

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 10/10/2024
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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848</p> <p>Based on observation, interview, clinical record review, and document review, the facility failed to ensure a resident was informed in advance of the menu options and alternative meal choices for 1 of 18 sampled residents (Resident #44). This deficient practice had the potential to result in a resident experiencing frustration due to a lack of choice and the resident having to wait longer to eat due to not wanting the offered meal and needing to request an alternative after the meal had been delivered.</p> <p>Findings include:</p> <p>Resident #44</p> <p>Resident #44 was admitted to the facility on [DATE], with diagnoses including multiple sclerosis, hypothyroidism, unspecified, and neuromuscular dysfunction of bladder, unspecified.</p> <p>On 10/07/2024 at 10:17 AM, Resident #44 verbalized the resident frequently had to send the resident's meal trays back to the kitchen and request a bowl of soup. The resident verbalized the resident was not aware of an alternative menu, but the facility was usually able to bring the resident a bowl of soup. The resident verbalized the resident was not notified of the menu in advance, so the resident did not know to request an alternative before the meal arrived. The resident verbalized the menu was posted on the wall on the other side of the resident's room and the resident was bedbound and unable to see the menu. The resident confirmed staff did not notify the resident of the items on the menu each day.</p> <p>The menu posted on the wall of Resident #44's room was dated for the previous week of 09/29/2024 through 10/05/2024.</p> <p>On 10/08/2024 at 1:52 PM, Resident #44 verbalized the resident had not been informed of the dinner menu for the day or a list of alternatives. The resident verbalized the resident was frustrated with the process of having to wait and see if the meal provided was something the resident would eat or if the resident would need to send the food back and request soup.</p> <p>The menu posted on the wall of Resident #44's room was still the menu dated for the previous week.</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
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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/09/2024 at 11:26 AM, the Dietary Manager (DM) verbalized the DM would deliver new menus to residents on Mondays. The DM verbalized the DM would tape the menu to the wall in the resident's room. The DM confirmed the DM did not have a process to ensure a resident with limited mobility was able to see the menu. The DM verbalized a staff member would need to read the menu to the resident and then read the alternative menu to the resident if they wanted an alternate meal.</p> <p>On 10/09/2024 at 11:56 AM, the Director of Nursing (DON) verbalized the menus in the resident's rooms should be the most up to date menu. The DON verbalized a bed bound resident with limited mobility would need to have the menu closer to the resident in an area where the resident could easily see the menu.</p> <p>On 10/10/2024 at 11:37 AM, a Certified Nursing Assistant (CNA) confirmed the menu posted on the wall in Resident #44's room was the menu from the previous week and the resident did not have a menu the resident would be able to see from the resident's bed. The CNA verbalized the CNAs did not notify residents of the menu items each day.</p> <p>The facility policy titled Resident Rights, dated 10/04/2016, documented the resident had the right to make choices about aspects of the resident's life in the facility which were important to the resident.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34524</p> <p>Based on clinical record review, interview, and document review, the facility failed to report resident to resident abuse to the State Agency (SA) within the required timeframes for 1 of 18 sampled residents (Resident #23).</p> <p>Findings include:</p> <p>Resident #23</p> <p>Resident #23 was admitted to the facility on [DATE], with diagnoses including vascular dementia, severe, with psychotic disturbance, and unspecified mood (affective) disorder.</p> <p>Resident #57</p> <p>Resident #57 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, with agitation, and unspecified mood (affective) disorder.</p> <p>A Behavior Note dated 10/05/2024, for Resident #57 documented upon walking into the resident's room, Resident #57 was seen slamming their wheelchair into their roommate, Resident #23's legs.</p> <p>A Facility Reported Incident (FRI) was submitted to the SA on 10/07/2024, documenting the resident to resident abuse between Resident #23 and Resident #57.</p> <p>On 10/10/2024 at 10:05 AM, the Abuse Coordinator verbalized abuse without serious bodily harm should be reported to the SA within 24 hours of the incident. The Abuse Coordinator confirmed the FRI was not reported to the SA within the required timeframes.</p> <p>The facility policy titled Abuse: Prevention of and Prohibition Against, revised 10/2022, documented allegations of abuse would be reported to the appropriate State or Federal agencies in the applicable timeframes, as per policy and applicable regulations.</p> <p>FRI #NV00072396</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848</p> <p>Based on observation, interview, clinical record review, and document review, the facility failed to ensure a care plan was developed to address side effects and necessary monitoring for a resident receiving an anticoagulant and experiencing symptoms of a gastrointestinal bleed and low hemoglobin (a protein carrying oxygen in red blood cells) and hematocrit (a measurement of the proportion of red blood cells in the blood) levels for 1 of 18 sampled residents (Resident #71); and failed to develop a care plan for a resident's diagnosis of hypoxemia and the administration of oxygen for 1 of 18 sampled residents (Resident #134). This deficient practice had the potential for the resident to suffer adverse health outcomes because of staff caring for the resident being unaware of the need to monitor for further signs of active bleeding.</p> <p>Findings include:</p> <p>Resident #71</p> <p>Resident #71 was admitted to the facility on [DATE], with diagnoses including cerebral infarction due to unspecified occlusion or stenosis of left cerebellar artery, chronic kidney disease, stage 3B, and acute cystitis without hematuria.</p> <p>On 10/07/2024 at 2:01 PM, the resident verbalized the resident had been on blood thinner medication and the resident had low blood.</p> <p>An order dated 09/04/2024, documented apixaban oral tablet 2.5 milligrams (mg), give one tablet by mouth two times a day for atrial fibrillation.</p> <p>A Change in Condition Progress Note, dated 09/30/2024, documented the resident had blood streaks in the stool. A Certified Nursing Assistant (CNA) had reported the resident had a blood-streaked stool. The licensed nurse visualized the stool and observed a red pigmentation in the stool. A sample was collected.</p> <p>An order dated 09/30/2024, documented labs: guaiac stool (a fecal occult blood test) - already collected and placed in the fridge.</p> <p>An Alert Charting Progress Note, dated 10/03/2024, documented the resident had low hemoglobin and hematocrit and to monitor for signs of gastrointestinal bleeding.</p> <p>The clinical record for Resident #71, lacked care plan documentation of the apixaban or the symptoms of gastrointestinal bleeding and did not include results of the fecal occult blood test.</p> <p>On 10/08/2024 at 1:52 PM, a Licensed Practical Nurse (LPN) providing care to Resident #71 verbalized the LPN was not familiar with Resident #71 having blood in the resident's stool or any concerns with the resident's lab values.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/09/2024 at 12:00 PM, the Director of Nursing (DON) verbalized a resident's use of a blood thinner medication would be care planned and the symptom of blood in a resident's stool would be care planned so staff caring for the resident would be aware of the issue and know to continue monitoring for further signs and symptoms of active bleeding. The DON confirmed the resident did not have a care plan for the apixaban or the concern related to blood in the resident's stool.</p> <p>On 10/09/2024 at 3:40 PM, the DON verbalized the stool sample had been sent to the lab in the wrong storage container on 09/30/2024, and a new sample had not been sent. The DON verbalized staff should have been aware of the need to track the results of the stool sample.</p> <p>The facility policy titled Best Practice in Change of Condition and Endorsement, revised 05/2016, documented after a change in medical condition, treatments/interventions would be updated on the care plan and the resident would be discussed during the next scheduled Comprehensive Care Plan meeting.</p> <p>31739</p> <p>Resident #134</p> <p>Resident #134 was admitted to the facility on [DATE], with a diagnosis of hypoxemia.</p> <p>On 10/07/2024 at 12:49 PM, Resident #134 was sitting in a wheelchair next to the bed. An oxygen concentrator, reading two liters-per-minute, next to the resident was on and the resident was receiving oxygen via a nasal cannula.</p> <p>Resident #134's clinical record lacked documented evidence a care plan had been developed for the resident's diagnosis of hypoxemia and the administration of oxygen.</p> <p>On 10/08/2024 at 2:42 PM, the DON confirmed Resident #134's diagnosis of hypoxemia and the resident had been receiving oxygen since admission. The DON confirmed Resident #134's clinical record lacked a care plan for the resident's diagnosis of hypoxemia and the administration of oxygen.</p> <p>The facility policy titled, Care and Treatment, Comprehensive Person-Centered Care Planning, revised 08/2017, documented the facility would develop a person-centered care plan with measurable objectives to meet the resident's medical needs.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848</p> <p>Based on interview, clinical record review, and document review, the facility failed to ensure laboratory (lab) results were monitored for timely completion and staff caring for a resident were informed of the resident's signs and symptoms of active bleeding while on anticoagulant therapy for 1 of 18 sampled residents (Resident #71). This deficient practice had the potential to result in a resident suffering a severe adverse health outcome because of blood loss.</p> <p>Findings include:</p> <p>Resident #71</p> <p>Resident #71 was admitted to the facility on [DATE], with diagnoses including cerebral infarction due to unspecified occlusion or stenosis of left cerebellar artery, chronic kidney disease, stage 3B, and acute cystitis without hematuria.</p> <p>On 10/07/2024 at 2:01 PM, the resident verbalized the resident had been on blood thinner medication and the resident had low blood.</p> <p>An order dated 09/04/2024, documented apixaban oral tablet 2.5 milligrams (mg), give one tablet by mouth two times a day for atrial fibrillation.</p> <p>A Change in Condition Progress Note, dated 09/30/2024, documented the resident had blood streaks in the stool. A Certified Nursing Assistant (CNA) had reported the resident had a blood-streaked stool. The licensed nurse visualized the stool and observed a red pigmentation in the stool. A sample was collected.</p> <p>An order dated 09/30/2024, documented labs: guaiac stool (a fecal occult blood test) - already collected and placed in the fridge.</p> <p>An Alert Charting Progress Note, dated 10/03/2024, documented the resident had low hemoglobin and hematocrit and to monitor for signs of gastrointestinal bleeding.</p> <p>The clinical record for Resident #71, lacked care plan documentation of the apixaban or the symptoms of gastrointestinal bleeding and did not include results of the fecal occult blood test.</p> <p>On 10/08/2024 at 1:52 PM, a Licensed Practical Nurse (LPN) providing care to Resident #71 verbalized the LPN was not familiar with Resident #71 having blood in the resident's stool or any concerns with the resident's lab values.</p> <p>On 10/09/2024 at 12:00 PM, the Director of Nursing (DON) verbalized a resident's use of a blood thinner medication would be care planned and the symptom of blood in a resident's stool would be care planned so staff caring for the resident would be aware of the issue and know to continue monitoring for further signs and symptoms of active bleeding. The DON confirmed the resident did not have a care plan for the apixaban or the concern related to blood in the resident's stool.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/09/2024 at 3:40 PM, the DON verbalized the stool sample had been sent to the lab in the wrong storage container on 09/30/2024, and a new sample had not been sent. The DON verbalized staff should have been aware of the need to track the results of the stool sample. The DON verbalized the results of the fecal occult blood test would be expected to be reported within two to three days and staff should have followed up with the lab and notified the physician so a new sample could have been collected.</p> <p>The facility policy titled Best Practice in Change of Condition and Endorsement, revised 05/2016, documented after a change in medical condition, treatments/interventions would be updated on the care plan and the resident would be discussed during the next scheduled Comprehensive Care Plan meeting.</p> <p>The facility standard of practice titled Fundamentals of Nursing, eighth edition, by [NAME] and [NAME], copyright 2013, documented the nurse would ensure fecal specimens were obtained accurately, labeled properly in appropriate containers, and transported to the laboratory on time. Special containers would be provided for fecal specimens (page 1097).</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31739</p> <p>Based on clinical record review, observation, interview, and document review, the facility failed to obtain a physician's order for the administration of oxygen for 1 of 18 sampled residents (Resident #134).</p> <p>Findings include:</p> <p>Resident #134</p> <p>Resident #134 was admitted to the facility on [DATE], with a diagnosis of hypoxemia.</p> <p>On 10/07/2024 at 12:49 PM, Resident #134 was sitting in a wheelchair next to the bed. An oxygen concentrator, reading two liters-per-minute, next to the resident was on and the resident was receiving oxygen via a nasal cannula.</p> <p>Resident #134's clinical record lacked documented evidence of a physician order for the administration of oxygen.</p> <p>On 10/08/2024 at 2:16 PM, Resident #134 verbalized not having used oxygen prior to being admitted to the facility and was unsure if the resident needed it.</p> <p>On 10/08/2024 at 2:42 PM, the Director of Nursing confirmed Resident #134 had been receiving oxygen since admission and confirmed Resident #134's clinical record lacked a physician order for oxygen.</p> <p>The facility policy titled, Licensed Nurse Procedures, Oxygen Administration, revised 04/2016, documented oxygen therapy was to be administered as ordered by a physician or as an emergency measure until an order could be obtained.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>34524</p> <p>Based on observation, interview, and document review the facility failed to ensure medications were not left unsecured in a medication cart. The deficient practice could have facilitated unauthorized access to medications in the cart.</p> <p>Findings include:</p> <p>On 10/09/2024 at 11:44 AM, a medication cart located outside of the nurse's station was unlocked and unattended while a resident and visitors were in the hallway.</p> <p>On 10/09/2024 at 11:46 AM, the Director of Nursing (DON) approached the medication cart and verbalized the expectation was medication carts remain locked when unattended. The DON confirmed the medication cart was unlocked and a resident and visitors were present.</p> <p>The facility policy titled Storage of Medication, dated 2007, documented only licensed nurses and those lawfully authorized to administer medications were allowed access to medication carts. Medication rooms, cabinets, and medication supplies should remain locked when not in use or attended by persons with authorized access.</p>

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31739</p> <p>Based on clinical record review, observation and interview, the facility failed to ensure a resident's diet order was followed for 1 of 18 sampled residents (Resident #134).</p> <p>Findings include:</p> <p>Resident #134</p> <p>Resident #134 was admitted to the facility on [DATE], with diagnoses including acute kidney failure and chronic kidney disease, stage four.</p> <p>On 10/07/2024 at 12:18 PM, Resident #134 was sitting in a wheelchair next to the bed. A tray table was in front of the resident with the resident's lunch meal of pureed cheese enchiladas, pureed Spanish rice and refried beans. A meal ticket, dated 10/07/2024 for lunch, documented Resident #134's name and room number, with a diet order of mechanical soft, low fiber. The resident appeared to have their own teeth.</p> <p>On 10/07/2024 at 12:20 PM, Resident #134 verbalized not knowing why the resident had been receiving meals with pureed or mechanically altered foods. The resident verbalized the food tasted good but did not like the texture of the soft food.</p> <p>A physician's order dated 10/01/2024, documented regular diet, regular texture, thin liquid consistency, low fiber.</p> <p>On 10/08/2024 at 12:14 PM, Resident #134 was eating lunch in the resident's room. The resident verbalized wanting to know why the resident had still been receiving mechanically altered meals as the resident had all their own teeth, had no swallowing issues, and had no food allergies.</p> <p>On 10/08/2024 at 12:40 PM, the Dietary Supervisor provided a Diet Communication Form, undated, for Resident #134. The form documented low fiber, (gastrointestinal (GI) soft) diet, thin liquids, and no known allergies.</p> <p>On 10/08/2024 at 12:41 PM, the Dietary Supervisor verbalized not having known what a GI soft diet was, and after having Googled what a GI soft diet was, concluded it to be a mechanically altered diet. The Dietary Supervisor verbalized not having communicated with nursing staff to clarify the resident's diet order.</p> <p>On 10/08/2024 at 2:02 PM, the Director of Nursing (DON) verbalized a GI diet was not considered a mechanically altered diet and the diet order should have been clarified with nursing if there had been any questions.</p> <p>On 10/08/2024 at 2:48 PM, the DON verbalized the facility did not have a policy related to following diet orders.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>34524</p> <p>Based on observation and interview, the facility failed to ensure the ice machine was free of buildup and refrigerated foods were covered, labeled and dated. The deficient practice could potentially expose residents to foodborne illnesses.</p> <p>Findings include:</p> <p>Ice Machine</p> <p>On 10/07/2024 at 8:18 AM, the ice machine in the kitchen had black buildup on the plastic visor above the ice.</p> <p>On 10/07/2024 at 8:35 AM, the Dietary Manager (DM) verbalized the ice machine was cleaned every three months. The expectation was the staff would clean any visible buildup in the machine. The DM confirmed the buildup in the ice machine and should have been cleaned.</p> <p>Uncovered Food</p> <p>On 10/09/2024 at 11:22 AM, three cups of fruit cocktail were uncovered in the trayline refrigerator.</p> <p>On 10/09/2024 at 11:27 AM, the [NAME] verbalized food stored in the refrigerator would be covered and labeled with the date. The [NAME] confirmed three cups of fruit cocktail were uncovered in the refrigerator.</p> <p>On 10/09/2024 at 11:30 AM, the DM verbalized the expectation was food in refrigerator was covered and labeled with the date.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>41848</p> <p>Based on interview and document review, the facility failed to ensure water samples were collected and submitted for Legionella testing on a five-year basis as per the facilities water management policy. This deficient practice had the potential to result in resident illnesses from undetected bacteria in the facility water lines.</p> <p>Findings include:</p> <p>On 10/09/2024 at 4:19 PM, the Director of Environmental Services (Director) verbalized the maintenance department was responsible for the water management program within the facility. The Director verbalized the facility did not have results of Legionella testing and the Director did not know when testing was last conducted. The Director verbalized the facility did not have a plan to conduct testing at a future date. The Director confirmed the current practice was not following the facility policy for Legionella testing frequency.</p> <p>The facility policy titled Rosewood Rehabilitation Center Control Measures, undated, documented control areas would have random water samples collected and submitted for Legionella testing on a five-year basis, to a certified testing facility. Additional testing and frequency would be completed depending on testing results as needed.</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 10/10/2024
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 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>50210</p> <p>Based on personnel record review, interview and document review, the facility failed to ensure annual elder abuse training was completed for 1 of 25 sampled employees (Employee #9).</p> <p>Findings include:</p> <p>Employee #9</p> <p>Employee #9 was hired as a Registered Nurse on 12/10/2015.</p> <p>Employee #9's personnel record documented elder abuse training completed on 08/27/2023 but lacked documented evidence elder abuse training was completed in 2024</p> <p>On 10/09/2024 at 11:18 AM, during an interview for review of personnel records, the Human Resources Representative (HRR) verbalized all staff were required to complete elder abuse training upon hire prior to starting on the floor, and annually thereafter. The HRR confirmed Employee #9's personnel record lacked annual elder abuse training in 2024.</p> <p>A facility policy titled Abuse: Prevention of and Prohibition Against, revised 05/2023, documented the facility would engage in training and orienting its new and existing nursing staff on topics to include prohibiting and preventing all forms of abuse, identifying what constitutes abuse, recognizing signs of abuse, and reporting abuse.</p>		