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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295020	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosewood Rehabilitation Center	2045 Silverada Blvd Reno, NV 89512

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34524 Based on clinical record review, interview, and document review, the facility failed to provide care to prevent Moisture Associated Skin Damage and a pressure injury for 1 of 4 closed records reviewed (Resident #184). This deficient practice led to a skin injury. Findings include: Resident #184 Resident #184 was admitted to the facility on [DATE], with diagnoses including displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing, and type two diabetes mellitus with foot ulcer. The resident was discharged on [DATE]. Resident #184's Daily Skilled Note dated 07/05/2024, documented no active skin conditions. Resident #184's Nursing Note dated 07/09/2024, documented a Certified Nursing Assistant (CNA) was doing rounds and noticed redness and an open area on the resident's coccyx . The nurse told the CNA to put cream on the resident and ensure the resident was being changed every two hours. Resident #184's Licensed Nurse Skin Evaluation dated 07/09/2024, documented redness and an open area to the coccyx, wound nurse aware. Resident #184's Daily Skilled Note dated 07/10/2024, documented Moisture Associated Skin Damage (MASD) located on buttocks. Resident response to treatment was continued weekly skin checks, barrier cream treatment to coccyx, pressure reducing device for chair and bed to maintain skin integrity, and turning/repositioning program to maintain skin integrity. A physician's order dated 07/03/2024, documented apply barrier cream on buttocks/perianal area every brief change, every shift, with indication for skin breakdown prevention protocol. A physician's order dated 07/03/2024, documented encourage and assist in turning and repositioning every shift. A physician's order dated 07/09/2024, documented equagel cushion for wheelchair, ensure placement every shift. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 07/09/2024, documented low air loss mattress for skin maintenance. A physician's order dated 07/13/2024, documented Wound: unstageable pressure injury to coccyx. Cleanse with wound cleanser, apply leptospermum honey gel, and cover. Monitor for signs and symptoms of infection every day shift, Monday, Wednesday, and Friday. Resident #184's Minimum Data Set 3.0 Assessment (MDS) Section M - Skin Conditions, dated 07/15/2024, documented one unhealed, unstageable pressure ulcer. On 10/09/2024 at 3:23 PM, the Wound Nurse verbalized Resident #184 did not admit to the facility with a pressure injury. The Wound Nurse explained MASD could be caused by incontinence or excess moisture in the area. The Wound Nurse confirmed Resident #184 developed MASD and a pressure injury in the facility. On 10/10/2024 at 9:13 AM, the Director of Nursing (DON) verbalized Resident #184 did not admit to the facility with a wound on the coccyx. The DON explained MASD could be caused by incontinence, excess moisture, and warmth. Repositioning, peri care, and barrier cream would help prevent a wound from developing. The DON confirmed the pressure injury was acquired at the facility. The facility policy titled Skin and Wound Monitoring and Management, revised 12/2023, documented it was the policy of the facility, a resident who entered the facility without a pressure injury not develop a pressure injury unless the resident's clinical condition or other factors demonstrated the pressure injury was unavoidable. Complaint #NV00071992

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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. 31739 Based on clinical record review, observation, interview, and document review, the facility failed to ensure a known tripping hazard was corrected to prevent potential falls by residents and visitors using the outside courtyard. Findings include: The Facility Reported Incident (FRI) #NV00071929, dated 08/13/2024, documented a resident was witnessed tripping over an irrigation sprinkler head in the courtyard, resulting in a fracture to the right elbow and patella. FRI #NV00071929 Final Report, dated 08/16/2024, documented the action taken to prevent future occurrences included education to the resident on mobility and safety outdoors. The Final Report lacked language to include the corrective measure(s) taken to prevent future occurrences of tripping caused by the sprinkler heads in the courtyard. On 10/09/2024 at 1:55 PM, the sprinkler heads located in the courtyard, between the grass and a concrete walkway, were in the off position. Five of the sprinkler heads were raised above the level of the ground approximately 1-2 inches. On 10/09/2024 at 1:55 PM, the Director of Environmental Services confirmed residents and visitors used the outside courtyard. The Director of Environmental Services confirmed five of the sprinkler heads were above ground level and were a potential tripping hazard. The Director of Environmental Services verbalized not having been aware a resident had tripped and fallen in the courtyard due to the sprinkler heads. On 10/09/2024 at 3:15 PM, the Director of Nursing (DON) confirmed a resident had a witnessed fall in the courtyard due to tripping over a sprinkler head. The DON could not confirm if the information from the resident fall had been conveyed to Maintenance. On 10/09/2024 at 3:26 PM, the Operations Manager verbalized having been unaware if Maintenance had been notified of a tripping hazard in the courtyard. The Operations Manager confirmed the FRI Final Report did not include corrective action to prevent future tripping occurrences. On 10/10/2024 at 1:11 PM, a Maintenance Staff member was in the courtyard digging up a sprinkler head. The Maintenance Staff member verbalized the sprinkler heads were being placed below ground level as they were a tripping hazard. The Maintenance Staff member confirmed the sprinkler heads were approximately 1-2 inches above ground level. The facility policy titled, Fall Management System, revised 12/2023, documented resident environments would be free from hazards with the potential to result in a fall, and interventions to prevent falls would be implemented. FRI #NV00071929