis center, a written contract and/or agreement with the dialysis provider, and a dialysis policy was developed for the care of a resident on dialysis for 1 of 13 sampled residents (Resident #2). This deficient practice had the potential to result in unmonitored and uncoordinated care for all residents on dialysis in the facility, and a preventable adverse event.Findings include: Resident #2 Resident #2 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including end stage renal disease and dependence on renal dialysis. A Comprehensive Care Plan included care plan initiated 07/22/2025, documenting Resident #2 required hemodialysis related to a diagnosis of end stage renal disease. A physician's order dated 04/25/2025, documented to take vital signs upon return from Dialysis on Mondays, Wednesdays, and Fridays one time a day. Resident #2's clinical record lacked documentation of an order for hemodialysis. The Dialysis and Nursing Home Handoff Communication Tool forms from May 2025 through July 2025, lacked documentation in the to be completed by dialysis section on the following dates:-05/02/2025.-05/23/2025.-05/31/2025.-06/02/2025.-06/06/2025.-06/11/2025.-06/16/2025. On 07/24/2025 at 9:14 AM, a Licensed Practical Nurse (LPN) verbalized Resident #2 was on dialysis and the [NAME] coordinated treatment with the dialysis center. The LPN explained the dialysis center provided all of Resident #2's care related to dialysis, including care of the fistula. The LPN verbalized the facility did measure vitals prior to dialysis appointments, however the dialysis center took responsibility for weighing the resident. The LPN verbalized if the LPN wanted to know the policy and procedures related to caring for a resident on dialysis, the LPN would reach out to the Interrem Director of Nursing (DON). On 07/24/2025 at 10:02 AM, the DON verbalized the facility did not have a contract with the dialysis center outlining roles and responsibilities of the dialysis center and the facility. The DON also verbalized the facility did not have a dialysis policy. The DON was unsure how staff would know how to care for residents on dialysis without a dialysis policy. On 07/24/2025 at 10:41 AM, the Chief Executive Officer (CEO) explained Resident #2 was the first and only resident on dialysis to be admitted to the facility. Resident #2's admission was discussed in depth at the monthly utilization review committee and was determined Resident #2 could be retained at the facility if the [NAME] took responsibility for the resident's transportation to and from the dialysis center. The CEO explained the facility was not responsible for any of the resident's care related to dialysis because the facility was not a dialysis center. The dialysis center took responsibility for the safety of the resident. The CEO explained confirmed there were no orders in Resident #2's clinical record for hemodialysis because the situation was treated the same as if the resident went home after a dialysis treatment. The facility was only responsible for taking pre and post treatment vitals. If there was a concern with the fistula site, the facility would refer the resident to the nephrologist at the Dialysis center. The CEO verbalized being unsure whether staff monitored the fistula site. On 07/24/2025 at 1:06 PM, the CEO explained the facility did not have a contract with the dialysis center because the facility would need to have a contract for everything, and the facility was not prepared to have a commitment over the resident's life. The CEO explained the facility was not involved with the dialysis center. The dialysis center took responsibility for the dialysis and the facility took responsibility of everything else while the resident was in the facility. The CEO verbalized being unsure what was expected of nursing staff for the care of residents on dialysis, what staff would monitor residents on dialysis for, and what information the facility received from the dialysis center. The CEO confirmed the incomplete Dialysis and Nursing Home Handoff Communication Tool form and verbalized being unsure whether staff reviewed the forms upon return to the facility. The CEO confirmed a contract with the dialysis center could assist in outlining responsibilities of the facility and the dialysis center to ensure coordination of care was implemented.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and document review, the facility failed to ensure the facility had a full time Director of Nursing (DON). This deficient practice could have allowed all 27 residents residing in the facility on the affected date to go without proper assessments or certain cares Registered Nurses (RN), Licensed Practical Nurses (LPN), and Certified Nursing Assistants (CNA) perform and compromise the supervision of proper assessments and proper care due to lack of oversight. Findings include: On 07/21/2025, during entrance conference, the Chief Executive Officer (CEO) explained the current Chief Nursing Officer (CNO) was acting as the Interim Director of Nursing (DON) until the position was filled. The Facility Assessment, last reviewed 03/2025, documented the Skilled Nursing Facility required a DON and hours would be based off of the facility needs. The Staffing Schedule for the week of 07/13/2025 through 07/26/2025, documented the DON was working in the facility for 32 hours each week. On 07/24/2025 at 8:51 AM, the DON explained working for the facility a total of 40 hours each week and the time worked was split working for the hospital 80 percent (%) of the time and working for the Long Term Care 20% of the total time. The DON verbalized working eight hours per week for the facility and confirmed the facility did not have a full time DON.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and document review, the facility failed to ensure a resident's Oxygen flow was administered per physician orders for a resident with chronic obstructive pulmonary disease for 1 of 13 sampled residents (Resident #9). This deficient practice had the potential to result in low Oxygen saturations and harm to the resident.Findings include: Resident #9 Resident #9 was admitted to the facility on [DATE], with diagnoses including chronic respiratory failure with hypoxia and chronic obstructive pulmonary disease, unspecified. A physician's order dated 09/26/2023, documented Oxygen (O2) via nasal canula (NC) at three liters per minute (LPM) as needed for shortness of breath. May remove as desired if breathing is comfortable. An Oxygen Saturations Summary Report documented an Oxygen flow of two LPM on the following dates:-On 07/06/2025 at 10:39 PM.-On 06/10/2025 at 8:22 PM.-On 06/09/2025 at 9:08 PM. -On 06/08/2025 at 8:03 PM.-On 05/01/2025 at 10:10 PM.-On 04/29/2025 at 8:13 PM. On 07/21/2025 at 9:53 AM, Resident #9 wore Oxygen via NC. Resident #9's oxygen concentrator was set to a flow of two LPM. On 07/21/2025 at 9:53 AM, Resident #9 verbalized Resident #9 wore Oxygen all the time and often needed to gasp for air. Resident #9 verbalized Resident #9's Oxygen was supposed to be set at four LPM. 07/23/2025 at 9:56 AM, a Licensed Practical Nurse (LPN) verbalized Resident #9's clinical record included a physician's order for Oxygen at three LPM as needed to address difficulty breathing. The LPN explained Resident #9 wore the Oxygen continuously because the resident's Oxygen levels desaturated when not in use. The LPN verbalized the resident did not have a known behavior of changing the Oxygen flow on the resident's oxygen concentrator. The LPN verbalized the LPN measured Resident #9's Oxygen saturations once a day and ensured the oxygen concentrator was at the dose prescribed per physician's orders. On 07/23/2025 at 10:10 AM, Resident #9 wore Oxygen via NC. Resident #9's Oxygen concentrator was set to a flow of two LPM. On 07/23/2025 at 10:10 AM, Resident #9 verbalized the resident was struggling to breathe and requested an as needed breathing treatment. On 07/23/2025 at 10:10 AM, the LPN observed Resident #9's oxygen concentrator and verbalized the flow was set to right below two LPM. The LPN verbalized Resident #9's clinical record did not include a physician order for Oxygen titration. The LPN explained it was important for Resident #9 to have Oxygen at the prescribed level to prevent shortness of breath and hyperventilation. On 07/23/2025 at 10:21 AM, the Interim Director of Nursing (DON) verbalized the DON expected medications to be administered at the correct dose as outlined in the physician order. The DON confirmed Oxygen was considered a medication. The DON verbalized Resident #9 did not wear the Oxygen continuously, however did use Oxygen fairly often. The DON reviewed Resident #9's clinical record and confirmed the resident had a physician order to administer Oxygen at three LPM. The DON confirmed Resident #9's Oxygen Saturations Summary Report documented Resident #9 received Oxygen at two LPM, against the physician's order of three LPM. 07/23/2025 at 11:26 AM, Resident #9 verbalized the resident did not touch the oxygen concentrator. All Oxygen was administered by the facility. The resident explained even if the resident wanted to change the resident's oxygen flow, Resident #9 would not know where to look or what to do. On 07/23/2025 at 11:28 AM, the DON verbalized the DON would consider a medication administered at an incorrect dose to be a medication error. The facility policy titled, Administration of Medications, revised 01/2021, documented prior to administering any medications, the administering nurse was to consider the ten rights: right resident, right drug, right dose, right route, right time, right documentation, right client education, right to refuse, right assessment, and right evaluation. Cross reference with F842.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on observation, interview, clinical record review, and document review, the facility failed to ensure the Facility Assessment (FA) was accurate and included nicotine dependence and addiction with the facility's common diagnoses and conditions. This deficient practice had the potential to result in facility staff not receiving adequate training on the care of residents with nicotine dependence and addiction diagnoses and the needs of those residents not being met. Findings include: During the entrance conference with the facility on 07/21/2025, a list of cigarette smokers (smokers) residing in the facility and the FA was provided by the facility. The list of smokers in the facility included five residents. The smoking location was designated off the outside patio accessed through the facility dining room. The Facility Assessment last reviewed March 2025, did not include nicotine abuse or addiction nor a list of the number of active or current substance abuse disorders. On 07/24/2025 at 8:37 AM, the Interim Director of Nursing (DON) verbalized the DON assisted with reviewing and completing the FA. The DON confirmed nicotine addiction was not identified on the FA as a diagnosis in the facility and the FA lacked documented evidence of the number of residents with active or current substance use disorders. The DON confirmed five residents in the facility were current cigarette smokers. The Centers for Disease Control and Prevention article titled Treatment of Substance Use Disorders, dated 04/25/2024, documented a substance use disorder was a treatable, chronic disease and could range in severity from moderate to severe. A substance use disorder could be applied to many types of drugs including tobacco (nicotine). The facility policy titled Facility Assessment Plan, undated, documented the FA would include the care required by the resident population considering the types of diseases and other pertinent facts present within the population.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and document review, the facility failed to ensure a resident's Oxygen administration was documented in the resident's medication administration record (MAR) for 1 of 13 sampled residents (Resident #9). This deficient practice had the potential to result in unmanaged Oxygen saturation levels.Findings include: Resident #9 Resident #9 was admitted to the facility on [DATE], with diagnoses including chronic respiratory failure with hypoxia and chronic obstructive pulmonary disease, unspecified. A physician's order dated 09/26/2023, documented to administer Oxygen (O2) via nasal canula (NC) at three liters per minute (LPM) as needed for shortness of breath. May remove as desired if breathing is comfortable. An Oxygen Saturations Summary Report documented an Oxygen flow of two LPM on the following dates:-On 07/06/2025 at 10:39 PM.-On 06/10/2025 at 8:22 PM.-On 06/09/2025 at 9:08 PM.-On 06/08/2025 at 8:03 PM.-On 05/01/2025 at 10:10 PM.-On 04/29/2025 at 8:13 PM. Resident #9's May, June, and July 2025 MARs lacked documentation Oxygen was administered on any day within the three-month time span. On 07/21/2025 at 9:53 AM, Resident #9 wore Oxygen via NC. Resident #9's oxygen concentrator was set to a flow of two LPM. On 07/21/2025 at 9:53 AM, Resident #9 verbalized the resident wore Oxygen all the time and often needed to gasp for air. Resident #9 verbalized believing Resident #9's Oxygen was supposed to be set at four LPM. On 07/21/2025 at 11:58 AM, Resident #9 wore Oxygen via NC. 07/23/2025 at 9:56 AM, a Licensed Practical Nurse (LPN) verbalized Resident #9's clinical record included a physician order for Oxygen at three LPM as needed to address difficulty breathing. The LPN explained Resident #9 wore the Oxygen continuously because the resident's Oxygen levels desaturated when not in use. The LPN verbalized the LPN did not document Resident #9's Oxygen administration anywhere in the electronic health record (EHR). On 07/23/2025 at 10:10 AM, Resident #9 wore Oxygen via NC. Resident #9's oxygen concentrator was set to a flow of two LPM. On 07/23/2025 at 10:10 AM, the LPN observed Resident #9's oxygen concentrator and verbalized the flow was set to right below two LPM. On 07/23/2025 at 10:21 AM, the Interim Director of Nursing (DON) verbalized the DON expected medication administration to be documented on the MAR at the time of administration. The DON confirmed Oxygen was considered a medication. The DON explained it was important to document as needed Oxygen administration to determine how often Oxygen was used and to assess whether the resident would benefit from alterations in the resident's medication regimen. The DON verbalized Resident #9 did not wear the Oxygen continuously, however did use Oxygen fairly often and had periodically observed the resident wearing the Oxygen. The DON confirmed Resident #9's May, June and July 2025 MARs lacked documented evidence of Oxygen administration on any day within the three-month time span. The DON verbalized the Oxygen administration should have been documented in the resident's MAR. 07/23/2025 at 11:26 AM, Resident #9 verbalized the resident did not touch the oxygen concentrator. All Oxygen was administered by the facility. The resident explained even if the resident wanted to change the resident's oxygen flow, Resident #9 would not know where to look or what to do. The facility policy titled, Administration of Medications, revised 01/2021, documented prior to administering any medications, the administering nurse was to consider the ten rights: right resident, right drug, right dose, right route, right time, right documentation, right client education, right to refuse, right assessment, and right evaluation. Chart all administered medication and treatments in the EHR within appropriate timeframes, and include all required information needed for the medication or treatment. Cross reference with F760.

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	295011	A. Building B. Wing	07/24/2025

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and document review, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to identify a concern and ensure corrective action was implemented related to the lack of tracking and trending of infections and antibiotic use within the Antibiotic Stewardship Program (ASP). This deficient practice had the potential to result in unnecessary antibiotic use and the development of antibiotic-resistant organisms.Findings include: On 07/24/2025 at 3:11 PM, during the QAPI review with the Chief Executive Officer (CEO), the CEO verbalized the facility ceased tracking of infection prevention and control from August 2024 through May 2025, due to not having an Infection Preventionist on staff at the facility. The CEO explained as a result, the QAPI committee did not identify a concern related to the lack of antibiotic stewardship tracking for resident antibiotics. The facility policy titled, Quality Management Program, revised 06/2025, documented the performance improvement plan would address all systems of care and management practice. Performance measures known to jeopardize the safety of residents would be monitored. At a minimum, performance measures related to medication management and infection prevention and control would be monitored by the performance improvement committee. Cross reference with F881 and F882.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and document review, the facility failed to ensure Transmission-Based Precautions (TBP) were implemented according to facility policy and Centers for Disease Control and Prevention (CDC) recommendations for 1 of 13 sampled residents (Resident #6). This deficient practice had the potential to increase risk of spreading infectious organisms throughout the facility. Findings include: Resident #6 Resident #6 was admitted to the facility on [DATE], with a diagnosis of methicillin resistant staphylococcus aureus (MRSA) infection, unspecified site. An aerobic bacterial culture report dated 03/27/2025, documented light growth of MRSA to the resident's left leg. A hospital Discharge summary dated [DATE], documented an order for contact precautions related to MRSA. A Comprehensive Care Plan included a care plan initiated 06/18/2025, documenting Resident #6 had a chronic fistula to the left inner knee related to chronic MRSA. An intervention initiated 04/06/2025, documented to instruct family, visitors, and caregivers to wear a disposable gown and gloves during physical contact with the resident. An intervention initiated 07/18/2025, documented contact precautions would be followed when providing treatment to the resident's wound. Resident #6's clinical record lacked documentation of an active order for contact precautions. On 07/21/2025 at 1:45 PM, the entrance of Resident #6's room lacked TBP signage and a Personal Protective Equipment (PPE) cart. On 07/21/2025 at 1:45 PM, Resident #6 verbalized Resident #6 had a staph (staphylococcus) infection in the resident's left inner thigh. On 07/23/2025 at 2:43 PM, Resident #6 verbalized staff wore gloves when providing wound care, transfer and dressing assistance, and food service. However, staff did not wear gowns or wear face masks at any point. On 07/23/2025 at 3:08 PM, a Certified Nursing Assistant (CNA) entered Resident #6's room, did not don PPE, provided snack service and pulled the blanket up to the resident's chest. The CNA washed their hands prior to exiting the resident's room. On 07/23/2025 at 3:11 PM, the CNA verbalized staff would don a gown and gloves prior to touching a resident or their environment for residents with MRSA. The CNA verbalized expecting a sign and PPE cart outside the room of a resident on TBP. The CNA verbalized being unaware Resident #6 had an active MRSA diagnosis and confirmed the CNA did not don PPE prior to entering Resident #6's room and touching the resident's environment. On 07/23/2025 at 3:15 PM, a Registered Nurse (RN) verbalized contact precautions were required for residents with confirmed or suspected contagious infections in order to prevent spread to residents and staff. Residents on contact precautions were to be given private rooms if available. The RN explained the Infection Preventionist (IP) was responsible for determining who would require TBP as well as ensuring signage and carts were present at room entrances. The RN confirmed Resident #6 was admitted to the facility with an active diagnosis of MRSA and described MRSA to be a highly transmissible infection. The RN confirmed a care plan indicating the use of contact precautions was included in Resident #6's clinical record. The RN verbalized the resident was not on contact precautions. On 07/24/2025 at 11:16 AM, the IP verbalized contact precautions were a type of TBP appropriate for residents with known or suspected infections of multidrug-resistant organisms (MDROs). Contact precautions required the use of gloves and gowns when caring for residents to protect both residents and staff. The IP would expect to see signage and carts available outside the rooms of residents on contact precautions. The IP verbalized the IP would expect residents with an active diagnosis of MRSA to be on contact precautions. The IP explained Resident #6 had an ongoing fistula with drainage and an active diagnosis of MRSA. The IP confirmed Resident #6 should have been on contact precautions. The facility policy titled Transmission Based Precautions, revised 08/2024, documented TBP was used for residents with a documented or suspected infection or colonization with highly transmissible pathogens. Contact precautions would be used for residents with known or suspected infections or evidence of syndromes that represent an increased risk for contact transmission. The facility followed CDC pathogen-specific recommendations. The CDC document titled 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, updated 09/2024, documented MDROs were generally defined as microorganisms which were resistant to one or more classes of antimicrobial agents. MDROs of concern included MRSA. Documented outbreaks in long-term care facilities were caused by various viruses and bacteria and could lead to substantial morbidity and mortality and increased medical costs. Prompt detection and implementation of effective control measures were required. Placement of a resident in a single room was preferred when there was concern about transmission of an infectious agent, including residents on contact and droplet precautions

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on document review and interview, the facility failed to ensure the facility maintained an Antibiotic Stewardship Program (ASP) including tracking and trending of infections and antibiotic use from 08/2024 through 05/30/2025. This deficient practice had the potential to result in residents not receiving the correct or best antibiotic for infections resulting in prolonged or exacerbated infections and the spread of infections throughout the facility.Findings include:On 07/24/2025 at 2:46 PM, the facility was not able to provide documented evidence of an ASP, including tracking and trending of infections and antibiotic use between 08/2024 and 05/30/2025. On 07/24/2025 at 2:47 PM, the Infection Preventionist (IP) confirmed the IP had not been documenting data related to tracking and trending of infections and antibiotic use. The IP explained how the IP tracked infections and antibiotic use and monitored for trends but did not document the findings. The IP began working at the facility on 05/12/2025 and began to perform tracking and trending of infections and antibiotic use on 05/30/2025.On 07/24/2025 at 3:12 PM, the interim Director of Nursing (DON) confirmed the facility was not able provide documented evidence of an ASP, including tracking and trending between 08/2024 and 05/30/2025. The DON explained the concern with not having an ASP, including tracking and trending was the risk of increased infections throughout the facility.The facility policy titled Antimicrobial Stewardship Program last revised 12/2024, documented the ASP proactively monitored for the use of antimicrobial prescriptions. The IP summarized and kept records of the antibiotic use from electronic health records and laboratory data. The data included the culture site and organism, infection start date, antibiotic name, strength, date, duration, how the medication was administered, antibiotic sensitivity, and if the infection was a healthcare associated infection or a community acquired infection. The IP used the Long Term Care Infection Map to document all infections each month. The IP monitored and kept track of the communication from the clinical staff regarding infections and prescribed antibiotics, the Four Moments document including the antibiotic time out information, and resident/guardian education, signatures and dates.Cross reference with F865 and F882

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on document review and interview, the facility failed to ensure an Infection Preventionist (IP) was employed by the facility at least part time each month from 12/27/2024 to 05/12/2025. This deficient practice had the potential to result in lapses in infection control and the Antibiotic Stewardship (ASP) program with potential for infections to spread throughout the facility and residents to be treated with ineffective antibiotics. Findings include: A facility document titled Payroll Status Form documented IP-1's last day of work at the facility was 12/26/2024. A facility document titled Payroll Status Form documented IP-2's first date of work at the facility was 05/12/2025. On 07/23/2025 at 8:42 AM, the Human Resource Manager (HRM) confirmed IP-1's last day of work at the facility was 12/26/2024, and IP-2's first day of work at the facility was 05/12/2025. The HRM verbalized to the best of the HRM's knowledge, there was not another individual who worked as an IP at the facility between 12/26/2024 and 05/12/2025. 07/23/2025 at 3:12 PM, the Chief Executive Officer (CEO) verbalized there were two additional employees at the facility with IP certification. The CEO confirmed the two additional employees had not worked in the role of the facility's IP including the antibiotic stewardship program, immunization, education of staff and residents, and surveillance of infection control practices throughout the facility. On 07/23/2025 at 3:13 PM, the interim Director of Nursing (DON) confirmed an IP had not worked at the facility from 12/27/2024 through 05/11/2025. The DON verbalized not having an IP working at the facility during this time span and the lack of oversight of the facility's Infection Prevention and Control Program and Antibiotic Stewardship Program could lead to increased infections throughout the facility.Cross reference with F881