

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2025
NAME OF PROVIDER OR SUPPLIER Rosewood Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557</p> <p>Based on interview, clinical record review, and document review the facility failed to ensure an allegation of neglect was thoroughly investigated for 1 of 10 sampled residents (Resident #2). This deficient practice had the potential for physical and/or emotional harm to residents due to allegations of neglect not being thoroughly investigated and protections not put in place to prevent future neglect.</p> <p>Findings include:</p> <p>Resident #2</p> <p>Resident #2 was admitted to the facility on [DATE], with diagnoses including wedge compression fracture of T7-T8 vertebra, subsequent encounter for fracture with routine healing and encounter for other orthopedic aftercare.</p> <p>An initial Facility Reported Incident (FRI) Report submitted by the facility on [DATE], documented the type of incident as neglect. The FRI Report documented a Certified Nursing Assistant (CNA) reported a Blood Pressure (BP) reading for Resident #2 of ,d+[DATE] around 6:00 AM. The resident was found in the resident's room with no pulse, cold to touch, and with signs of rigor mortis around 7:10 AM. Emergency Medical Services (EMS) was called and arrived around 7:30 AM. The Vital Signs (VS) reported and the timeline of the patient passing away were not in agreement.</p> <p>A Nursing Progress Note dated [DATE], documented a CNA reported when delivering Resident #2's breakfast tray the resident was not responding to verbal stimuli and was cold to touch. The nurse entered the room, turned on the lights, and noted the resident was pale. The resident was not responsive to verbal stimuli or sternal rub, was cold to touch and stiff. Code blue initiated at 7:05 AM, Cardiopulmonary Resuscitation (CPR) was administered, and 911 was called. EMS arrived and the resident was pronounced deceased . The assigned CNA stated the CNA last saw and took the resident's VS at 6:00 AM.</p> <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2025
NAME OF PROVIDER OR SUPPLIER Rosewood Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 3:41 PM the Assistant Director of Nursing (ADON) confirmed the ADON was familiar with the incident reported on [DATE] involving Resident #2. The ADON recalled the ADON was involved in the investigation of the incident and collected statements from staff members. The ADON verbalized the ADON called the night (NOC) shift staff to ask when the last time the NOC shift staff had seen Resident #2 and asked if the resident was breathing at the time. The NOC shift staff did not report and were not asked about any care provided, if the resident was awake the last time the resident was seen by staff, or if the resident had experienced any changes in condition during the shift.</p> <p>Documentation of the facility's investigation of the incident, provided for review during the survey, included the following: the initial and final FRI reports submitted to the State Agency, a VS flowsheet, a Nursing Progress Note dated [DATE] written by the ADON, a Nursing Progress Note dated [DATE] written by the day shift LPN assigned to care for Resident #2, a typed statement written by the ADON, a typed statement written by the alleged perpetrator, and a handwritten statement from a second CNA working the day shift on [DATE]. The investigation lacked documentation of interviews with Resident #2's roommate at the time of the incident, interviews with other residents whom the accused CNA provided care or services to, and interviews with staff from other shifts who had provided care to Resident #2 or who had contact with the accused CNA.</p> <p>On [DATE] at 3:56 PM, the Administrator confirmed the Administrator oversaw the investigation into the allegation of neglect involving Resident #2. The Administrator recalled being notified at approximately 8:30 AM on [DATE] of the incident. The investigation was initiated and the ADON was to collect statements from staff members. During the investigation, record review consisted of VS to determine when VS had last been documented for Resident #2. The Administrator denied the Administrator saw any documentation of contact with Resident #2 after the NOC shift VS were documented at approximately 7:30 PM on [DATE]. After receiving the statements obtained by the ADON, the Administrator reviewed the statements in an attempt to determine if the actions of the alleged perpetrator were considered negligent. The Administrator denied the Administrator spoke to the alleged perpetrator during the investigation. The Administrator denied the Administrator spoke to or had knowledge of anyone speaking to staff members working the NOC shift on [DATE], and verbalized the Administrator should have asked the NOC shift CNA when the CNA had last seen Resident #2. The Administrator denied interviews were conducted with any residents as part of the investigation.</p> <p>The facility policy titled Abuse: Prevention of and Prohibition Against, reviewed ,d+[DATE], documented each resident had the right to be free from abuse and neglect. All allegations of abuse and neglect were to be promptly and thoroughly investigated by the Administrator or his/her designee. The investigation would include the following: an interview with the person reporting the incident, an interview with the resident, interviews with any witnesses to the incident including the alleged perpetrator, a review of the resident's medical record, an interview with staff members on all shifts who may have information regarding the alleged incident, interviews with other residents to whom the accused employee provides care or services to or who may have information regarding the alleged incident, interviews with staff members on all shifts having contact with the accused employee, and a review of all circumstances surrounding the incident. The investigation, and the results of the investigation, would be documented.</p> <p>FRI #NV00073992</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2025
NAME OF PROVIDER OR SUPPLIER Rosewood Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557</p> <p>Based on observation, interview, clinical record review, and document review the facility failed to ensure tube feeding was administered to a resident per physician order and a physician's order for tube feeding was complete prior to administration for 1 of 10 sampled residents (Resident #8). This deficient practice had the potential to result in malnutrition, dehydration, inadequate and inappropriate caloric intake.</p> <p>Findings include:</p> <p>Resident #8</p> <p>Resident #8 was admitted to the facility on [DATE], with a diagnosis of dysphagia following cerebral infarction.</p> <p>A Physician Order dated 03/09/2025, documented Enteral Feed Order at bedtime, 40 milliliters (ml)/ hour (hr). Hang at 8:00 PM and take down at 6:00 AM. The discontinue date was 04/22/2025 at 1:41 PM.</p> <p>A Physician Order dated 04/22/2025, with a start date of 04/23/2025, documented Enteral Feed Order one time a day, Jevity 1.2. On at 8:00 PM at 50 cubic centimeters (cc)/ hr for ten hours, off at 6:00 AM.</p> <p>On 04/23/2025 at 12:37 PM, a Licensed Practical Nurse 1 (LPN) explained staff knew a resident required tube feeding by reviewing orders in the Electronic Medical Record (EMR). The LPN1 verbalized Resident #8 received tube feeding. The LPN1 reviewed Resident #8's EMR and verbalized the resident's current tube feeding order documented Jevity 1.2 at 50 cc/ hr, starting at 8:00 PM and off at 6:00 AM. The order had a start date of 04/23/2025. The LPN1 explained the resident had been receiving tube feeding since admission to the facility and the LPN1 was unsure why the order had been updated.</p> <p>On 04/23/2025 at 12:51 PM, the interim Director of Nursing (DON) confirmed Resident #8's tube feeding order was updated 04/22/2025. The interim DON confirmed the tube feeding order in place prior to 04/22/2025 did not include the type of formula to be administered.</p> <p>On 04/23/2025 at 1:35 PM, Resident #8 was sitting on the resident's bed. The resident had a gastrostomy tube and explained the resident received tube feeding at night because the resident did not get enough liquid and protein during the day. Resident #8 verbalized a staff member reported Resident #8 had refused the tube feeding the evening of 04/21/2025. Resident #8 denied Resident #8 refused tube feeding as refusing the feeding could hurt the resident.</p> <p>Resident #8's Treatment Administration Record (TAR) for April 2025, documented Enteral Feed Order at bedtime, 40 ml/ hr. Hang at 8:00 PM and take down at 6:00 AM. The order date was 03/09/2025, and the discontinue date was 04/22/2025. The TAR documented a checkmark for the enteral feed from 04/01/2025 through 04/21/2025.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2025
NAME OF PROVIDER OR SUPPLIER Rosewood Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/23/2025 at 2:23 PM, the interim DON explained a checkmark on a TAR indicated the treatment was administered and denied it would be appropriate for staff to mark a treatment as administered prior to completion of the administration. The interim DON explained the facility's process when administering tube feeding to residents included assuring proper placement of the tube, positioning of the resident, assessing the insertion site, and assuring the order included the formula and rate of administration. If tube feeding was administered without a complete order, the resident could receive the wrong formula type, amount or for the wrong length of time.</p> <p>On 04/24/2025 at 2:06 PM, an LPN2 explained if a resident refused a medication or treatment the LPN2 would document the refusal in the resident's EMR. The LPN2 confirmed the LPN2 worked the night (NOC) shift on 04/21/2025 and Resident #8 was in the LPN2's assigned section. The LPN2 confirmed Resident #8 received nutrition via tube feeding. The feedings were ordered to be administered during the NOC shift. The LPN2 explained after completing the PM medication pass during the NOC shift beginning on 04/21/2025, the LPN2 prepared Resident #8's tube feeding, documented the administration as complete in the resident's EMR, and entered the resident's room. Resident #8 declined to have the tube feeding started at the time and asked the LPN2 to return in a few minutes. The LPN2 explained the LPN2 forgot to return to the room and administer Resident #8's tube feeding and had not documented a refusal. The LPN2 confirmed the tube feeding was not administered to Resident #8 as ordered and the completed administration was documented in error.</p> <p>The facility policy titled Tube Feeding - Nasogastric or Gastrostomy, revised 02/2024, documented it was the policy of the facility to assure safe practice in providing tube feedings. The procedure included preparing the feeding according to the physician's order, adding feeding sufficient for the resident's order, and documenting the feeding on the tube feeding record.</p> <p>A License Vocational Nurse / Licensed Practical Nurse Job Description, signed by the LPN2 on 03/04/2024, documented the primary purpose of the job position was to provide primary care to residents under the medical direction and supervision of the attending physician. Essential duties and responsibilities included administration of services within applicable scope of nursing practice such as tube feedings, preparing and administering medications as ordered by the physician, and charting nurses' notes to accurately and thoroughly reflect care provided to the resident.</p> <p>FRI #NV00074062</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2025
NAME OF PROVIDER OR SUPPLIER Rosewood Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557</p> <p>Based on clinical record review, interview, and document review the facility failed to ensure a clinical record was complete for 1 of 10 sampled residents (Resident #1). This deficient practice had the potential for care provided to residents, resident response to care provided, and refusals of care to not be documented and available for review as necessary.</p> <p>Findings include:</p> <p>Resident #1</p> <p>Resident #1 was admitted to the facility on [DATE], with diagnoses including multiple fractures of ribs, bilateral, subsequent encounter for fracture with delayed healing and mild protein-calorie malnutrition.</p> <p>Resident #1's Documentation Survey Report for September 2024, documented an intervention/task of bathing. The report documented Resident #1 received a shower on 09/02/2024 and 09/16/2024, and a full-body bath on 09/14/2024. The intervention/task had a blank space for the PM shifts on 09/06/2024, 09/11/2024 and 09/15/2024.</p> <p>An intervention/task titled shower/bathe self documented the resident received partial/moderate assistance from an Occupational Therapist (OT) with completion of the task on 09/03/2024.</p> <p>On 04/09/2025 at 1:24 PM, a Certified Nursing Assistant (CNA) verbalized residents were usually offered a shower two times per week. Showers were documented in the Point of Care (POC) system and a paper form was filled out if the CNA noted any concerns with the resident's skin during the shower. If a resident refused a shower, the CNA would attempt to reschedule the shower and/or offer an alternative such as a bed bath or partial bath. If the resident continued to refuse, the CNA would document the reason for the refusal, attempts to reschedule or alternative offered, and notify the resident's nurse.</p> <p>On 04/09/2025 at 3:56 PM, the Assistant Director of Nursing (ADON) explained residents were given showers two times per week and more frequently as needed. Showers were documented under the tasks section of the electronic medical record.</p> <p>On 04/09/2025 at 4:57 PM, the Administrator explained the usual days for showers for the room Resident #1 was in was Wednesdays and Saturdays. The Administrator reviewed the Documentation Survey Report for September 2024 and verbalized Resident #1 received a shower on 09/02/2024 and 09/03/2024 (Monday and Tuesday), by Saturday 09/07/2024, Resident #1 had tested positive for Covid-19. The Administrator explained when a resident was positive for Covid-19, the facility tried to limit the resident from using the communal shower room to help prevent the spread of infection. Facility staff would always offer a bed bath to residents positive for Covid-19 and verbalized if a resident refused, it was the Administrator's expectation the refusal would be documented.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2025
NAME OF PROVIDER OR SUPPLIER Rosewood Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/09/2025 at 5:25 PM, the Administrator confirmed Resident #1's clinical record lacked documentation of a shower or bed bath being provided to the resident and any resident refusals from 09/04/2024 through 09/13/2024.</p> <p>The facility policy titled Resident Care - Activities of Daily Living (ADLs), revised 10/2023, documented interventions would be provided by staff in accordance with professional standards of quality and clinical practices. ADL support and resident performance would be documented electronically using Point of Care (POC).</p>